



MCNA Insurance Company
Dental Benefit Management Program Request for Proposals

RFP # 305PUR-DHHRFP-DENTAL-PAHP-MVA



Part One: Mandatory Requirements

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Scoring Grid (Part One)

LOUISIANA BAYOU HEALTH PROGRAM DBP PROPOSAL SUBMISSION AND EVALUATION REQUIREMENTS RFP # 305PUR-DHHRFP-DENTAL-PAHP-MVA			
Proposer Name	MCNA Insurance Company		
THE PROPOSER MUST COMPLETE THIS FORM AND SUBMIT WITH THEIR PROPOSAL			
PART ONE: MANDATORY REQUIREMENTS			
<p>The Proposer shall address ALL Mandatory Requirements section items and should provide, in sequence, the information and documentation as required (referenced with the associated item references).</p> <p>The DHH Division of Contracts and Procurement Support will review all general mandatory requirements.</p> <p>The DHH Division of Contracts and Procurement Support will also review the proposal to determine if the Mandatory Requirement Items (below) are met and mark each with included or not included.</p> <p>Any contract resulting from this RFP process shall incorporate by reference the respective proposal responses to all items below as a part of said Contract (Refer to Section IV and V of RFP).</p> <p>The Proposer shall adhere to the specification outlined in Section IV and V of the RFP in responding to this RFP. The Proposer should complete all columns marked in ORANGE ONLY.</p> <p>NOTICE: In addition to these requirements, DHH will also evaluate compliance with ALL other RFP provisions.</p>			
Proposal Section and Page Number	PART ONE: MANDATORY REQUIREMENT ITEMS	For State Use Only	
		Included/Not Included	DHH Comments
A-1	A.1 Provide the Proposal Certification Statement (RFP Attachment II) completed and signed, in the space provided, by an individual empowered to bind the Proposer to the provisions of this RFP and any resulting contract. <i>The Proposer must sign the Proposal Certification Statement without exception or qualification.</i>		
A-3	A.2 Provide a statement signed by an individual empowered to bind the Proposer to the provisions of this RFP and any resulting contract guaranteeing that there will be no conflict or violation of the Ethics Code if the Proposer is awarded a contract. Ethics issues are interpreted by the Louisiana Board of Ethics.		

A Word From Our Founder

REDACTED

REDACTED

Letter of Intent



January 17, 2014

Mary Fuentes
Department of Health and Hospitals
Division of Contracts and Procurement Support
628 N 4th Street, 5th Floor
Baton Rouge, LA 70802

Dear Ms. Fuentes:

MCNA Insurance Company, a Texas accident and health insurance company ("MCNA") is proud to submit this Notice of Intent to Propose in response to **RFP# 305PUR-DHHRFP-DENTAL-PAHP-MVA, Dental Benefit Management Program Request for Proposals** (the "RFP"). MCNA specializes in administering dental benefits for nearly three million economically challenged children and adults eligible for CHIP and Medicaid programs in Florida and Texas. We have successfully administered diverse dental benefit plans for this population for nearly a decade.

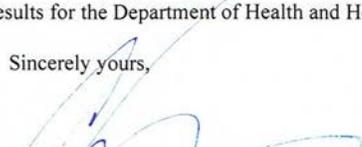
This letter will confirm the intent of MCNA to submit a statewide response to RFP# 305PUR-DHHRFP-DENTAL-PAHP-MVA to provide statewide dental benefits to all eligible children in all 64 parishes of the state of Louisiana.

For the purposes of this RFP response, I shall be the designated official vendor contact with full authority to attend vendor meetings and bind MCNA to a contract or amendment. Here is my contact information:

Carlos A. Lacasa, Esq.
Senior Vice President and General Counsel
200 West Cypress Creek Road, Suite #500
Fort Lauderdale, FL 33309
Tel: 954-730-7131, ext. 163
Fax: 954-628-3337
Email: clacasa@mcna.net

We look forward to the opportunity to serve the Medicaid eligible children and adults of Louisiana and to deliver high quality and cost effective results for the Department of Health and Hospitals and the state.

Sincerely yours,



Carlos A. Lacasa
Senior Vice President and General Counsel

Cc. Dr. Jeffrey P. Feingold, CEO

200 West Cypress Creek Road • Suite 500 • Fort Lauderdale, Florida 33309
(954) 730-7131 • (800) 494-6262 • Fax (954) 730-7875 • www.mcna.net

Section A.1

Provide the **Proposal Certification Statement (RFP Attachment II)** completed and signed, in the space provided, by an individual empowered to bind the Proposer to the provisions of this RFP and any resulting contract.

The Proposer must sign the Proposal Certification Statement without exception or qualification.

CERTIFICATION STATEMENT

The undersigned hereby acknowledges she/he has read and understands all requirements and specifications of the Request for Proposals (RFP), including attachments.

OFFICIAL CONTACT: The State requests that the Proposer designate one person to receive all documents and the method in which the documents are best delivered. Identify the Contact name and fill in the information below: (Print Clearly)

Date:	March 1, 2014
Official Contact Name:	Carlos A. Lacasa, Esq.
Email Address:	clacasa@mcna.net
Fax Number with Area Code:	(954) 628-3337
Telephone Number:	(954) 730-7131, x163
Street Address:	200 West Cypress Creek Road, Suite #500
City, State, and ZIP:	Fort Lauderdale, Florida 33309

Proposer certifies that the above information is true and grants permission to the Department to contact the above named person or otherwise verify the information I have provided.

By its submission of this proposal and authorized signature below, proposer certifies that:

1. The information contained in its response to this RFP is accurate;
2. Proposer complies with each of the mandatory requirements listed in the RFP and will meet or exceed the functional and technical requirements specified therein;
3. Proposer accepts the procedures, evaluation criteria, mandatory contract terms and conditions, and all other administrative requirements set forth in this RFP.

Part One: Mandatory Requirements



Section A: Mandatory Requirements

- 4. Proposer's technical proposals are valid for at least 90 days from the date of proposer's signature below;
- 5. Proposer understands that if selected as the successful Proposer, he/she will have **45** calendar days from the date of delivery of initial contract in which to complete contract negotiations, if any, and execute the final contract document. The Department has the option to waive this deadline if actions or inactions by the Department cause the delay.
- 6. Proposer certifies, by signing and submitting a proposal for \$25,000 or more, that their company, any subcontractors, or principals are not suspended or debarred by the General Services Administration (GSA) in accordance with the requirements in OMB Circular A-133. (A list of parties who have been suspended or debarred can be viewed via the internet at <https://www.sam.gov>).

Authorized Signature: <i>Original Signature Only: Electronic or Photocopy Signature are NOT Allowed</i>	
Print Name:	Carlos A. Lacasa, Esq.
Title:	Senior Vice President and General Counsel

Section A.2

Provide a statement signed by an individual empowered to bind the Proposer to the provisions of this RFP and any resulting contract guaranteeing that there will be no conflict or violation of the Ethics Code if the Proposer is awarded a contract. Ethics issues are interpreted by the Louisiana Board of Ethics.

I, Carlos A. Lacasa, Senior Vice President and General Counsel, am empowered to bind MCNA to the provisions of the RFP and any resulting contract and hereby guarantee that there will be no conflict or violation of the Ethics Code if MCNA is awarded a contract. I further understand and agree that ethics issues are interpreted by the Louisiana Board of Ethics.

Carlos A. Lacasa, Esq.

Senior Vice President and General Counsel

Part Two: Technical Approach

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M	Grievances and Appeals
N	Fraud and Abuse
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P	Claims Management
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Scoring Grid (Part Two)

LOUISIANA BAYOU HEALTH PROGRAM DBP PROPOSAL SUBMISSION AND EVALUATION REQUIREMENTS RFP # 305PUR-DHHRFP-DENTAL-PAHP-MVA				
Proposer Name	MCNA Insurance Company			
THE PROPOSER MUST COMPLETE THIS FORM AND SUBMIT WITH THEIR PROPOSAL				
PART TWO: TECHNICAL PROPOSAL AND EVALUATION GUIDE				
<p>The Proposer should adhere to the specifications outlined in Section V of the RFP in responding to this RFP. The Proposer should address ALL section items and provide, in sequence, the information and documentation as required (referenced with the associated item references and text and complete all columns marked in ORANGE ONLY).</p> <p>Proposal Evaluation Teams, made up of teams of State employees, will evaluate and score the proposal's responses.</p> <p>For those items in Part II that state "Included/Not Included" the proposals will be scored as follows:</p> <ol style="list-style-type: none"> a. All items scored Included = 0 points b. If 1-3 items are scored "Not Included" = -10 points c. If 4-5 items are scored "Not Included" = -20 points d. If more than 6 items are scored "Not Included" = -30 points <p>Any contract resulting from this RFP process shall incorporate by reference the respective proposal responses to all items below as a part of said contract.</p>				
Proposal Section and Page Number	PART TWO: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	B. Qualifications and Experience (Sections 2, 3, and 4 of the RFP)	155		
B-1	<p>B.1 Indicate your organization's legal name, trade name, <i>dba</i>, acronym, and any other name under which you do business; the physical address, mailing address, and telephone number of your headquarters office. Provide the legal name for your organization's ultimate parent (e.g. publicly traded corporation).</p> <p>Describe your organization's form of business (i.e., individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and detail the names, mailing address, and telephone numbers of its officers and directors and any partners (if applicable). Provide the name and address of any oral health care professional that has at least a five percent (5%) financial interest in your organization, and the type of financial interest.</p>	Included/Not Included		

Part Two: Technical Approach

Scoring Grid (Part Two)



Proposal Section and Page Number	PART TWO: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	<p>Provide your federal taxpayer identification number and Louisiana taxpayer identification number.</p> <p>Provide the name of the state in which you are incorporated and the state in which you are commercially domiciled. If out-of-state, provide the name and address of the local representative; if none, so state.</p> <p>If you have been engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state.</p>			
B-4	<p>B.2 Provide a statement of whether there have been any mergers, acquisitions, or sales of your organization within the last ten years, and if so, an explanation providing relevant details. If any change of ownership is anticipated during the 12 months following the Proposal Due Date, describe the circumstances of such change and indicate when the change is likely to occur. Include your organization's parent organization, affiliates, and subsidiaries.</p>	Included/Not Included		
B-5	<p>B.3 Provide a statement of whether you or any of your employees, agents, independent contractors, or subcontractors have ever been convicted of, pled guilty to, or pled <i>nolo contendere</i> to any felony and/or any Medicaid or health care related offense or have ever been debarred or suspended by any federal or state governmental body. Include an explanation providing relevant details and the corrective action plan implemented to prevent such future offenses. Include your organization's parent organization, affiliates, and subsidiaries.</p>	0 to -25		
B-6	<p>B.4 Provide a statement of whether there is any pending or recent (within the past five years) litigation against your organization. This shall include but not be limited to litigation involving failure to provide timely, adequate or quality dental services. You do not need to report workers' compensation cases. If there is pending or recent litigation against you, describe the damages being sought or awarded and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Include a name and contact number of legal counsel to discuss pending litigation or recent litigation. Also include any SEC filings discussing any pending or recent litigation. Include your organization's parent organization, affiliates, and subsidiaries.</p>	0 to -25		

Part Two: Technical Approach

Scoring Grid (Part Two)



Proposal Section and Page Number	PART TWO: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
B-8	<p>B.5 Provide a statement of whether, in the last ten years, you or a predecessor company has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, provide an explanation providing relevant details including the date in which the Proposer emerged from bankruptcy or expects to emerge. If still in bankruptcy, provide a summary of the court-approved reorganization plan. Include your organization's parent organization, affiliates, and subsidiaries.</p>	0 to -50		
B-9	<p>B.6 If your organization is a publicly-traded (stock-exchange-listed) corporation, submit the most recent United States Securities and Exchange Commission (SEC) Form 10K Annual Report, and the most-recent 10-Q Quarterly report.</p> <p>Provide a statement whether there have been any Securities Exchange Commission (SEC) investigations, civil or criminal, involving your organization in the last ten (10) years. If there have been any such investigations, provide an explanation with relevant details and outcome. If the outcome is against the Proposer, provide the corrective action plan implemented to prevent such future offenses. Also provide a statement of whether there are any current or pending Securities Exchange Commission investigations, civil or criminal, involving the Proposer, and, if such investigations are pending or in progress, provide an explanation providing relevant details and provide an opinion of counsel as to whether the pending investigation(s) will impair the Proposer's performance in a contract/Agreement under this RFP. Include your organization's parent organization, affiliates, and subsidiaries.</p>	0 to -10		
B-10	<p>B.7 If another corporation or entity either substantially or wholly owns your organization, submit the most recent detailed financial reports for the parent organization. If there are one (1) or more intermediate owners between your organization and the ultimate owner, this additional requirement is applicable only to the ultimate owner.</p> <p>Include a statement signed by the authorized representative of the parent organization that the parent organization will unconditionally guarantee performance by the proposing organization of each and every obligation, warranty, covenant, term and condition of the Contract.</p>	Included/Not Included		

Part Two: Technical Approach

Scoring Grid (Part Two)



Proposal Section and Page Number	PART TWO: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
B-15	<p>B.8 Describe your organization's number of employees, client base, and location of offices. Submit an organizational chart (marked as Chart A of your response) showing the structure and lines of responsibility and authority in your company. Include your organization's parent organization, affiliates, and subsidiaries.</p>	Included/Not Included		
B-21	<p>B.9 Provide a narrative description of your proposed Bayou Health project team, its members, and organizational structure including an organizational chart showing the Louisiana organizational structure, including staffing and functions performed at the local level.</p>	5		
B-24	<p>B.10 Attach a personnel roster and resumes of key people who shall be assigned to perform duties or services under the Contract, highlighting the key people who shall be assigned to accomplish the work required by this RFP and illustrate the lines of authority. Submit current resumes of key personnel documenting their educational and career history up to the current time. Include information on how long the personnel have been in these positions and whether the position included Medicaid managed care experience.</p> <p>If any of your personnel named is a current or former Louisiana state employee, indicate the Agency where employed, position, title, termination date, and last four digits of the Social Security Number.</p> <p>If personnel are not in place, submit job descriptions outlining the minimum qualifications of the position(s). Each resume or job description should be limited to 2 pages.</p> <p>For key positions/employees which are not full time provide justification as to why the position is not full time. Include a description of their other duties and the amount of time allocated to each.</p>	15		
B-69	<p>B.11 Provide a statement of whether you intend to use major subcontractors (as defined in the RFP Glossary), and if so, the names and mailing addresses of the subcontractors and a description of the scope and portions of the work for each subcontractor with more than \$100,000 annually. Describe how you intend to monitor and evaluate subcontractor performance. Also specify whether the subcontractor is currently providing services for you in other states and where the subcontractor is located.</p> <p>In addition, as part of the response to this item, for</p>	5		

Part Two: Technical Approach

Scoring Grid (Part Two)



Proposal Section and Page Number	PART TWO: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	<p>each major subcontractor that is not your organization's parent organization, affiliate, or subsidiary, restate and respond to items B.1 through B.7, B.10 and, B.15 through B.23</p> <p>If the major subcontractor is your organization's parent organization, affiliate, or subsidiary, respond to items B.1, B.8 and B.9. You do not need to respond to the other items as part of the response to B11; note, however, responses to various other items in Section B must include information on your organization's parent organization, affiliates, and subsidiaries, which would include any major subcontractors that are your organization's parent organization, affiliate, or subsidiary.</p>			
B-73	B.12 Provide a description your Corporate Compliance Program including the Compliance Officer's levels of authority and reporting relationships. Include an organizational chart of staff (marked as Chart B in your response) involved in compliance along with staff levels of authority.	10		
B-98	B.13 Provide copies of any press releases in the twelve (12) months prior to the Deadline for Proposals, wherein the press release mentions or discusses financial results, acquisitions, divestitures, new facilities, closures, layoffs, significant contract awards or losses, penalties/fines/ sanctions, expansion, new or departing officers or directors, litigation, change of ownership, or other very similar issues, Do not include press releases that are primarily promotional in nature.	5		
B-107	B.14 Provide the following information (in Excel format) based on each of the financial statements provided in response to item B:27: (1) Working capital; (2) Current ratio; (3) Quick ratio; (4) Net worth; and (5) Debt-to-worth ratio.	10		
B-108	B.15 Identify, in Excel format, all of your organization's publicly-funded managed care contracts for Medicaid/CHIP and/or other low-income individuals within the last five (5) years. In addition, identify, in Excel format your organization's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP and/or other low-income individuals within the last five (5) years. For each prior experience identified, provide the trade name, a brief description of the scope of work, the duration of the contract, the contact name and phone number, the number of members and the population types (e.g., TANF, ABD, duals, CHIP), the annual contract	25		

Part Two: Technical Approach

Scoring Grid (Part Two)



Proposal Section and Page Number	PART TWO: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	<p>payments, whether payment was capitated or other, and the role of subcontractors, if any. If your organization has not had any publicly-funded managed care contracts for Medicaid/SCHIP individuals within the last five (5) years, identify the Proposer's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP individuals within the last five (5) years and provide the information requested in the previous sentence. Include your organization's parent organization, affiliates, and subsidiaries.</p>			
B-113	<p>B.16 Identify whether your organization has had any contract terminated or not renewed within the past five (5) years. If so, describe the reason(s) for the termination/nonrenewal, the parties involved, and provide the address and telephone number of the client. Include your organization's parent organization, affiliates, and subsidiaries.</p>	Included/Not Included		
B-115	<p>B.17 If the contract was terminated/non-renewed in B.16 above, based on your organization's performance, describe any corrective action taken to prevent any future occurrence of the problem leading to the termination/non-renewal. Include your organization's parent organization, affiliates, and subsidiaries.</p>	0 to -50		
B-116	<p>B.18 As applicable, provide (in table format) the Proposer's current ratings as well as ratings for each of the past three years from each of the following:</p> <ul style="list-style-type: none"> • AM Best Company (financial strengths ratings); • TheStreet.com, Inc. (safety ratings); and • Standard & Poor's (long-term insurer financial strength). 	Included/Not Included		
B-117	<p>B.19 For any of your organization's contracts to provide oral health services within the past five years, has the other contracting party notified the Proposer that it has found your organization to be in breach of the contract? If yes: (1) provide a description of the events concerning the breach, specifically addressing the issue of whether or not the breach was due to factors beyond the Proposer's control. (2) Was a corrective action plan (CAP) imposed? If so, describe the steps and timeframes in the CAP and whether the CAP was completed. (3) Was a sanction imposed? If so, describe the sanction, including the amount of any monetary sanction (e.g., penalty or liquidated</p>	0 to -20		

Part Two: Technical Approach

Scoring Grid (Part Two)



Proposal Section and Page Number	PART TWO: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	damage) (4) Was the breach the subject of an administrative proceeding or litigation? If so, what was the result of the proceeding/litigation? Include your organization's parent organization, affiliates, and subsidiaries.			
B-118	B.20 Provide (as an attachment) a copy of the most recent external quality review report (pursuant to Section 1932(c)(2) of the Social Security Act) for the Medicaid contract identified in response to item B.16 that had the largest number of enrollees as of January 1, 2012. Provide the entire report. In addition, provide a copy of any corrective action plan(s) requested of your organization (including your organization's parent organization, affiliates, and subsidiaries) in response to the report.	10		
B-150	B.21 Identify and describe any regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against your organization within the last five (5) years. In addition, identify and describe any letter of deficiency issued by as well as any corrective actions requested or required by any federal or state regulatory entity within the last five (5) years that relate to Medicaid or CHIP contracts. Include your organization's parent organization, affiliates, and subsidiaries.	0 to -15		
B-153	B.22 Provide a statement of whether your organization is currently the subject or has recently (within the past five (5) years) been the subject of a criminal or civil investigation by a state or federal agency other than investigations described in response to item B.6. If your organization has recently been the subject of such an investigation, provide an explanation with relevant details and the outcome. If the outcome is against your organization, provide the corrective action plan implemented to prevent such future offenses. Include your organization's parent company, affiliates and subsidiaries.	0 to -10		
B-154	B.23 Submit customer references (minimum of two, maximum of five) for your organization for major contracts; with at least one reference for a major contract you have had with a state Medicaid agency or other large similar government or large private industry contract. Each reference must be from contracts within the last five (5) years. References for your organization shall be submitted to the State using the questionnaire contained in RFP Attachment VII. You are solely responsible for obtaining the fully	20		

Part Two: Technical Approach

Scoring Grid (Part Two)



Proposal Section and Page Number	PART TWO: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	<p>completed reference check questionnaires, and for submitting them sealed by the client providing the reference, with your Proposal, as described herein. You should complete the following steps:</p> <ol style="list-style-type: none"> a. Make a duplicate (hard copy or electronic document) of the appropriate form, as it appears in RFP Attachment VII (for your organization or for subcontractors, adding the following customized information: <ol style="list-style-type: none"> a. Your/Subcontractor’s name; b. Reference organization’s name; and c. Reference contact’s name, title, telephone number, and email address. b. Send the form to each reference contact along with a new, sealable standard #10 envelope; c. Give the contact a deadline that allows for collection of all completed questionnaires in time to submit them with your sealed Proposal; d. Instruct the reference contact to: <ol style="list-style-type: none"> a. Complete the form in its entirety, in either hard copy or electronic format (if completed electronically, an original should be printed for submission); b. Sign and date it; c. Seal it in the provided envelope; d. Sign the back of the envelope across the seal; and e. Return it directly to you. e. Enclose the unopened envelopes in easily identifiable and labeled larger envelopes and include these envelopes as a part of the Proposal. When DHH the opens your Proposal, it should find clearly labeled envelope(s) containing the sealed references. <p>THE STATE WILL NOT ACCEPT LATE REFERENCES OR REFERENCES SUBMITTED THROUGH ANY OTHER CHANNEL OF SUBMISSION OR MEDIUM, WHETHER WRITTEN, ELECTRONIC, VERBAL, OR OTHERWISE.</p>			

Part Two: Technical Approach

Scoring Grid (Part Two)



Proposal Section and Page Number	PART TWO: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	<p>Each completed questionnaire should include:</p> <ul style="list-style-type: none"> Proposing Organization/Subcontractor's name; Reference Organization's name; Name, title, telephone number, and email address of the organization contact knowledgeable about the scope of work; Date reference form was completed; and Responses to numbered items in RFP Attachment # (as applicable). <p>DHH reserves the authority to clarify information presented in questionnaires and may consider clarifications in the evaluation of references. However DHH is under no obligation to clarify any reference check information.</p>			
B-156	<p>B.24 Indicate the website address (URL) for the homepage(s) of any website(s) operated, owned, or controlled by your organization, including any that the Proposer has contracted to be run by another entity as well as details of any social media presence (e.g. Facebook, Twitter). If your organization has a parent, then also provide the same for the parent, and any parent(s) of the parent. If no websites and/or social media presence, so state.</p>	Included/Not Included		
B-162	<p>B.25 Provide evidence that the Proposer has applied to Louisiana Department of Insurance for a certificate of authority (COA) to establish and operate a prepaid entity as defined in RS 22:1016 and in accordance with rules and regulations as defined by the Department of Health and Hospitals.</p>	0 to -10		
B-163	<p>B.26 Provide the following as documentation of financial responsibility and stability:</p> <ul style="list-style-type: none"> a current written bank reference, in the form of a letter, indicating that the Proposer's business relationship with the financial institution is in positive standing; two current written, positive credit references, in the form of a letters, from vendors with which the Proposer has done business or, documentation of a positive credit rating determined by an accredited credit bureau within the last 6 months; a copy of a valid certificate of insurance indicating liability insurance in the amount of at least one million dollars (\$1,000,000) per 	25		

Part Two: Technical Approach

Scoring Grid (Part Two)



Proposal Section and Page Number	PART TWO: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	<p>occurrence and three million dollars (\$3,000,000) in the aggregate; and</p> <ul style="list-style-type: none"> a letter of commitment from a financial institution (signed by an authorized agent of the financial institution and detailing the Proposer's name) for a general line of credit in the amount of five-hundred thousand dollars (\$500,000.00). 			
<p>B-171</p>	<p>B.27 Provide the following as documentation of the Proposer's sufficient financial strength and resources to provide the scope of services as required:</p> <ul style="list-style-type: none"> The two most recent independently audited financial statements and associated enrollment figures from the Proposer. Compiled or reviewed financial statements will not be accepted. The audited financial statements must be: <ul style="list-style-type: none"> Prepared with all monetary amounts detailed in U.S. currency; Prepared under U.S. generally accepted accounting principles; Audited under U.S. generally accepted auditing standards. The audited financial statements must include the auditor's opinion letter, financial statements, and the notes to the financial statements. The Proposer's four (4) most recent internally prepared unaudited quarterly financial statements (and Year-to-Date), with preparation dates indicated. The statements must include documentation disclosing the amount of cash flows from operating activities. This documentation must indicate whether the cash flows are positive or negative, and if the cash flows are negative for the quarters, the documentation must include a detailed explanation of the factors contributing to the negative cash flows. Verification of any contributions made to the Proposer to improve its financial position after its most recent audit (e.g., copies of bank statements and deposit slips), if applicable. <p>Proposer shall include the Proposer's parent organization.</p>	<p>25</p>		

Part Two: Technical Approach

Scoring Grid (Part Two)



Proposal Section and Page Number	PART TWO: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	Section C: Planned Approach to Project	75		
C-1	<p>Describe how you will launch a network and set up operations capable of supporting its membership and meeting the requirements of the RFP by May 1, 2014.</p> <p>C.1 Discuss your approach for meeting the implementation requirements and include:</p> <ul style="list-style-type: none"> • A detailed description of your project management methodology. The methodology should address, at a minimum, the following: <ul style="list-style-type: none"> ○ Issue identification, assessment, alternatives analysis and resolution; ○ Resource allocation and deployment; ○ Reporting of status and other regular communications with DHH, including a description of your proposed method for ensuring adequate and timely reporting of information to DHH project personnel and executive management; and ○ Automated tools, including use of specific software applications. 	20		
C-20	<p>C.2 Provide a work plan for the implementation of the Louisiana Medicaid DBP Program. At a minimum the work plan should include the following:</p> <ul style="list-style-type: none"> • Tasks associated with your establishment of a “project office” or similar organization by which you will manage the implementation of the DBP Program; • An itemization of activities that you will undertake during the period between the awarding of this procurement and the start date of the DBP Program. These activities shall have established deadlines and timeframes and as needed conform to the timelines established under this RFP for deliverables. <ul style="list-style-type: none"> ○ All activities to prepare for and participate in the Readiness Review Process; and ○ All activities necessary to obtain required contracts for mandatory 	15		

Part Two: Technical Approach

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Proposal Section and Page Number	PART TWO: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	<p>dental care providers as specified in this RFP.</p> <ul style="list-style-type: none"> • An estimate of person-hours associated with each activity in the Work Plan; • Identification of interdependencies between activities in the Work Plan; and • Identification of your expectations regarding participation by DHH and/or its agents in the activities in the Work Plan and dependencies between these activities and implementation activities for which DHH will be responsible. (In responding the DBP shall understand DHH shall not be obligated to meet the DBP's expectation.) 			
<p>C-22</p>	<p>C.3 Describe your Risk Management Plan.</p> <ul style="list-style-type: none"> • At a minimum address the following contingency scenarios that could be encountered during implementation of the program: <ul style="list-style-type: none"> ○ Delays in building the appropriate Provider Network as stipulated in this RFP; ○ Delays in building and/or configuring and testing the information systems within your organization's Span of Control required to implement the DBP program; ○ Delays in hiring and training of the staff required to operate program functions; ○ Delays in the construction and/or acquisition of office space and the delivery of office equipment for staff required to operate program functions; ○ Delays in enrollment processing during the implementation of DBP; and ○ Delays in the publication of marketing and related materials and/or the delivery of these materials to DHH and/or its agents. • For each contingency scenario identified in the Proposal, at a minimum the Risk 	<p>15</p>		

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	<p>Management Plan must include the following:</p> <ul style="list-style-type: none"> ○ Risk identification and mitigation strategies; ○ Risk management implementation plans; and ○ Proposed or recommended monitoring and tracking tools. 			
C-34	C.4 Provide a copy of the work plan, generated in Microsoft Project or similar software product that includes the aforementioned implementation activities along with the timeframes, person-hours, and dependencies associated with this activities.	15		
C-42	C.5 Provide a roster of the members of the proposed implementation team including the group that will be responsible for finalizing the provider network.	5		
C-44	C.6 Provide the resume of the Implementation Manager (the primary person responsible for coordinating implementation activities and for allocating implementation team resources).	5		
	Section D: Member Enrollment and Disenrollment	20		
D-1	D.1 Describe how you will ensure that you will coordinate with DHH and its Agent to transmit and obtain files sent by the Fiscal Intermediary.	10		
D-5	D.2 Describe the steps you will take to assign a member to a different Provider in the event a Primary Care Dentist requests the Member be assigned elsewhere.	10		
	Section E: Service Coordination	75		
E-1	<p>E.1 DHH intends to provide DBPs with two years of historic claims data for members enrolled in the DBP effective the start date of operations. Describe how you will ensure the continuation of all active prior authorized services for members effective the start date of operations. The description should include:</p> <ul style="list-style-type: none"> • How you will identify these enrollees, and how you will uses this information to identify these enrollees; 	10		

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	<ul style="list-style-type: none"> • What additional information you will request from DHH, if any, to assist you in ensuring continuation of services; • How you will ensure continuation of services and use of non-contract providers; • What information, education, and training you will provide to your providers to ensure continuation of services; and • What information you will provide your members to assist with the transition of care. 			
E-5	<p>E.2 Provide your communication plans with the Bayou Health Plans and Medicaid fee-for-service in coordinating the following services which will continue to be provided by the Medicaid fee-for-service and Bayou Health programs:</p> <ul style="list-style-type: none"> • Outpatient facility fees for dental services • Fluoride Varnish performed by Primary Care Physician • Current Procedural Terminology (CPT) codes billed by Oral Surgeons 	20		
E-9	<p>E.3 What specific measures will you take to ensure that members in rural parishes are able to access specialty care? Also address specifically how will you ensure members with disabilities have access?</p>	15		
E-13	<p>E.4 Detail the strategies you will use to influence the behavior of members to access oral health care resources appropriately and adapt healthier lifestyles. Include examples from your other Medicaid/CHIP managed care contracts as well as your plan for Louisiana Medicaid DBP members.</p>	20		
E-18	<p>E.5 Much faith based, social and civic groups, resident associations, and other community-based organizations now feature health education and outreach activities, incorporate health education in their events, and provide direct oral health services. Describe what specific ways would you leverage these resources to support the oral health and wellness of your members.</p>	10		

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Proposal Section and Page Number	PART TWO: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	Section F: Provider Network	100		
F-1	<p>F.1 Provide a listing of the proposed provider network using the List of Required In- Network and Allowable Out-of-Network Providers as described in this RFP, including only those providers with whom you have obtained a signed LOI or executed subcontract. LOIs and signed subcontracts will receive equal consideration. LOIs and subcontracts should NOT be submitted with the proposal. DHH may verify any or all referenced LOIs or contracts. Along with the provider listing, provide the number of potential linkages per primary care dentist.</p> <p>Using providers, with whom you have signed letters of intent or executed contracts, provide individual maps and coding by parish. You should provide individual maps as well as overlay maps to demonstrate distance relationships between provider types, if applicable (i.e, pediatrics, general dentist and orthodontist).</p> <p>The DBP should provide an Excel spreadsheet of their proposed provider network and include the following information: (Sample spreadsheet is available in the Procurement Library)</p> <ol style="list-style-type: none"> 1. Practitioner Last Name, First Name and Title - For types of service such as primary care dentist and specialist, list the practitioner's name and practitioner title such as DDS, DMD, etc. 2. Practice Name/Provider Name - - Indicate the name of the provider. For practitioners indicate the professional association/group name, if applicable. 3. Business Location Address - Indicate the business location address where services are provided including but not limited to, 1st line of address, 2nd line of address, City, State, Postal Code 4. Provider Type and Specialty Code - Indicate the practitioner's specialty using Medicaid Provider Type and Specialty Codes. 5. New Patient - Indicate whether or not the provider is accepting new patients. 6. Age Restriction - Indicate any age restrictions for the provider's practice. For instance, if a provider only sees patients up to age 19, indicate < 19; if a provider only sees patients age 13 or above, indicate > 	25		

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	<p>13.</p> <p>7. Primary Care Dentist - the number of potential linkages.</p> <p>8. If LOI or contract executed.</p> <p>9. Designate if Significant Traditional Provider.</p> <p>10. Maps for this location.</p>			
F-141	<p>F.2 Describe how you will handle the potential loss (i.e., contract termination, closure) in a parish of all providers within a certain specialty.</p>	5		
F-144	<p>F.3 The DBP is encouraged to offer to contract with Significant Traditional Providers (STPs) who meet your credentialing standards and all the requirements in the DBP’s subcontract. DHH will make available on www.MakingMedicaidBetter.com a listing of STPs by provider type by parish.</p> <p>Describe how you will encourage the enrollment of STPs into your network; and indicate on a copy of the listing which of the providers included in your listing of network providers (See F.1) are STPs.</p>	15		
F-146	<p>F.4 Based on discussions with providers in obtaining Letters of Intent and executed subcontracts as well as other activities you have undertaken to understand the delivery system and enrollee population in the parish(es) for which a proposal is being submitted, discuss your observations and the challenges you have identified in terms of developing and maintaining a provider network. Provide a response tailored to each parish of the following provider types/services:</p> <ul style="list-style-type: none"> • Primary Care • Specialty Care • FQHC/RHC 	5		
F-181	<p>F.5 Describe your process for monitoring and ensuring adherence to DHH’s requirements regarding appointments and wait times.</p>	10		
F-183	<p>F.6 Describe your primary care dentist assignment process and the measures taken to ensure that every member in your DBP is assigned in a timely manner. Include your process for permitting members with chronic conditions to select a specialist as their</p>	5		

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Proposal Section and Page Number	PART TWO: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	primary care dentist and whether you allow specialists to be credentialed to act as primary care dentists.			
F-186	<p>F.7 Describe how you will monitor providers and ensure compliance with provider subcontracts. In addition to a general description of your approach, address each of the following:</p> <ul style="list-style-type: none"> • Compliance with cost sharing requirements; • Compliance with dental record documentation standards; • Compliance with conflict of interest requirements; • Compliance with lobbying requirements; • Compliance with disclosure requirements; and • Compliance with member education requirements. 	5		
F-191	F.8 Provide an example from your previous experience of how you have handled provider noncompliance with contract requirements.	10		
F-193	F.9 Describe in detail how you will educate and train providers about billing requirements, including both initial education and training prior to the start date of operations and ongoing education and training for current and new providers.	5		
F-200	F.10 Describe how you will educate and train providers that join your network after program implementation. Identify the key requirements that will be addressed.	5		
F-207	<p>F.11 Describe your practice of profiling the quality of care delivered by network general dentists, and any other acute care providers including the methodology for determining which and how many Providers will be profiled.</p> <ul style="list-style-type: none"> • Submit sample quality profile reports used by you, or proposed for future use (identify which). • Describe the rationale for selecting the performance measures presented in the 	5		

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Proposal Section and Page Number	PART TWO: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	<p>sample profile reports.</p> <ul style="list-style-type: none"> Describe the proposed frequency with which you will distribute such reports to network providers, and identify which providers will receive such profile reports. 			
F-220	F.12 Describe the process for accepting and managing provider inquiries, complaints, and requests for information that are received outside the provider grievance and appeal process.	5		
F-223	F.13 If the Department receives written or verbal complaints on behalf of any provider in regards to excessive, unwarranted, and/or aggressive attempts to require any information to fulfill network adequacy requirements during the RFP process.	0 to -50		
Section G: Utilization Management (UM)		100		
G-1	G.1 Describe how you will ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope as specified in the Louisiana Medicaid State Plan.	30		
G-10	G.2 If the UM guidelines were developed internally, describe the process by which they were developed and when they were developed or last revised.	20		
G-14	<p>G.3 Regarding your utilization management (UM) staff:</p> <ul style="list-style-type: none"> Provide a detailed description of the training you provide your UM staff; Describe any differences between your UM phone line and your provider services line with respect to bullets (2) through (7) in item K.1; If your UM phone line will handle both Louisiana DBP and non- Louisiana DBP calls, <ul style="list-style-type: none"> explain how you will track DBP calls separately; and how you will ensure that applicable DHH timeframes for prior authorization decisions are met. 	25		

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Proposal Section and Page Number	PART TWO: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
G-25	<p>G.4 Describe how utilization data is gathered, analyzed, and reported. Include the process for monitoring and evaluating the utilization of services when a variance has been identified (both under- and over- utilization) in the utilization pattern of a provider and a member. Provide an example of how your analysis of data resulted in successful interventions to alter unfavorable utilization patterns in the system. Individuals who will make medical necessity determinations must be identified if the criteria are based on the dental training, qualifications, and experience of the DBP dental director or other qualified and trained professionals.</p>	25		
Section H: EPSDT		40		
H-1	<p>H.1 Describe your system for tracking each member's screening, diagnosis, and treatment including, at minimum, the components of the system, the key features of each component, the use of technology, and the data sources for populating the system.</p>	10		
H-4	<p>H.2 Describe your approach to member education and outreach regarding EPSDT including the use of the tracking system described in H.1 above and any innovative/non-traditional mechanisms. Include:</p> <ul style="list-style-type: none"> • How you will conduct member education and outreach regarding EPSDT including any innovative/non-traditional methods that go beyond the standard methods; • How you will work with members to improve compliance with the periodicity schedule, including how you will motivate parents/members and what steps you will take to identify and reach out to members (or their parents) who have missed screening appointments (highlighting any innovative/non-traditional approaches); and • How you will design and monitor your education and outreach program to ensure compliance with the RFP. 	20		
H-11	<p>H.3 Describe your approach to ensuring that providers deliver and document all required components of EPSDT screening.</p>	10		

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Proposal Section and Page Number	PART TWO: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	Section I: Quality Management	100		
I-1	<p>I.1 Document experience in other States to positively impact the healthcare status of Medicaid and or CHIP populations. Examples of areas of interest include, but are not limited to the following:</p> <ul style="list-style-type: none"> • Reduction of inappropriate utilization of emergent services • EPSDT • Children with special health care needs • Case management • Reduction in racial and ethnic health care disparities to improve health status 	25		
I-23	<p>I.2 Describe how you will identify quality improvement opportunities. Describe the process that will be utilized to select a performance improvement project, and the process to be utilized to improve care or services. Include information on how interventions will be evaluated for effectiveness. Identify proposed members of the Quality Assessment Committee.</p>	5		
I-38	<p>I.3 Provide a description of focus studies performed, quality improvement projects, and any improvements you have implemented and their outcomes. Such outcomes should include cost savings realized, process efficiencies, and improvements to member health status. Such descriptions should address such activities since 2002 and how issues and root causes were identified, and what was changed.</p>	5		
I-45	<p>I.4 Describe your proposed Quality Assessment and Performance Improvement (QAPI). Such description should address:</p> <ul style="list-style-type: none"> • The QAPI proposed to be implemented during the term of the contract. • How the proposed QAPI s will expand quality improvement services. • How the proposed QAPI will improve the health care status of the Louisiana Medicaid population. • Rationale for selecting the particular programs including the identification of particular health care problems and issues identified within the Louisiana Medicaid population that each program will address 	20		

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	<p>and the underlying cause(s) of such problems and issues.</p> <ul style="list-style-type: none"> • How your will keep DHH informed of QAPI program actions, recommendations and outcomes on an ongoing and timely manner. • How the proposed QAPIs may include, but is not necessarily, limited to the following: <ul style="list-style-type: none"> ○ New innovative programs and processes. ○ Contracts and/or partnerships being established to enhance the delivery of health care such as contracts/partnerships with school districts and/or School Based Health Clinics. 			
I-61	<p>I.5 Describe how feedback (complaints, survey results etc.) from members and providers will be used to drive changes and/or improvements to your operations. Provide a member and a provider example of how feedback has been used by you to drive change in other Medicaid managed care contracts.</p>	5		
I-67	<p>I.6 Provide, in Excel format, the proposer's results for:</p> <ul style="list-style-type: none"> • HEDIS measures specified below for the last three measurement years (2010, 2011, 2012) for each of your State Medicaid contracts. <ul style="list-style-type: none"> ○ If you do not have results for a particular measure or year, provide the results that you do have. ○ If you do not have results for your Medicaid product line in a state where you have a Medicaid contract, provide the commercial product line results with an indicator stating the product line. ○ If you do not have Medicaid HEDIS results for at least five states, provide your commercial HEDIS measures for your largest contracts for up to five states (e.g., if you have HEDIS results for the three states where you have a Medicaid contract, you only have Medicare HEDIS for one other state, provide 	40		

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	<p>commercial HEDIS results for another state).</p> <ul style="list-style-type: none"> ○ If you do not have HEDIS results for five states, provide the results that you do have. ○ In addition to the spreadsheet, please provide an explanation of how you selected the states, contracts, product lines, etc. that are included in the spreadsheet and explain any missing information (measure, year, or Medicaid contract). Include the Proposer's parent organization, affiliates, and subsidiaries. ○ Provide results for the following HEDIS measures: <ul style="list-style-type: none"> ▪ Annual Dental Visit • 416 Report measures specified below for the last three measurement CMS years (2010, 2011, and 2012) for each of your State Medicaid contracts. <ul style="list-style-type: none"> ○ Line 12a - Total Eligibles Receiving Any Dental Services ○ Line 12b - Total Eligibles Receiving Preventive Dental Services ○ Line 12c - Total Eligibles Receiving Dental Treatment ○ Line 12d — Total Eligibles Receiving a Sealant on a Permanent Molar Tooth, and ○ Line 12e — Total Eligibles Receiving Diagnostic Dental Services ○ For each of your State Medicaid contracts that received a CMS State Focused Dental Review (2008), please outline all findings, recommendations, etc. revealed in the State-specific reports, as well as the steps that were taken to improve recommendations and rectify all findings. Focus 			

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	Section J: Member Materials	15		
J-1	J.1 Describe proposed content for your member educational materials) and attach a examples used with Medicaid or CHIP populations in other states.	5		
J-59	J.2 Describe how you will ensure that all written materials meet the language requirements and which reference material you anticipate you will use to meet the sixth (6th) grade reading level requirement.	2.5		
J-61	J.3 Describe your strategy for ensuring the information in your provider directory is accurate and up to date, including the types and frequency of monitoring activities and how often the directory is updated.	5		
J-63	J.4 Describe how you will fulfill Internet presence and Web site requirements, including: <ul style="list-style-type: none"> • Your procedures for up-dating information on the Web site; • Your procedures for monitoring e-mail inquiries and providing accurate and timely responses; and • The procedures, tools and reports you will use to track all interactions and transactions conducted via the Web site activity including the timeliness of response and resolution of said interaction/transaction. 	2.5		
	Section K: Member/Provider Service	100		
K-1	K.1 Provide a narrative with details regarding your member services line including: <ul style="list-style-type: none"> • Training of customer service staff (both initial and ongoing); • Process for routing calls to appropriate persons, including escalation; The type of information that is available to customer service staff and how this is provided (e.g., hard copy at the person's desk or on-line search capacity); • Process for handling calls from members with Limited English Proficiency and persons who are hearing impaired; • Monitoring process for ensuring the quality and accuracy of information provided to members; 	25		

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Proposal Section and Page Number	PART TWO: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	<ul style="list-style-type: none"> Monitoring process for ensuring adherence to performance standards; How your customer service line will interact with other customer service lines maintained by state, parish, or city organizations (eg. Partners for Healthy Babies, WIC, housing assistance, and homeless shelters); and After hours procedures. 			
K-11	<p>K.2 Provide member hotline telephone reports for your Medicaid or CHIP managed care contract with the largest enrollment as of January 1, 2013 for the most recent four (4) quarters, with data that show the monthly call volume, the trends for average speed of answer (where answer is defined by reaching a live voice, not an automated call system) and the monthly trends for the rate.</p>	25		
K-13	<p>K.3 Describe the procedures a Member Services representative will follow to respond to the following situations:</p> <ul style="list-style-type: none"> A Member has received a bill for payment of covered services from a network provider or out-of-network provider; A Member is unable to reach his/her a provider within the network after normal business hours; A Member is having difficulty scheduling an appointment for preventive care with her primary care dentist; and A Member becomes ill while traveling outside of the state. 	20		
K-18	<p>K.4 Describe how you will ensure culturally competent services to people of all cultures, races, ethnic backgrounds, and religions as well as those with disabilities in a manner that recognizes values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each.</p>	15		
K-25	<p>K.5 Describe how you will ensure that covered services are provided in an appropriate manner to members with Limited English proficiency and members who are hearing impaired, including the provision of interpreter services.</p>	15		

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	Section L: Emergency Management Plan	20		
L-1	<p>L.1 Describe your emergency response continuity of operations plan. Attach a copy of your plan or, at a minimum, summarize how your plan addresses the following aspects of pandemic preparedness and natural disaster recovery:</p> <ul style="list-style-type: none"> • Employee training; • Identified essential business functions and key employees within your organization necessary to carry them out; • Contingency plans for covering essential business functions in the event key employees are incapacitated or the primary workplace is unavailable; • Communication with staff and suppliers when normal systems are unavailable; • Specifically address your plans to ensure continuity of services to providers and members; and • How your plan will be tested. 	10		
L-51	<p>L.2 Describe your plan in the following Emergency Management Plan scenario for being responsive to DHH, to members who evacuate, to network providers, and to the community.</p> <ul style="list-style-type: none"> • You have thirty thousand (30,000) or more DBP members residing in hurricane prone parishes. Louisiana parishes include coastal and inland areas subject to mandatory evacuation orders during a major hurricane. A category 5 hurricane is approaching, with landfall predicted in 72 hours and certain parishes are under a mandatory evacuation order. State assisted evacuations and self-evacuations are underway. Members are evacuated to or have evacuated themselves to not only all other areas of Louisiana, but to other States. • Your provider call center and member call center are both located in Baton Rouge and there is a high likelihood of high winds, major damage and power outages for 4 days or more in the Baton Rouge Area (reference Hurricane Gustav impact on Baton Rouge). It is expected that repatriation of the evacuated, should damages be minimal, will not occur for 14 	10		

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	<p>days. If damage is extensive, there may be limited repatriation, while other members may be indefinitely relocated to other areas in Louisiana or other states.</p>			
	Section M: Grievances and Appeals	25		
M-1	<p>M.1 Provide a flowchart (marked as Chart C) and comprehensive written description of your member grievance and appeals process which comply with the RFP requirements, including your approach for meeting the general requirements and plan to:</p> <ul style="list-style-type: none"> • Ensure that the Grievance and Appeals System policies and procedures, and all notices will be available in the Member's primary language and that reasonable assistance will be given to Members to file a Grievance or Appeal; • Ensure that individuals who make decisions on Grievances and Appeals have the appropriate expertise and were not involved in any previous level of review; and • Ensure that an expedited process exists when taking the standard time could seriously jeopardize the Member's health. As part of this process, explain how you will determine when the expedited process is necessary. <p>Include in the description how data resulting from the grievance system will be used to improve your operational performance.</p>	25		
	Section N: Fraud & Abuse	25		
N-1	<p>N.1 Describe your approach for meeting the program integrity requirements including a compliance plan for the prevention, detection, reporting, and corrective action for suspected cases of Fraud and Abuse in the administration and delivery of services. Discuss your approach for meeting the coordination with DHH and other agencies requirement.</p>	25		
	Section O: Third Party Liability	25		
O-1	<p>O.1 Describe how you will coordinate with DHH and comply with the requirements for cost avoidance and the collection of third party liability (TPL) specified in this RFP, including:</p>	25		

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	<ul style="list-style-type: none"> How you will conduct diagnosis and trauma edits, including frequency and follow-up action to determine if third party liability exists; (2) How you will educate providers to maximize cost avoidance; Collection process for pay and chase activity and how it will be accomplished; How subrogation activities will be conducted; How you handle coordination of benefits in your current operations and how you would adapt your current operations to meet contract requirements; Whether you will use a subcontractor and if so, the subcontractor's responsibilities; and What routine systems/business processes are employed to test, update and validate enrollment and TPL data. 			
	Section P: Claims Management	125		
P-1	<p>P.1 Describe the capabilities of your claims management systems as it relates to each of the requirements as specified in Electronic Claims Management Functionality Section and the Adherence to Key Claims Management Standards Section. In your response explain whether and how your systems meet (or exceed) each of these requirements. Cite at least three examples from similar contracts.</p>	75		
P-22	<p>P.2 Describe your methodology for ensuring that claims payment accuracy standards will be achieved per, Adherence to Key Claims Management Standards Section. At a minimum address the following in your response:</p> <ul style="list-style-type: none"> The process for auditing a sample of claims as described in Key Claims Management Standards Section; The sampling methodology itself; Documentation of the results of these audits; and The processes for implementing any necessary corrective actions resulting from an audit. 	25		

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P-31	<p>P.3 Describe your methodology for ensuring that the requirements for claims processing, including adherence to all service authorization procedures, are met.</p>	25		
Section Q: Information Systems		125		
Q-1	<p>Q.1 Describe your approach for implementing information systems in support of this RFP, including:</p> <ul style="list-style-type: none"> • Demonstrate capability and capacity assessment to determine if new or upgraded systems, enhanced systems functionality and/or additional systems capacity are required to meet contract requirements; • Configuration of systems (e.g., business rules, valid values for critical data, data exchanges/interfaces) to accommodate contract requirements; • System setup for intake, processing and acceptance of one-time data feeds from the State and other sources, e.g., initial set of DBP enrollees, claims/service utilization history for the initial set of DBP enrollees, active/open service authorizations for the initial set DBP enrollees, etc.; and • Internal and joint (DBP and DHH) testing of one-time and ongoing exchanges of eligibility/enrollment, provider network, claims/encounters and other data. • Provide a Louisiana Medicaid DBP-Program-specific work plan that captures: <ul style="list-style-type: none"> ○ Key activities and timeframes and ○ Projected resource requirements from your organization for implementing information systems in support of this contract. • Describe your historical data process including but not limited to: <ul style="list-style-type: none"> ○ Number of years retained; ○ How the data is stored; and ○ How accessible is it. <p>The work plan should cover activities from contract award to the start date of operations.</p>	20		

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Q-20	<p>Q.2 Describe your processes, including procedural and systems-based internal controls, for ensuring the integrity, validity and completeness of all information you provide to DHH and the Enrollment Broker. In your description, address separately the encounter data-specific requirements in, Encounter Data Section of the RFP as well as how you will reconcile encounter data to payments according to your payment cycle, including but not limited to reconciliation of gross and net amounts and handing of payment adjustments, denials and pend processes. Additionally, describe how you will accommodate DHH-initiated data integrity, validity and provide independent completeness audits.</p>	10		
Q-27	<p>Q.3 Describe in detail how your organization will ensure that the availability of its systems will, at a minimum, be equal to the standards set forth in the RFP. At a minimum your description should encompass: information and telecommunications systems architecture; business continuity/disaster recovery strategies; availability and/or recovery time objectives by major system; monitoring tools and resources; continuous testing of all applicable system functions, and periodic and ad-hoc testing of your business continuity/disaster recovery plan.</p> <p>Identify the timing of implementation of the mix of technologies and management strategies (policies and procedures) described in your response to previous paragraph, or indicate whether these technologies and management strategies are already in place.</p> <p>Elaborate, if applicable, on how you have successfully implemented the aforementioned mix of technologies and management strategies with other clients.</p>	10		
Q-35	<p>Q.4 Describe in detail:</p> <ul style="list-style-type: none"> • How your <i>key production systems</i> are designed to <i>interoperate</i>. In your response address all of the following: <ul style="list-style-type: none"> ○ How identical or closely related data elements in different systems are named, formatted and maintained: <ul style="list-style-type: none"> ▪ Are the data elements named consistently; ▪ Are the data elements formatted similarly (# of 	10		

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Proposal Section and Page Number	PART TWO: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	<p>characters, type-text, numeric, etc.);</p> <ul style="list-style-type: none"> ▪ Are the data elements updated/refreshed with the same frequency or in similar cycles; and ▪ Are the data elements updated/refreshed in the same manner (manual input, data exchange, automated function, etc.). <ul style="list-style-type: none"> ○ All exchanges of data between key production systems. <ul style="list-style-type: none"> ▪ How each data exchange is triggered: a manually initiated process, an automated process, etc. ▪ The frequency/periodicity of each data exchange: “real-time” (through a live point to-point interface or an interface “engine”), daily/nightly as triggered by a system processing job, biweekly, monthly, etc. • As part of your response, provide diagrams that illustrate: <ul style="list-style-type: none"> ○ point-to-point interfaces, ○ information flows, ○ internal controls and ○ the networking arrangement (AKA “network diagram”) associated with the information systems profiled. <p>These diagrams should provide insight into how your Systems will be organized and interact with DHH systems for the purposes of exchanging Information and automating and/or facilitating specific functions associated with the Louisiana Medicaid DBP Program.</p>			
<p>Q-38</p>	<p>Q.5 Describe your ability to provide and store encounter data in accordance with the requirements in this RFP. In your response:</p> <ul style="list-style-type: none"> • Explain whether and how your systems meet (or exceed) each of these 	<p>5</p>		

Part Two: Technical Approach

Scoring Grid (Part Two)



Proposal Section and Page Number	PART TWO: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	<p>requirements.</p> <ul style="list-style-type: none"> Cite at least three currently-live instances where you are successfully providing encounter data in accordance with DHH coding, data exchange format and transmission standards and specifications or similar standards and specifications, with at least two of these instances involving the provision of encounter information from providers with whom you have capitation arrangements. In elaborating on these instances, address all of the requirements in the Technical Requirements section. Also, explain how that experience will apply to the Louisiana Medicaid DBP Program. If you are not able at present to meet a particular requirement contained in the aforementioned section, identify the applicable requirement and discuss the effort and time you will need to meet said requirement. (4) Identify challenges and “lessons learned” from your implementation and operations experience in other states and describe how you will apply these lessons to this contract. 			
<p>Q-44</p>	<p>Q.6 Describe your ability to receive, process, and update eligibility/enrollment, provider data, and encounter data to and from the Department and its agents. In your response:</p> <ul style="list-style-type: none"> Explain whether and how your systems meet (or exceed) each of these requirements. Cite at least three currently-live instances where you are successfully receiving, processing and updating eligibility/enrollment data in accordance with DHH coding, data exchange format and transmission standards and specifications or similar standards and specifications. In elaborating on these instances, address all of the requirements in the Technical Requirements section. Also, explain how that experience will apply to the Louisiana Medicaid DBP Program. If you are not able at present to meet a particular requirement contained in the aforementioned sections, identify the applicable requirement and discuss the effort and time you will need to meet said 	<p>5</p>		

Part Two: Technical Approach

Scoring Grid (Part Two)



Proposal Section and Page Number	PART TWO: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	<p>requirement.</p> <p>Identify challenges and “lessons learned” from implementation in other states and describe how you will apply these lessons to this contract.</p>			
Q-50	<p>Q.7 Describe the ability within your systems to meet (or exceed) each of the requirements in the Technical Requirements section. Address each requirement. If you are not able at present to meet a particular requirement contained in the aforementioned section, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.</p>	10		
Q-57	<p>Q.8 Describe your information systems change management and version control processes. In your description address your production control operations.</p>	10		
Q-60	<p>Q.9 Describe your approach to demonstrating the readiness of your information systems to DHH prior to the start date of operations. At a minimum your description must address:</p> <ul style="list-style-type: none"> • provider contract loads and associated business rules; • eligibility/enrollment data loads and associated business rules; • claims processing and adjudication logic; and • encounter generation and validation prior to submission to DHH. 	5		
Q-64	<p>Q.10 Describe your reporting and data analytic capabilities including:</p> <ul style="list-style-type: none"> • generation and provision to the State of the management reports prescribed in the RFP; • generation and provision to the State of reports on request; • the ability in a secure, inquiry-only environment for authorized DHH staff to create and/or generate reports out of your systems on an <i>ad-hoc</i> basis; and • Reporting back to providers within the network. 	5		

Part Two: Technical Approach

Scoring Grid (Part Two)



Proposal Section and Page Number	PART TWO: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
Q-70	Q.11 Provide a detailed profile of the key information systems within your span of control.	5		
Q-73	Q.12 Provide a profile of your current and proposed Information Systems (IS) organization.	5		
Q-75	Q.13 Describe what you will do to promote and advance electronic claims submissions and assist providers to accept electronic funds transfers.	5		
Q-78	Q.14 Indicate how many years your IT organization or software vendor has supported the current or proposed information system software version you are currently operating. If your software is vendor supported, include vendor name(s), address, contact person and version(s) being used.	Included/Not Included		
Q-79	Q.15 Describe your plans and ability to support network providers' "meaningful use" of Electronic Health Records (EHR) and current and future IT Federal mandates. Describe your plans to utilizing ICD-10 and 5010.	10		
Q-80	Q.16 Describe the procedures that will be used to protect the confidentiality of records in DHH databases, including records in databases that may be transmitted electronically via e-mail or the Internet.	10		
	Section R: Veteran or Hudson Initiative	125		
R-1	R.1 Certified Veteran or Hudson Initiative small entrepreneurship or who will engage the participation of one or more certified Veteran or Hudson Initiatives small entrepreneurialships as subcontractors. (See Attachment I)	125		

Section B.1

Indicate your organization's legal name, trade name, *dba*, acronym, and any other name under which you do business; the physical address, mailing address, and telephone number of your headquarters office. Provide the legal name for your organization's ultimate parent (e.g. publicly traded corporation).

Describe your organization's form of business (i.e., individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and detail the names, mailing address, and telephone numbers of its officers and directors and any partners (if applicable). Provide the name and address of any oral health care professional that has at least a five percent (5%) financial interest in your organization, and the type of financial interest.

Provide your federal taxpayer identification number and Louisiana taxpayer identification number.

Provide the name of the state in which you are incorporated and the state in which you are commercially domiciled. If out-of-state, provide the name and address of the local representative; if none, so state.

If you have been engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state.

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Part Two: Technical Approach

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Section B.2

Provide a statement of whether there have been any mergers, acquisitions, or sales of your organization within the last ten years, and if so, an explanation providing relevant details. If any change of ownership is anticipated during the 12 months following the Proposal Due Date, describe the circumstances of such change and indicate when the change is likely to occur. **Include your organization's parent organization, affiliates, and subsidiaries.**

REDACTED

Section B.3

Provide a statement of whether you or any of your employees, agents, independent contractors, or subcontractors have ever been convicted of, pled guilty to, or pled *nolo contendere* to any felony and/or any Medicaid or health care related offense or have **ever** been debarred or suspended by any federal or state governmental body. Include an explanation providing relevant details and the corrective action plan implemented to prevent such future offenses. **Include your organization's parent organization, affiliates, and subsidiaries.**

No employees, agents, independent contractors, or subcontractors of MCNA (including MCNA's parent organization, affiliates, and subsidiaries) have ever been convicted of, pled guilty to, or pled *nolo contendere* to any felony and/or any Medicaid or health care related offense or have ever been debarred or suspended by any federal or state governmental body.

Section B.4

Provide a statement of whether there is any pending or recent (within the past five years) litigation against your organization. This shall include but not be limited to litigation involving failure to provide timely, adequate or quality dental services. You do not need to report workers' compensation cases. If there is pending or recent litigation against you, describe the damages being sought or awarded and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Include a name and contact number of legal counsel to discuss pending litigation or recent litigation. Also include any SEC filings discussing any pending or recent litigation. **Include your organization's parent organization, affiliates, and subsidiaries.**

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Section B.5

Provide a statement of whether, in the last ten years, you or a predecessor company has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, provide an explanation providing relevant details including the date in which the Proposer emerged from bankruptcy or expects to emerge. If still in bankruptcy, provide a summary of the court-approved reorganization plan. **Include your organization's parent organization, affiliates, and subsidiaries.**

MCNA is pleased to provide the State of Louisiana with assurances of our financial solvency and strong fiscal track record. Neither MCNA (including MCNA's parent organization, affiliates, and subsidiaries) nor a predecessor company has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors.

Section B.6

If your organization is a publicly-traded (stock-exchange-listed) corporation, submit the most recent United States Securities and Exchange Commission (SEC) Form 10K Annual Report, and the most-recent 10-Q Quarterly report.

Provide a statement whether there have been any Securities Exchange Commission (SEC) investigations, civil or criminal, involving your organization in the last ten (10) years. If there have been any such investigations, provide an explanation with relevant details and outcome. If the outcome is against the Proposer, provide the corrective action plan implemented to prevent such future offenses. Also provide a statement of whether there are any current or pending Securities Exchange Commission investigations, civil or criminal, involving the Proposer, and, if such investigations are pending or in progress, provide an explanation providing relevant details and provide an opinion of counsel as to whether the pending investigation(s) will impair the Proposer's performance in a contract/Agreement under this RFP. **Include your organization's parent organization, affiliates, and subsidiaries.**

This provision is not applicable to MCNA (including MCNA's parent organization, affiliates, and subsidiaries), as we are not a publicly-traded (stock-exchange-listed) corporation. In addition, there have been no United States Securities and Exchange Commission (SEC) investigations involving MCNA or any of its affiliated companies in the last ten years. There are no current or pending SEC investigations, civil or criminal, involving MCNA.

Section B.7

If another corporation or entity either substantially or wholly owns your organization, submit the most recent detailed financial reports for the parent organization. If there are one (1) or more intermediate owners between your organization and the ultimate owner, this additional requirement is applicable only to the ultimate owner.

Include a statement signed by the authorized representative of the parent organization that the parent organization will unconditionally guarantee performance by the proposing organization of each and every obligation, warranty, covenant, term and condition of the Contract.

MCNA Insurance Company (MCNA) is a wholly owned subsidiary of MCNA Health Care Holdings, LLC, its parent. Accordingly, MCNA hereby submits the most recent financial report of its parent organization for the period ending December 31, 2013.

MCNA Health Care Holdings, LLC, also submits the following unconditional corporate guaranty of performance signed by our duly authorized representative, Dr. Jeffrey P. Feingold, Chairman and Chief Executive Officer.

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Section B.8

Describe your organization's number of employees, client base, and location of offices. Submit an organizational chart (marked as Chart A of your response) showing the structure and lines of responsibility and authority in your company. **Include your organization's parent organization, affiliates, and subsidiaries.**

Corporate Overview

MCNA Health Care Holdings, LLC, is the parent organization of the Texas based respondent, MCNA Insurance Company. **Our proposal combines the financial strength of MCNA Insurance Company and the unparalleled dental managed care experience of its affiliate, Managed Care of North America, Inc., to deliver to the Louisiana Department of Health and Hospitals a turnkey solution and seamless transition from the DHH's fee-for-service system to dental managed care.**

Hereinafter, our services and organizations will be collectively referred to as "MCNA."

Dr. Jeffrey P. Feingold, a Diplomate of the American Board of Periodontology, founded MCNA. He earned his Bachelor of Arts degree from **Tulane University**, his Doctorate of Dental Surgery (DDS) degree from the New York University College of Dentistry, and his certification in Periodontology and Master of Science in Dentistry (MSD) in Periodontology from Fairleigh Dickinson University Dental School. Dr. Feingold has been a licensed Florida Periodontist since 1971. He serves as a member of the Board of Trustees of Florida Atlantic University.



He has served as a Board and Executive Board Member of Tulane University Associates, on the NYU Dental School Dean's Advisory Board, on the NYU Stern School of Business Steering Committee, and as Vice Chairman of Columbia University Parents Council. Dr. Feingold is a member of the American Dental Association, Florida Dental Association, American Academy of Periodontology, and other professional organizations.

Dr. Feingold's experience with evolving care standards and dental insurance startups in the late 1970's led to our **innovative approach to member outreach and proven utilization management standards**. As an intern at the Eastman Dental Center in Rochester, New York, the epicenter of dental innovation for nearly one hundred years, Dr. Feingold participated in developing clinical protocols for dental sealants in children. Opening numerous rural Florida specialty care practices with a general dental component geared toward prevention of tooth loss and early detection of tooth decay in children, he developed one of the first dental disease management programs in the nation. His "lessons learned" about quality dental health care for children in his early practice and experience with dental managed care became the cornerstone of a dental plan built on the firm foundation of provider engagement and sophisticated information technology. MCNA enjoys 20 years of exemplary experience in dental benefits administration.

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Our ability to effectively transition new markets from fee-for-service Medicaid to dental managed care is enhanced by the wisdom, experience, and guidance of our Vice Chairman of the Board, Albert Hawkins. MCNA welcomed Mr. Hawkins onto our Texas team in 2011.

Mr. Hawkins has over 30 years of experience in public service, with expertise in health and human services policy, financing and operations, and Texas legislative processes and practices. He served as Executive Commissioner of the Texas Health and Human Services Commission, where he was responsible for the oversight of five health and human services agencies. He provided strategic direction for areas including planning and budget, the improvement of system-wide business operations, and the administration of eligibility determination functions for Medicaid Acute Care and the Children's Health Insurance Program (CHIP).



Client Base

MCNA has developed into one of our country's leading administrators of dental benefits for state Medicaid and CHIP programs. MCNA is currently contracted with the Texas Health and Human Services Commission, the Florida Agency for Health Care Administration, and the Florida Healthy Kids Corporation for their Children's Medicaid and CHIP programs. MCNA also has extensive experience providing adult benefits to Medicaid, Medicare, Long Term Care, Nursing Home Diversion, and Dual Eligible members through multiple contracts with health plans. Finally, MCNA administers commercial dental benefits to private employers, individuals, and families.

Offices and Employees

Our Corporate Office, located in Ft. Lauderdale, Florida, and our Regional Office, located in San Antonio, Texas, has a combined roster of **over 500 employees**.

MCNA's Corporate Office is located at:

MCNA Dental Plans
200 West Cypress Creek Road, Suite 500
Fort Lauderdale, Florida 33309

Over 200 of MCNA's San Antonio call center staff are provided by Media Riders, Inc., a Texas certified small business enterprise, under a Staff Augmentation agreement with MCNA. MCNA will duplicate this model in Louisiana using Quality Medical Staffing, Inc., a Hudson Initiative subcontractor.

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Section B.9

Provide a narrative description of your proposed Bayou Health project team, its members, and organizational structure including an organizational chart showing the Louisiana organizational structure, including staffing and functions performed at the local level.

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Section B.10

Attach a personnel roster and resumes of key people who shall be assigned to perform duties or services under the Contract, highlighting the key people who shall be assigned to accomplish the work required by this RFP and illustrate the lines of authority. Submit current resumes of key personnel documenting their educational and career history up to the current time. Include information on how long the personnel have been in these positions and whether the position included Medicaid managed care experience.

If any of your personnel named is a current or former Louisiana state employee, indicate the Agency where employed, position, title, termination date, and last four digits of the Social Security Number.

If personnel are not in place, submit job descriptions outlining the minimum qualifications of the position(s). Each resume or job description should be limited to 2 pages.

For key positions/employees which are not full time provide justification as to why the position is not full time. Include a description of their other duties and the amount of time allocated to each.

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Section B.11

Provide a statement of whether you intend to use major subcontractors (as defined in the RFP Glossary), and if so, the names and mailing addresses of the subcontractors and a description of the scope and portions of the work for each subcontractor with more than \$100,000 annually. Describe how you intend to monitor and evaluate subcontractor performance. Also specify whether the subcontractor is currently providing services for you in other states and where the subcontractor is located.

In addition, as part of the response to this item, for each major subcontractor that is not your organization's parent organization, affiliate, or subsidiary, restate and respond to items B.1 through B.7, B10 and, B.15 through B.23

If the major subcontractor is your organization's parent organization, affiliate, or subsidiary, respond to items B.1, B.8 and B.9. You do not need to respond to the other items as part of the response to B11; note, however, responses to various other items in Section B must include information on your organization's parent organization, affiliates, and subsidiaries, which would include any major subcontractors that are your organization's parent organization, affiliate, or subsidiary.

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Section B.12

Provide a description your Corporate Compliance Program including the Compliance Officer's levels of authority and reporting relationships. Include an organizational chart of staff (marked as Chart B in your response) involved in compliance along with staff levels of authority.

MCNA is committed to maintaining the highest level of professional and ethical standards in the conduct of our business. We place great value upon our hard-earned reputation for honesty, integrity and high ethical standards. Consistent with our commitment to providing quality, compassionate care to our members and providers, MCNA developed a comprehensive Compliance Program and robust Compliance department to oversee its implementation. The program is our solemn commitment to our members, providers and partners, and to the government agencies that regulate us, that we will provide quality services in an ethical and compliant manner.

Our Compliance Program has due diligence mechanisms in place to prevent and detect criminal conduct. It promotes an organizational culture that encourages ethical conduct and a commitment to compliance with the law. MCNA's Compliance Program complies with the Office of Inspector General's seven elements of an effective compliance program and 42 CFR 438.608. MCNA's Board of Directors has appointed Mayre Herring as the Chief Compliance Officer to implement and manage MCNA's Compliance Program, Compliance Committee, and related activities.

Mayre Herring, M.H.A. has a proven track record of success resolving compliance issues and creating and maintaining professional relationships with our regulators and clients. She takes a proactive approach to identifying potential compliance issues and is able to achieve the company's compliance objectives with her thorough knowledge of state and federal regulations and accrediting organization standards.

As a former regulator with Florida Medicaid, Ms. Herring successfully managed contract compliance oversight for managed care health plans while working at the Florida Agency for Healthcare Administration. She understands the importance of establishing a positive working relationship with our state regulators. She has received accolades from regulators and executive management for her compliance expertise and hard work.



MCNA's Compliance Department and Contract Compliance

As MCNA's Chief Compliance Officer, Ms. Herring oversees the Compliance department and acts as the company's internal regulator. MCNA's Compliance department strives to ensure the company maintains full compliance with all regulations, policies, and guidelines through education while monitoring our efforts to address instances where compliance has not been achieved and corrective

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measures have been put into place. To ensure compliance with state contracts, Ms. Herring has developed a Regulatory Compliance team dedicated exclusively for monitoring contract compliance and compliance with state and federal regulations governing our state contracts.

Our Regulatory Compliance team utilizes the Compliance module in DentalTrac™, MCNA's proprietary management information system, to store and track the following department activities:

- Compliance committee meetings, including agendas and meeting minutes
- Compliance monitoring and auditing work plan, results of monitoring and auditing efforts and scorecards
- Risk assessments and results
- Internal and external referrals or complaints about potential non-compliance that are received through the compliance hotline, inbox or other means
- Investigations and corrective actions
- Contract requirements
- Track updates to state and federal regulations
- Policies and procedures
- Training materials
- Educational and awareness activities



Compliance Module

The module also integrates a functionality that has an automatic revision control to ensure that only the most current version of a document is accessible and available. The Chief Compliance Officer has the ability to generate reports that are used to measure the company's performance and identify and correct the causes of noncompliance and noncompliant processes.

In preparation for this contract, Ms. Herring has assigned a dedicated team of compliance specialists to oversee the DHH contract and support the company's compliance efforts. As Chief Compliance Officer, Ms. Herring will be responsible for communicating and coordinating with DHH.

Overview of MCNA's Compliance Program

Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable state and federal standards

MCNA creates and maintains corporate policies and procedures that guides the manner in which we conduct our business. These policies and procedures are specific to each business area within the company. In order to ensure an expeditious go-live on May 1, 2014, all new and revised corporate policies and procedures recommended by MCNA's Quality Improvement Committee and adopted by the Board of Directors shall be submitted for approval by DHH before implementation.

Designation of a Compliance Officer and a Compliance Committee that are accountable to Senior Management

The MCNA Compliance Officer is an executive leader of the company who reports to the Chief Executive Officer and MCNA's Board of Directors. The Compliance Officer serves as the primary focal point for all compliance activities and has the primary responsibility of overseeing and monitoring the implementation of our Compliance Program, and ensuring that all policies and procedures are implemented and integrated at every level of MCNA's operations. Coordination and communication are key functions of the Compliance Officer. This position serves as a channel of communication to receive and direct compliance issues to appropriate resources for investigation and resolution, and as a final internal resource with which concerned parties may communicate after other formal channels have been exhausted. MCNA's Compliance Committee advises the Compliance Officer and assists in implementing the Compliance Program.

On a quarterly basis, the Compliance Officer reports to MCNA's Chief Executive Officer, Board of Directors, and Compliance Committee regarding the company's performance under the Compliance Program and MCNA's exposure to risk, fraud and abuse.

Effective training and education for the compliance officer and the organization's employees

All MCNA employees receive general compliance training within 30 days of initial hiring, on adoption of updates to the Compliance Program, and annually as a condition of employment. Thirty days before an employee's anniversary, the Human Resources department sends an e-mail reminder to all employees to notify them of their upcoming annual training.

The training is web-based and employees access the content in the Learning Management module of DentalTrac™. Employees are trained to be cognizant of all applicable state and federal laws and regulations that apply to MCNA's operations and competitive practices, as well as the day-to-day activities of the company and its employees. Outlined below is the training curriculum for the compliance training:

- Chief Compliance Officer roles and responsibilities
- Overview of Compliance department
- Overview of MCNA's Compliance Program
 - Designated Compliance Officer and Compliance Committee
 - Written policies and procedures

- Written Codes of Ethical Conduct
- Effective lines of communication
- Internal auditing and monitoring activities
- Effective education and training
- Well-publicized disciplinary guidelines to enforce standards
- Prompt response and corrective action
- Standards of Conduct
- Confidentiality and conflicts of interest
- Reporting violations of the Compliance Program
- MCNA's investigation process to inquiries
- Disciplinary guidelines
- Employee role and responsibilities
- HIPAA and HITECH Acts

The Human Resource department generates reports on a continuous basis to ensure new hire and annual trainings are completed within the required timeframe. If an employee has not completed scheduled training, the employee's immediate supervisor is notified of the need for the employee to complete the training. If the employee has not completed the training within the required timeframe, the Human Resources Director will notify the supervisor of the non-compliance, and the employee will be removed from his or her duties until the training is complete.

Ongoing training is provided to departments affected by a material change in policies or procedures, and state and federal regulations. The training of employees at all levels is an essential component of an effective Compliance Program. On an annual basis, members of the Board of Directors receive annual compliance training as well.

The Chief Compliance Officer is a member of the Health Care Compliance Association and stays fully abreast of changes and updates in the industry. Her membership gives her access to industry news updates, an extensive library of resources, online webinars and events.

Effective lines of Communication Between the Compliance Officer and the Organization's Employees

MCNA staff has 24/7 open lines of communication to report suspected violations of MCNA policies and instances of fraud, waste and abuse of Federal and State government funds earmarked for Medicare and Medicaid enrollees. MCNA's Compliance department has established the following mechanisms to allow employees to report activities involving ethical violations or criminal conduct. Violations can be reported anonymously to our confidential Compliance Hotline (855-683-6262) and email (compliance_reporting@mcna.net), or by regular mail. Violations could include:

- Conflicts of interest
- Inappropriate accounting of financial records and reports
- Inappropriate record keeping
- Employee fraud
- Confidentiality, privacy, and security violations
- Member rights
- Record retention policy

- Kickbacks and bribes
- Money laundering
- Confidentiality and protection of company information, property and resources
- HIPAA violations

MCNA's Chief Compliance Officer (CCO) is committed to creating a culture conducive to open discussion of business practices. She believes in maintaining an "open door policy" that allows individuals to report actual or perceived violations of the Compliance Program. She is always available to answer calls or emails about any issues an employee may have.

MCNA upholds a Zero Tolerance policy for retaliation against employees who report "suspected" or "potential" misconduct or abuse. MCNA employees and subcontractors are trained to know that they are protected from retaliation under 31 U.S.C. 3730(h) for *False Claims Act* complaints, as well as other applicable anti-retaliation protections.

Enforcement of standards through well-publicized disciplinary guidelines

Disciplinary action for violations of the program, state and federal laws or MCNA's standards of business ethics, will be undertaken according to applicable policies and procedures in consultation with Human Resources and the Legal Counsel. The obligations imposed by the Compliance Program are enforced by the standard disciplinary measures. MCNA's Compliance Officer is responsible for investigating suspected compliance violations. Each action is considered on a case-by-case basis and will be imposed in accordance with our disciplinary actions policies subject to internal corrective action measures. Our Compliance Officer reserves the right to impose disciplinary actions to employees, contractors and contracted entities for committing a non-compliant act or omission of knowledge of a non-compliant act.

Provision for internal monitoring and auditing

A critical component of MCNA's compliance with state and federal laws is conducting regular auditing and monitoring activities to identify and to promptly rectify any potential barriers to such compliance. Audits of MCNA's Compliance Program focus on regulatory compliance and at-risk areas. The Compliance department conducts a series of monitoring and auditing activities on a monthly, quarterly or annual basis to ensure that MCNA is meeting all state, federal and accrediting organization requirements. Our monitoring techniques involve sampling protocols that permit the Compliance staff to identify if any compliance issues exist.

The Compliance department meets with the department director to discuss the results of an audit and any identified non-compliance. Audit results between 81% and 90% will trigger a quality improvement project, including enhanced education and training. Audit results of 80% or less will trigger a corrective action plan. Audit results are reported to the Compliance Committee on a quarterly basis. The Compliance Committee provides support for action plans to improve high-risk areas and ensure accountability and responsibility. Audit findings that represent significant risk to the organization are reported immediately to the CEO and Board of Directors.

Provision for prompt response to detected offenses and for development of corrective action

MCNA's Compliance Program includes procedures for promptly responding to compliance issues as they are raised, as a result of internal audits, raised member or provider issues, and employee or contractor violations. The Compliance Officer is able to correct any compliance problems quickly and thoroughly to reduce the potential for reoccurrence and ensure ongoing compliance with federal and state requirements. All research, inquiries, information and activities are kept confidential. Corrective action plans implemented by the Compliance Officer include measures taken to correct contract non-compliance, breach, suspension or termination in the case of an employee or consultant and termination of contracts in the case of business entities or dental providers.

Where appropriate, the Compliance Officer will also take corrective action against supervisors who fail to detect or report misconduct on the part of employees or business partners under their supervision.

Effective program implementation and measuring program performance

On an annual basis, MCNA's Compliance Program performance is evaluated to assess its effectiveness. This evaluation helps MCNA's Board of Directors and Compliance Committee measure the company's improvement and identify whether established compliance activities are contributing to the success of the company's plans.

MCNA's employees understand that compliance with the Compliance Program is necessary in order for the company to remain successful.

Part Two: Technical Approach

Section B: Qualifications and Experience



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Part Two: Technical Approach

Section B: Qualifications and Experience



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Part Two: Technical Approach

Section B: Qualifications and Experience



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Part Two: Technical Approach

Section B: Qualifications and Experience



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Part Two: Technical Approach

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Section B.13

Provide copies of any press releases in the twelve (12) months prior to the Deadline for Proposals, wherein the press release mentions or discusses financial results, acquisitions, divestitures, new facilities, closures, layoffs, significant contract awards or losses, penalties/fines/ sanctions, expansion, new or departing officers or directors, litigation, change of ownership, or other very similar issues, Do not include press releases that are primarily promotional in nature.

MCNA submits the following copies of press releases issued in the twelve-month period commencing January 2013.

MCNA Press Release [1/8]



**HUMANA – CARESOURCE
EXPANDS STATEWIDE WITH
MCNA**

MCNA DENTAL PLANS

200 W. Cypress Creek Rd., Ste 500
Fort Lauderdale, Florida 33309

T: 1-800-494-6262

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W: www.mcna.net

PRESS CONTACT:

Eric Sarmany

Director of Media Relations
mediainquiries@mcna.net

PRESS RELEASE – FOR IMMEDIATE RELEASE

FORT LAUDERDALE, FL – January 22, 2014

MCNA’s demonstration of service excellence during its entry into an initial partnership with Humana – CareSource to provide dental services to Region 3 of the Kentucky Medicaid Program has led to the expansion into a statewide contract beginning January 1, 2014.

MCNA worked closely with Humana – CareSource to implement all of the classic transition plan elements ensuring a fully credentialed and trained network of general dentists and specialists. Providers were educated about program benefits, utilization management, and other key program features. The extensive forethought given to such preparation and coaching enabled our client to enter the market with no disruption in care.

“Our thoroughness and dedication during the rollout of services in the initial region put a spotlight on the quality MCNA brings to the table,” said Glenn Kollen, Vice President of Provider Services and Network Development. *“Our track record of flawless performance speaks for itself; MCNA will continue to build upon our past successes to make great strides into the future.”*

###

MCNA is a leading dental benefit management company committed to providing high quality services. We serve Medicaid and CHIP members across the nation. For nearly 20 years, we have been committed to improving the overall health of our members by making sure they get great dental care, and service they can trust. At MCNA, we care about your smile. More information can be found at our corporate website, <http://www.mcna.net>.

MCNA_ALL_X_PRESSREL-CSRC-EXPANSION_021401

MCNA Press Release [2/8]



MCNA PROUDLY JOINS THE DENTAL QUALITY ALLIANCE

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Eric Sarmany
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PRESS RELEASE – FOR IMMEDIATE RELEASE

SAN ANTONIO, TX – January 6, 2014

MCNA is pleased to announce its new relationship with the Dental Quality Alliance (DQA), a national organization established by the American Dental Association focused on improving all aspects of oral health care through measurement.

MCNA supports the mission of the DQA to advance performance measurement as a means to improve oral health, patient care and safety through a consensus-building process. MCNA is pleased to be part of this national effort to enhance the quality of dental care and promote a high level of professional accountability and transparency in its provision.

“Our membership in the Dental Quality Alliance allows us to contribute our expertise to the development of these performance measures,” said Dr. Philip Hunke, President of MCNA Insurance Company. *“We look forward to working closely with the other member organizations to find innovative ways to improve oral health care and strengthen the professional dental community.”*

###

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MCNA_ALL_PRESREL-DQA_201401

MCNA Press Release [3/8]



MCNA JOINS SUNSHINE HEALTH LTC IN EXPANSION

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Eric Sarmany
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PRESS RELEASE – FOR IMMEDIATE RELEASE

FORT LAUDERDALE, FL – September 1, 2013

MCNA has expanded the availability of its dental health care services by contracting with Sunshine Health to provide benefits to its Long Term Care (LTC) enrollees. The rollout of the new plan began August 2013 and is scheduled to be completed March 1, 2014. It provides long-term care services to people with a chronic illness or disability. As a partner working with Sunshine Health, MCNA provides dental and denture benefits to its members, ensuring their oral health needs are met.

MCNA has provided dental services for Sunshine members since 2008. The company is also currently delegated to provide claims, utilization management, network development services, and customer service through its dedicated Member Services Department.

“This new plan allows MCNA to reach a special population of Sunshine members,” said Glen Feingold, Chief Operating Officer. “We are pleased to be able to offer quality dental care benefiting those who are dealing with sometimes challenging long-term needs.”

###

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MCNA_ALL_X_PRESSREL-SUNSHIN-EXPANSION_v201309

MCNA Press Release [4/8]



COVENTRY SELECTS MCNA TO PROVIDE DENTAL CARE SERVICES

MCNA DENTAL PLANS

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Eric Sarmany

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PRESS RELEASE – FOR IMMEDIATE RELEASE

FORT LAUDERDALE, FL – August 27, 2013

Coventry Health Care of Florida has selected MCNA to provide dental care services to its Long Term Care (LTC) members in the state. MCNA began serving Coventry LTC members on August 1, 2013, in Region 7 (Brevard, Orange, Osceola, and Seminole Counties) with three more regions scheduled to become active over the next few months. MCNA is pleased to provide the members with access to high quality care and services through our network of providers.

“MCNA is proud to be a partner with Coventry Health Care in providing dental care that makes a difference in the lives of Medicaid members who require long term care,” said Glen Feingold, Chief Operating Officer. *“Our services contribute to their quality of life.”*

###

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MCNA_ALL_PRESSREL-COVENTRY_201308

MCNA Press Release [5/8]



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**MCNA RECERTIFIED BY
NATIONAL COMMITTEE FOR
QUALITY ASSURANCE (NCQA)**

PRESS RELEASE – FOR IMMEDIATE RELEASE

FORT LAUDERDALE, FL – August 20, 2013

The National Committee for Quality Assurance (NCQA) has recertified MCNA's outstanding Credentialing Department for another two years. MCNA's credentialing processes meet and exceed the rigorous standards that this illustrious certification represents. NCQA standards are the benchmark for excellence in the dental and health care industries, and certification is a badge of quality. With the award of this recertification, MCNA once again stands out among dental managed care organizations as an industry leader.



MCNA's Credentialing Department first achieved NCQA certification for its provider credentialing processes in 2011. The department upheld the high standards that earned the original certification, making the survey process for recertification that began in June 2013 a smooth one. MCNA garnered praise for the quality of its extensive record keeping practices.

"The complete commitment from my team in achieving this milestone represents the larger culture of quality present within MCNA," said Sophia Wallen, Director of Credentialing. "Hard work and dedication always pays off, and this continuation of MCNA's NCQA certification is indicative of how the entire organization executes all operations."

###

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MCNA_ALL_PRESREL-NCQA-CRED-RECERT_201308

MCNA Press Release [6/8]



MCNA RENEWS PARTNERSHIP WITH FLORIDA HEALTHY KIDS CORPORATION

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PRESS RELEASE – FOR IMMEDIATE RELEASE

FORT LAUDERDALE, FL – July 1, 2013

MCNA is proud to announce the renewal of its contract with Florida Healthy Kids Corporation (FHKC) to provide dental health care services for Florida CHIP enrollees. The contract renewal, effective from July 1, 2013, ensures MCNA continues its longtime partnership with FHKC providing dental services to eligible children through a high-quality statewide provider network.

MCNA first contracted with FHKC in 2005. Since then the company has provided excellent dental care services for FHKC members, resulting in the first contract renewal in 2009. With this most recent renewal, MCNA will ensure the dental health care needs of children enrolled in the plan will continue to be met in the future.

###

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MCNA_ALL_X_PRESREL-FHKC-RENEWAL-2013_v001307

MCNA Press Release [7/8]



MCNA DENTAL APPOINTS NEW DIRECTOR OF UTILIZATION MANAGEMENT

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PRESS RELEASE – FOR IMMEDIATE RELEASE

FORT LAUDERDALE, FL – January 23, 2013

MCNA Dental appointed Denise Kissane, RN, MHM, CCM, as the new Director of Utilization Management (UM) effective January 14, 2013. Ms. Kissane oversees the complete functioning of all UM and Case Management activities, and is committed to MCNA Dental's proactive approach to care.

Ms. Kissane has over 28 years of experience in the medical field. Her diverse background includes utilization management, case management, administration, and operations. She came to MCNA Dental from Broward Health Coral Springs Medical Center where she held the position of Regional Manager of Case Management and Social Services. Ms. Kissane's previous experience also includes teaching as an adjunct professor at Broward College, and supervising all utilization management services for Kemper National Services, a managed health care company.

"My goals at MCNA Dental are to guide the UM and Case Management Departments in providing member-centered, high quality dental care and services," said Ms. Kissane. *"We will strive to be a proactive team where every team member is focused on achieving positive oral health outcomes."*

###

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MCNA_ALL_PRESSREL-KISSANE-UM-DIR_201301

MCNA Press Release [8/8]



MCNA BEGINS SERVING HUMANA – CARESOURCE MEMBERS

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PRESS RELEASE – FOR IMMEDIATE RELEASE

FORT LAUDERDALE, FL – January 5, 2013

MCNA is excited to announce the commencement of operations to provide dental services to Humana – CareSource members in Region 3 of the Kentucky Medicaid Dental Program.

This partnership launched January 1, 2013. In preparation for go-live, MCNA worked closely with the providers in Jefferson and the surrounding 15 counties to ensure a robust, fully-credentialed provider network for Humana – CareSource members.

“MCNA has been a longtime quality dental care provider serving Kentucky’s Medicaid and CHIP beneficiaries,” said Glen Feingold, Executive Vice President and Chief Operating Officer. *“We are pleased to expand our presence in the state and continue to provide dental benefits to the individuals who need them most.”*

###

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MCNA_ALL_X_PRESSREL-CSRC-INITIAL_CON_V01301

Section B.14

Provide the following information (in Excel format) based on each of the financial statements provided in response to item B:27: (1) Working capital; (2) Current ratio; (3) Quick ratio; (4) Net worth; and (5) Debt-to-worth ratio.

REDACTED

Section B.15

Identify, in Excel format, all of your organization’s publicly-funded managed care contracts for Medicaid/CHIP and/or other low-income individuals within the last five (5) years. In addition, identify, in Excel format your organization’s ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP and/or other low-income individuals within the last five (5) years. For each prior experience identified, provide the trade name, a brief description of the scope of work, the duration of the contract, the contact name and phone number, the number of members and the population types (e.g., TANF, ABD, duals, CHIP), the annual contract payments, whether payment was capitated or other, and the role of subcontractors, if any. If your organization has not had any publicly-funded managed care contracts for Medicaid/SCHIP individuals within the last five (5) years, identify the Proposer’s ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP individuals within the last five (5) years and provide the information requested in the previous sentence. **Include your organization’s parent organization, affiliates, and subsidiaries.**

R E D A C T E D

Part Two: Technical Approach

Section B: Qualifications and Experience



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Part Two: Technical Approach

Section B: Qualifications and Experience



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Part Two: Technical Approach

Section B: Qualifications and Experience



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Part Two: Technical Approach

Section B: Qualifications and Experience



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Section B.16

Identify whether your organization has had any contract terminated or not renewed within the past five (5) years. If so, describe the reason(s) for the termination/nonrenewal, the parties involved, and provide the address and telephone number of the client. **Include your organization's parent organization, affiliates, and subsidiaries.**

REDACTED

Part Two: Technical Approach

Section B: Qualifications and Experience



REDACTED

Section B.17

If the contract was terminated/non-renewed in B.16 above, based on your organization's performance, describe any corrective action taken to prevent any future occurrence of the problem leading to the termination/non-renewal. **Include your organization's parent organization, affiliates, and subsidiaries.**

MCNA has not had a contract that was terminated or non-renewed for performance reasons.

Section B.18

As applicable, provide (in table format) the Proposer's current ratings as well as ratings for each of the past three years from each of the following:

- AM Best Company (financial strengths ratings);
- TheStreet.com, Inc. (safety ratings); and
- Standard & Poor's (long-term insurer financial strength).

B.18 is not applicable to MCNA.

Section B.19

For any of your organization's contracts to provide oral health services within the past five years, has the other contracting party notified the Proposer that it has found your organization to be in breach of the contract? If yes: (1) provide a description of the events concerning the breach, specifically addressing the issue of whether or not the breach was due to factors beyond the Proposer's control. (2) Was a corrective action plan (CAP) imposed? If so, describe the steps and timeframes in the CAP and whether the CAP was completed. (3) Was a sanction imposed? If so, describe the sanction, including the amount of any monetary sanction (e.g., penalty or liquidated damage) (4) Was the breach the subject of an administrative proceeding or litigation? If so, what was the result of the proceeding/litigation? **Include your organization's parent organization, affiliates, and subsidiaries.**

In the past five years, no contracting party has notified MCNA, or its parent organization, MCNA Health Care Holdings, LLC, or its affiliates, MCNA Dental Plans and MCNA Systems Corp. that any such organization was found to be in breach of contract.

Section B.20

Provide (as an attachment) a copy of the most recent external quality review report (pursuant to Section 1932(c)(2) of the Social Security Act) for the Medicaid contract identified in response to item B.16 that had the largest number of enrollees as of January 1, 2012. Provide the entire report. In addition, provide a copy of any corrective action plan(s) requested of your organization (**including your organization's parent organization, affiliates, and subsidiaries**) in response to the report.

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Part Two: Technical Approach

Section B: Qualifications and Experience



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Part Two: Technical Approach

Section B: Qualifications and Experience



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Section B.21

Identify and describe any regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against your organization within the last five (5) years. In addition, identify and describe any letter of deficiency issued by as well as any corrective actions requested or required by any federal or state regulatory entity within the last five (5) years that relate to Medicaid or CHIP contracts. **Include your organization's parent organization, affiliates, and subsidiaries.**

REDACTED

Part Two: Technical Approach

Section B: Qualifications and Experience



REDACTED

Part Two: Technical Approach

Section B: Qualifications and Experience



REDACTED

Section B.22

Provide a statement of whether your organization is currently the subject or has recently (within the past five (5) years) been the subject of a criminal or civil investigation by a state or federal agency other than investigations described in response to item B.6. If your organization has recently been the subject of such an investigation, provide an explanation with relevant details and the outcome. If the outcome is against your organization, provide the corrective action plan implemented to prevent such future offenses. **Include your organization's parent company, affiliates and subsidiaries.**

MCNA (including its parent organization, affiliates, and subsidiaries) has never been the subject of a criminal or civil investigation by a state or federal agency.

Section B.23

Submit customer references (minimum of two, maximum of five) for your organization for major contracts; with at least one reference for a major contract you have had with a state Medicaid agency or other large similar government or large private industry contract. Each reference must be from contracts within the last five (5) years. References for your organization shall be submitted to the State using the questionnaire contained in RFP Attachment VII. You are solely responsible for obtaining the fully completed reference check questionnaires, and for submitting them sealed by the client providing the reference, with your Proposal, as described herein. You should complete the following steps:

- a. Make a duplicate (hard copy or electronic document) of the appropriate form, as it appears in RFP Attachment VII (for your organization or for subcontractors, adding the following customized information:
 - Your/Subcontractor's name;
 - Reference organization's name; and
 - Reference contact's name, title, telephone number, and email address.
- b. Send the form to each reference contact along with a new, sealable standard #10 envelope;
- c. Give the contact a deadline that allows for collection of all completed questionnaires in time to submit them with your sealed Proposal;
- d. Instruct the reference contact to:
 - Complete the form in its entirety, in either hard copy or electronic format (if completed electronically, an original should be printed for submission);
 - Sign and date it;
 - Seal it in the provided envelope;
 - Sign the back of the envelope across the seal; and
 - Return it directly to you.
- e. Enclose the unopened envelopes in easily identifiable and labeled larger envelopes and include these envelopes as a part of the Proposal. When DHH the opens your Proposal, it should find clearly labeled envelope(s) containing the sealed references.

THE STATE WILL NOT ACCEPT LATE REFERENCES OR REFERENCES SUBMITTED THROUGH ANY OTHER CHANNEL OF SUBMISSION OR MEDIUM, WHETHER WRITTEN, ELECTRONIC, VERBAL, OR OTHERWISE.

Each completed questionnaire should include:

- Proposing Organization/Subcontractor's name;
- Reference Organization's name;
- Name, title, telephone number, and email address of the organization contact knowledgeable about the scope of work;
- Date reference form was completed; and
- Responses to numbered items in RFP Attachment # (as applicable).

DHH reserves the authority to clarify information presented in questionnaires and may consider clarifications in the evaluation of references. However DHH is under no obligation to clarify any reference check information.

REDACTED

Part Two: Technical Approach

Section B: Qualifications and Experience



REDACTED

Section B.24

Indicate the website address (URL) for the homepage(s) of any website(s) operated, owned, or controlled by your organization, including any that the Proposer has contracted to be run by another entity as well as details of any social media presence (e.g. Facebook, Twitter). If your organization has a parent, then also provide the same for the parent, and any parent(s) of the parent. If no websites and/or social media presence, so state.

MCNA believes communication with members and providers is integral to the provision of quality dental care. Helping members understand their benefits and how to access care will assist with EPSDT periodicity compliance and enhance HEDIS scores related to dental care. Keeping providers up to speed on claims submission guidelines and evidence-based dental practices ensures a strong network of satisfied providers. MCNA provides newsletters, communications, brochures, and websites where visitors can easily find plan information.

Our Social Media Mission is to reach members where they spend their Internet and cell phone time with educational materials and reminders to make appointments to see their health care providers. MCNA will target multiple social media outlets to ensure maximum market penetration. Our strategy for the use of social media to conduct outreach to our Louisiana members will be submitted to DHH for prior approval. The following are third party social media services that MCNA uses to reach our members and providers:

- **Facebook**
<http://www.facebook.com/MCNADental>
- **Twitter**
<http://www.twitter.com/MCNADental>
- **YouTube**
<http://www.youtube.com/MCNADental>



Twitter: quick access to the blog as well as updates from our website, reminders, and oral health tips



YouTube: as an extended educational tool with How-To Videos



Facebook: additional communication with reminders and links to our blog, YouTube videos, and website

Please see the following descriptions of each of the websites operated by MCNA, as well as a description of our online Provider Portal.

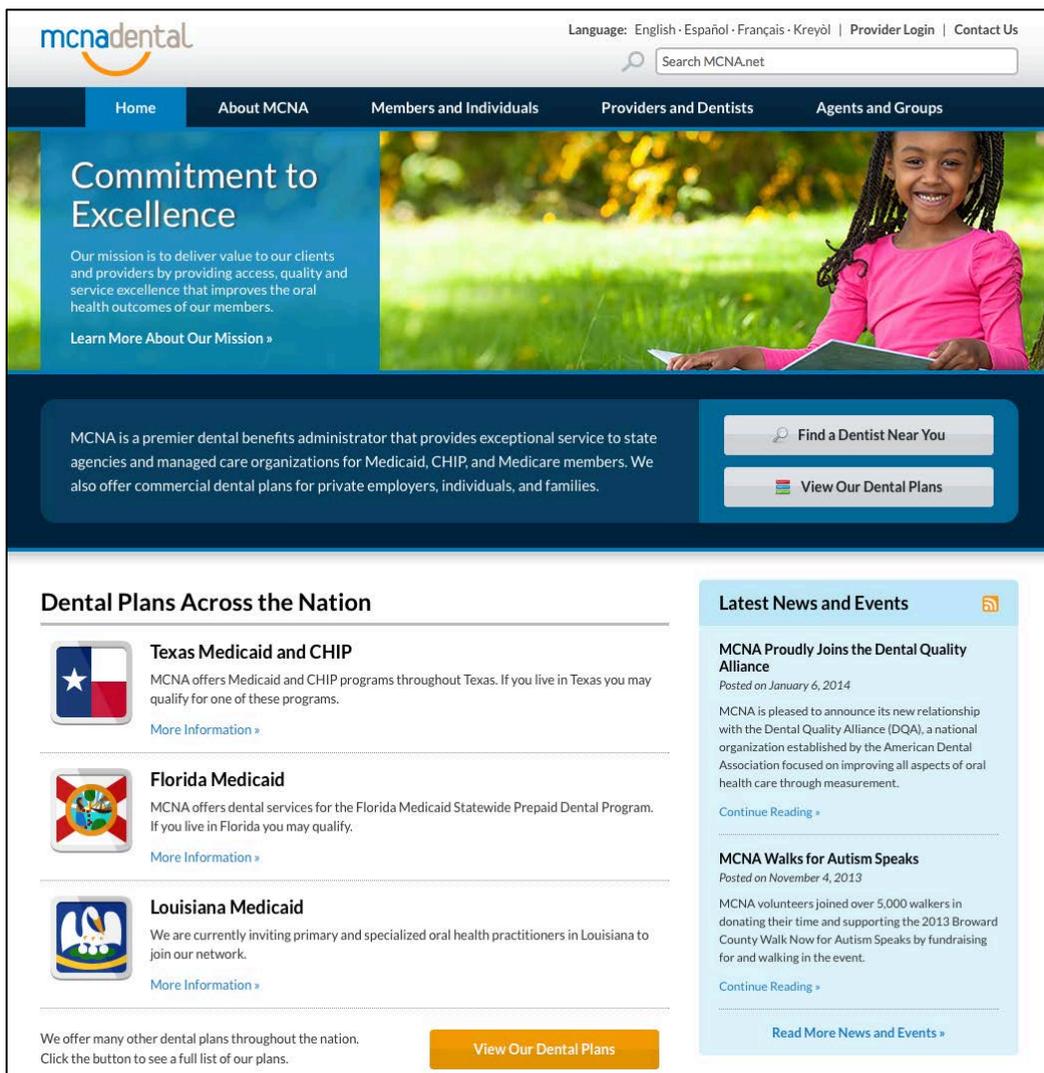
Publicly Accessible Websites Owned and Controlled by MCNA or its Affiliates

Corporate Website

<http://www.mcna.net>

Operational Since: January 2003

MCNA.net serves as the main website for Managed Care of North America, Inc., d/b/a MCNA Dental Plans. The site offers information about the company, our dental plans, contact information, oral health education resources, news articles and press releases, and much more. The website is tailored to meet the needs of the populations we serve with cultural sensitivity and competency. Our website is currently available in English, Spanish, French, and Creole. **This enables MCNA to immediately serve Louisiana’s diverse population through our website on the go-live date of May 1, 2014.** The current corporate website was developed and is maintained by MCNA Systems Corp.



Louisiana Medicaid Website

<http://www.mcnala.net>

Operational Since: August 2012

The Louisiana Medicaid website currently offers providers the ability to submit Letters of Intent to participate in MCNA's Louisiana network. Providers also have the ability to download credentialing forms. Prior to the go-live date, the website will be expanded to include more information about the plan, resources for members and providers, provider training schedules and presentations, member handbooks, provider manuals, and much more. The website is currently available in English for providers and will be made available in other applicable languages prior to the go-live date. The Louisiana Medicaid website was developed and is maintained by MCNA Systems Corp.

mcnadental MCNA Dental Plans
Louisiana Network Enrollment

Welcome Enroll by Fax Enroll by Mail Contact Us

Louisiana Network Enrollment

We invite you to join our network of primary and specialized oral health practitioners. MCNA is a provider friendly program. The key to our success has been our relationships with our providers in each region.

About MCNA Dental Plans

MCNA Dental Plans is a leading dental benefit management company committed to providing high quality services. We currently serve approximately 3 million children and adults throughout the nation. For nearly 20 years, we have been committed to improving the overall health of our members by making sure they get great dental care and service they can trust. At MCNA, we care about your smile.

For more information about MCNA Dental Plans, visit our main website at <http://www.MCNA.net>.

Providers May Enroll Now!

Phase 1: Letter of Intent

Select an option below to submit a Letter of Intent for your dental facility.

- Enroll by Fax
- Enroll by Mail

Phase 2: Credentialing Forms

Once MCNA has received your Letter of Intent (Phase 1, above), you may download and complete the forms below to begin the contracting and credentialing process. (Adobe Reader may be required to view PDF files.)

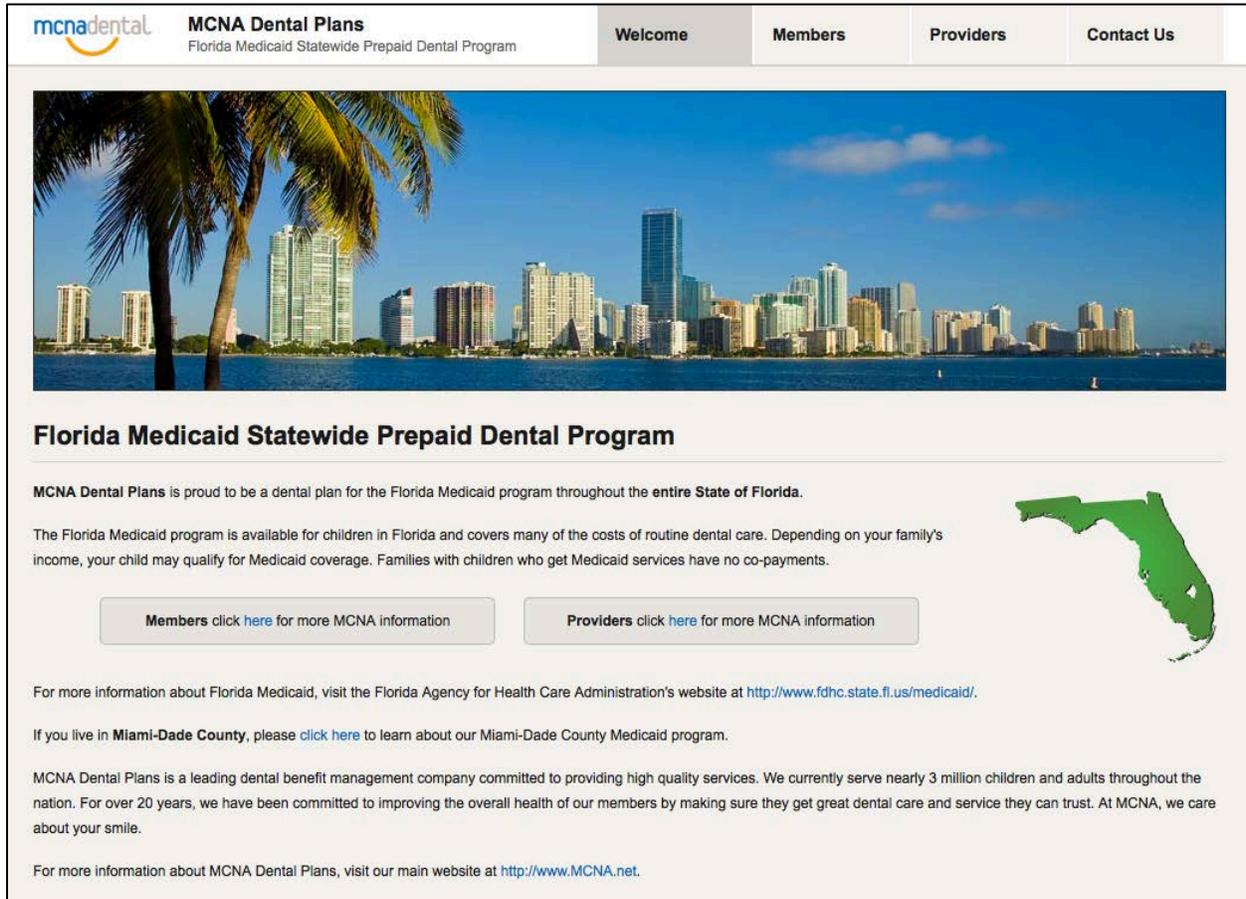
- Step 1: Download and complete the [Credentialing Application](#).

Florida Medicaid Statewide Dental Program Website

<http://www.mcnafl.net>

Operational Since: October 2011

The Florida Medicaid Statewide Dental Program website provides information to members and providers about the plan including FAQs about the plan, how to access the provider directory, benefit detail, and other useful information. The Florida Medicaid Statewide Dental Program website was developed and is maintained by MCNA Systems Corp.



MCNA Dental Plans
Florida Medicaid Statewide Prepaid Dental Program

Welcome Members Providers Contact Us

Florida Medicaid Statewide Prepaid Dental Program

MCNA Dental Plans is proud to be a dental plan for the Florida Medicaid program throughout the **entire State of Florida**.

The Florida Medicaid program is available for children in Florida and covers many of the costs of routine dental care. Depending on your family's income, your child may qualify for Medicaid coverage. Families with children who get Medicaid services have no co-payments.

Members click [here](#) for more MCNA information

Providers click [here](#) for more MCNA information

For more information about Florida Medicaid, visit the Florida Agency for Health Care Administration's website at <http://www.fdhc.state.fl.us/medicaid/>.

If you live in **Miami-Dade County**, please [click here](#) to learn about our Miami-Dade County Medicaid program.

MCNA Dental Plans is a leading dental benefit management company committed to providing high quality services. We currently serve nearly 3 million children and adults throughout the nation. For over 20 years, we have been committed to improving the overall health of our members by making sure they get great dental care and service they can trust. At MCNA, we care about your smile.

For more information about MCNA Dental Plans, visit our main website at <http://www.MCNA.net>.

Texas Medicaid and CHIP Website

<http://www.mcnatx.net>

Operational Since: October 2011

The Texas Medicaid and CHIP website provides detailed information for members and providers about a variety of topics such as how to access value added services, how to enroll with MCNA, FAQs, provider training webinars, and other helpful information and links. The Texas Medicaid and CHIP website was developed and is maintained by MCNA Systems Corp.

The screenshot shows the mcnadental website interface. At the top, there is a navigation bar with the mcnadental logo and menu items: Welcome, Members, Providers, About Us, and Español. The main content area features a large heading "Texas, it's time to smile." followed by introductory text about MCNA Dental's role in the Texas Medicaid and CHIP programs. A section titled "We care about your smile!" lists member benefits, including a free \$10 Walmart Gift Card, a free Dental Hotline, and a free Dental Kit. Below this is a "Walmart \$10giftcard" image. A section titled "Enroll with MCNA Dental" provides a link to enroll children. The page is organized into three main columns: "for members" (green), "for providers" (orange), and "about mcna" (purple). Each column contains a list of links with right-pointing arrows. The "for members" column includes links for "About our Texas Program", "Enroll with MCNA Dental", "Our Value-Added Services", "Frequently Asked Questions", "Find a Dentist Near You", and "Call our Member Services Hotline". The "for providers" column includes links for "Contract with MCNA Dental", "Frequently Asked Questions", "Documents and Resources", "Log in to Your Provider Portal", "Information, Tips, and Support", and "Provider Training Webinars". The "about mcna" column includes links for "Our Background and Services", "Our Provider Network", "Our Commitment to You", "Our Company Leadership", "Contact MCNA Dental", and "Visit our Corporate Website". At the bottom, there are two blue boxes: "to learn more" with contact information for MCNA Dental (1-855-691-6262) and TTY (1-800-955-8771), and "to enroll now" with contact information for Medicaid (1-800-964-2777) and CHIP (1-877-543-7669). The footer contains the mcnadental logo and the CHIP Children's Medicaid logo with the tagline "We've got your kids covered."

Part Two: Technical Approach

Section B: Qualifications and Experience



Online Provider Portal

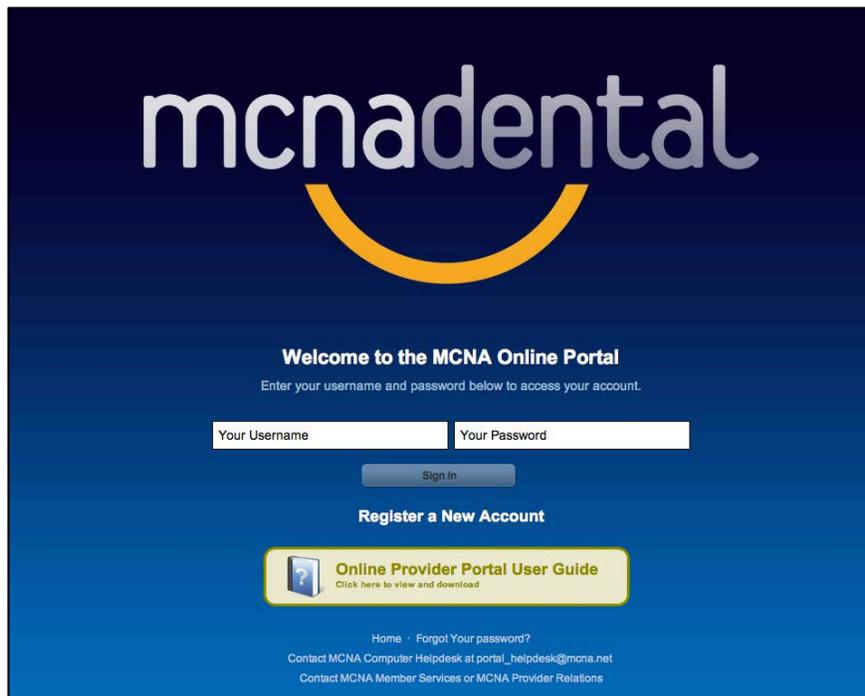
<http://portal.mcna.net>

Operational Since: July 2009

MCNA offers our participating providers access to our free Online Provider Portal. The Portal is an all-in-one tool that we encourage all of our providers to take advantage of. The Provider Portal was developed and is maintained by MCNA Systems Corp.

Providers can access our secure Provider Portal. This integrated, online portal offers an ideal solution for providers to easily perform the following necessary day-to-day functions:

- Verify member eligibility
- Submit claims
- View missing information from any claims submitted
- Submit and review the status of appeals
- Request prior authorizations and referrals
- Print Remittance Advices (RAs)
- Review a member's dental treatment history
- Create an appointment book
- Manage fee schedules
- View Member Roster
- View and update demographic information
- View individual scorecards and provider profile reports
- Access Provider Manual and newsletter updates
- Additional features



Section B.25

Provide evidence that the Proposer has applied to Louisiana Department of Insurance for a certificate of authority (COA) to establish and operate a prepaid entity as defined in RS 22:1016 and in accordance with rules and regulations as defined by the Department of Health and Hospitals.

MCNA Insurance Company is currently authorized by the Louisiana Department of Insurance (LDI) to operate as a Health and Accident insurer in all 64 Louisiana parishes. MCNA was granted a Certificate of Authority (COA) by the LDI on December 26, 2012. A copy of the COA is included below.



Section B.26

Provide the following as documentation of financial responsibility and stability:

- a current written bank reference, in the form of a letter, indicating that the Proposer's business relationship with the financial institution is in positive standing;
- two current written, positive credit references, in the form of a letters, from vendors with which the Proposer has done business or, documentation of a positive credit rating determined by an accredited credit bureau within the last 6 months;
- a copy of a valid certificate of insurance indicating liability insurance in the amount of at least one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) in the aggregate; and
- a letter of commitment from a financial institution (signed by an authorized agent of the financial institution and detailing the Proposer's name) for a general line of credit in the amount of five-hundred thousand dollars (\$500,000.00).

REDACTED

Part Two: Technical Approach

Section B: Qualifications and Experience



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Part Two: Technical Approach

Section B: Qualifications and Experience



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Part Two: Technical Approach

Section B: Qualifications and Experience



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Part Two: Technical Approach

Section B: Qualifications and Experience



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Part Two: Technical Approach

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Part Two: Technical Approach

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REDACTED

Section B.27

Provide the following as documentation of the Proposer's sufficient financial strength and resources to provide the scope of services as required:

- The two most recent independently audited financial statements and associated enrollment figures from the Proposer. Compiled or reviewed financial statements will not be accepted. The audited financial statements must be:
 - Prepared with all monetary amounts detailed in U.S. currency;
 - Prepared under U.S. generally accepted accounting principles; and
 - Audited under U.S. generally accepted auditing standards. The audited financial statements must include the auditor's opinion letter, financial statements, and the notes to the financial statements.
- The Proposer's four (4) most recent internally prepared unaudited quarterly financial statements (and Year-to-Date), with preparation dates indicated. The statements must include documentation disclosing the amount of cash flows from operating activities. This documentation must indicate whether the cash flows are positive or negative, and if the cash flows are negative for the quarters, the documentation must include a detailed explanation of the factors contributing to the negative cash flows.
- Verification of any contributions made to the Proposer to improve its financial position after its most recent audit (e.g., copies of bank statements and deposit slips), if applicable.

Proposer shall include the Proposer's parent organization.

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Part Two: Technical Approach

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Part Two: Technical Approach

Section B: Qualifications and Experience



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Section C.1

Describe how you will launch a network and set up operations capable of supporting its membership and meeting the requirements of the RFP by May 1, 2014.

Discuss your approach for meeting the implementation requirements and include:

- A detailed description of your project management methodology. The methodology should address, at a minimum, the following:
 - Issue identification, assessment, alternatives analysis and resolution;
 - Resource allocation and deployment;
 - Reporting of status and other regular communications with DHH, including a description of your proposed method for ensuring adequate and timely reporting of information to DHH project personnel and executive management; and
 - Automated tools, including use of specific software applications.

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Part Two: Technical Approach

Section C: Planned Approach to Project



REDACTED

Part Two: Technical Approach

Section C: Planned Approach to Project



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Part Two: Technical Approach

Section C: Planned Approach to Project



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Part Two: Technical Approach

Section C: Planned Approach to Project



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- Using the Medicaid Dental Provider List for the State of Louisiana to establish a baseline of leads
- Purchasing the Louisiana State Board List of Licensed Dentists to include the “non-Medicaid” dentists in our efforts
- Contacting each provider until we exhausted the baseline listing to both prioritize and ensure our Network Development team reached out to all the Significant Traditional Providers

We understand that sometimes a member may have a dentist that is “just across the border”, so our final step was to extend our efforts to include dentists who are at or near the Louisiana State line. As the preferred dental plan manager for Texas Medicaid and CHIP members, we are very conscious of the needs of some of our members who live on state borders. If needed to ensure adequate coverage we will work with DHH to allow our Texas providers to serve Louisiana members. We believe this exemplifies our commitment to providing dentists who are geographically proximal to our members.

MCNA has two dedicated Louisiana residents who have served as Network Development Specialists since August 2012. They have focused on building an in-person, on-site relationship with each and every prospective provider. Together they have visited virtually every dentist in the state with the goal of creating the most comprehensive dental services network possible for our Louisiana members. Our team is committed to our prospective providers and to building very honest and friendly relationships that are meant to last. As a result, many prospective providers have given us positive feedback that allows us to quantify and verify the success of MCNA’s efforts thus far. We know that our proven, proactive approach enables us to bring the program into operation quickly, efficiently, and on schedule.

The scope and depth of our work plan is indicative of the attention to detail that MCNA applies to every facet of our managed care operations. We believe this plan will enable us to achieve our goal of creating a member-focused, efficient, and cost effective DBP for the State of Louisiana.

MCNA’s Project Management Methodology

MCNA knows a successful implementation of the Louisiana Dental Benefit Program requires a flexible work plan, well-defined milestones and expectations, robust communication, ample financial and manpower resources, and a strong leadership team. Our initial Transition and Implementation Plan (TIP) for Louisiana has been developed based on our experience with similar transitions in Texas, Florida and Kentucky.

MCNA recognizes that the transition phase will include all activities that must be completed successfully prior to MCNA’s operational start date, including all Readiness Review activities, and that DHH will conduct Readiness Reviews to determine whether MCNA has implemented all systems and processes necessary to begin serving our Louisiana members. MCNA agrees to satisfy all requirements by April 1, 2014, thirty (30) days prior to go-live.

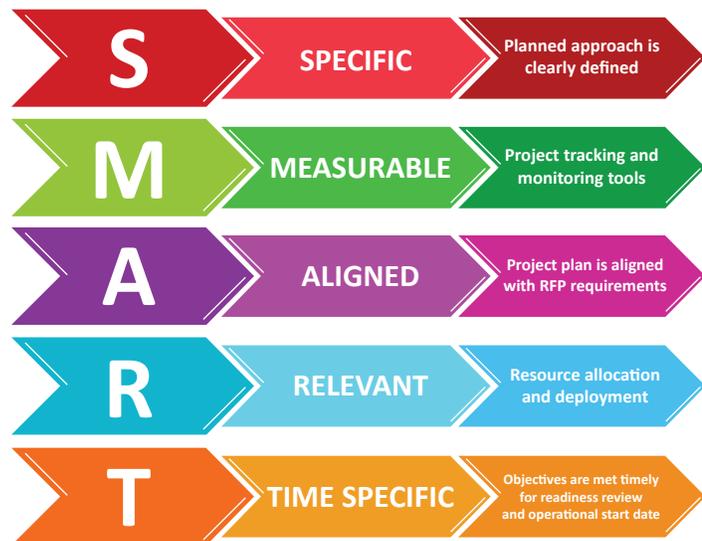
During the Contract Start-Up and Planning phase, MCNA will work with DHH to define the project management and reporting standards to be followed. These standards will include the establishment of

communication protocols for DHH and MCNA staff, contacts with other DHH contractors, schedules for key activities and milestones, a comprehensive plan for exchanging information, and the finalization of parameters for the contract deliverables.

MCNA believes setting sound goals is critical to the success of this project. MCNA uses the SMART strategy to establish goals, measure progress, and ensure requirements and resources are in line with the RFP objectives.

The SMART approach ensures the following are outlined in the project plan:

- Goals
- Scope
- Deliverables
- Resources
- Metrics (including timeliness)
- Staffing
- Communication protocols



Our transition planning process is comprehensive and involves the leadership of every major operational unit of MCNA. Weekly internal team meetings, documentation of requirements, continuous risk management, dedicated resources and support, and continuous communication with DHH throughout the process, including post implementation, are the hallmarks of MCNA's turnkey approach to DBPM operations. DHH will be reassured of our **System and Operational Readiness** by the level of planning and execution our highly skilled and dedicated staff will bring to the TIP. All activities necessary for a successful commencement of operations including provider network development, MIS and administrative system testing, care coordination planning, and all activities needed to ensure the requirements described in the RFP are carried out to the satisfaction of the DHH are outlined in the plan.

All member and provider educational materials such as Member Handbooks, Provider Directories, and Provider Manuals will be submitted to DHH for approval prior to distribution. Our provider orientation training sessions, seminars, and webinars will follow a DHH approved schedule. Finally, we will work with DHH, providers, and any other parties to identify and promptly resolve any problems arising after the operational start date, communicating to all parties the remedial steps taken by MCNA.

Project Management Office (PMO)

In anticipation of the RFP award announcement, MCNA has organized our project management office (PMO) in order to be fully prepared for our pre- and post-contract work plan development activities with DHH. Our PMO is located at MCNA Systems Corp. to enable collaboration among business units, business analysts, reporting analysts, enrollment and EDI teams, and MCNA's DentalTrac™ development team. MCNA uses a variety of technology-based tools to manage large scale implementations.

At MCNA, the PMO is engaged for all projects in order to ensure flawless implementation through a dedicated team. With the knowledge that versatile and varied core strengths are needed in order to ensure successful implementation, the PMO is comprised of:

Dedicated Project Management Office with Certified PMs, SMEs, and DEs assigned to the DBPM

- **Project Managers (PMs)**
- **Subject Matter Experts (SMEs)**
- **Domain Experts (DEs)**

Each team member is certified in his or her specialty through the Project Management Institute (PMI) as Project Management Professionals (PMP) or International Institute of Business Analysis (IIBA) as Certified Business Analysis Professionals (CBAP). Our dynamic team utilizes highly efficient processes and methodologies in order to ensure flawless implementation and smooth transitions. With proficient Project Management skills, we bring a combined healthcare implementation experience level in excess of 100 years to the table.

MCNA strives to be a lean company and constantly improves its processes and methodologies. This allows us to have a robust PMO in place. Our processes are based on best practices, proven effective strategies and global PMI Community of Practice recommendations. As such, our project team is quickly able to start the process of implementation using the following management techniques:

- Assignment of the right balance of SMEs, PMs and DEs as part of the overall project team
- Allocation of Operational Process Assets (OPA's) and contract to project team
- Kickoff meeting for contract and Service Level Agreement (SLA) review
- Development of Project Plan through Microsoft Project® with critical milestones
- Weekly implementation meetings with DHH staff and MCNA project team
- Development of Project Charter, Action Log and Risk Register
- Formal communication of plan and project update sharing with DHH staff
- Identification of reporting needs and development efforts
- Complete training plan and internal and external training rollout
- Internal readiness reviews and pre go-live testing
- Post go-live support structure placement

The collective knowledge and ability of our team ensures a well-managed project. We work diligently to ensure that all aspects of the project are well understood, well documented and shared with all resources. Understanding that the knowledge-sharing component is key to the success of the project,

Part Two: Technical Approach

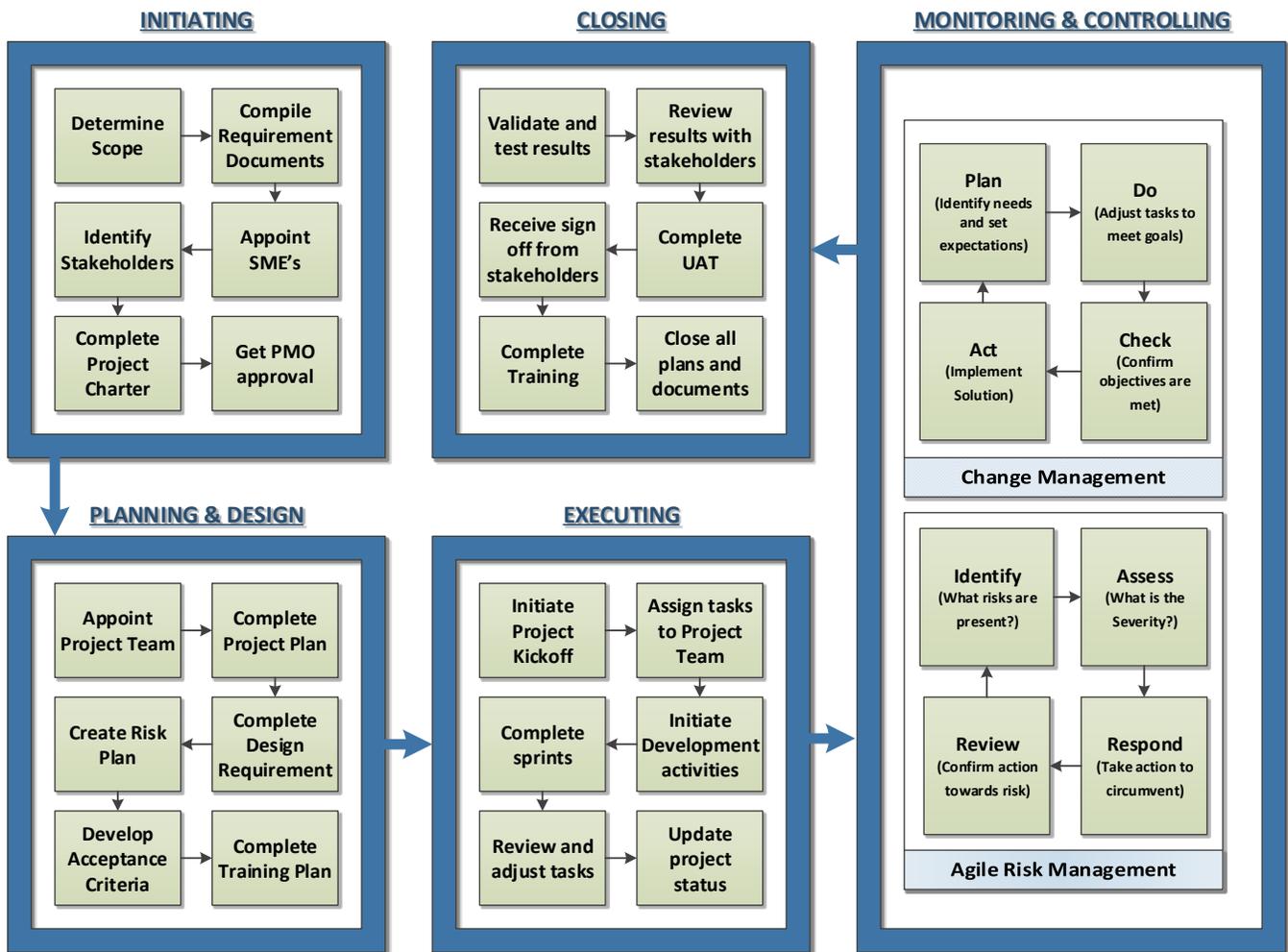
Section C: Planned Approach to Project

we schedule **regular checkpoint calls** including all stakeholders to give periodic updates and review the status.

MCNA utilizes the skillset of its SMEs for each project in the arena of IT and health care. Additionally, the skillset of the DEs are utilized for any technological requirements to implement a technological solution or approach to the project. Both SMEs and DEs work in collaboration with the Project Managers at MCNA to ensure all deliverables are identified, scrutinized and presented on time. This team is involved from the concept to delivery stage and plays a key role from the analyzing and responding of RFPs to the actual implementation. This involvement from the start ensures a consistent and dedicated approach allowing each project to be successfully concluded.

The PMO is directly involved during all implementation phases by reviewing the project status on a bi-weekly basis. The PM provides an updated Project Plan, Action Plan and Risk Register for review by the implementation team, which may include DHH personnel. During these reviews, SMEs and DEs are required to give a business and technical status report in relation to our progress.

MCNA utilizes the proven Project Life Cycle approach to all implementations.



Although the implementation is based on strict standards, each one is handled with a tailored approach: Issue Identification, Assessment, Alternative Analysis and Resolution.

MCNA's project team follows a strict standard of quality control of the ongoing project to identify and resolve any issues that may arise during the implementation. Both change management and risk management activities are conducted on a regular basis to proactively identify and resolve such issues. The activities undertaken by the project team and the PMO are outlined below.

1. A Project Charter is authored collaboratively between the PM and the SMEs in order to describe every aspect of the implementation. MCNA's experience has been that a Charter allows the identification of issues, both prospective and current, which can be discussed well in advance for a thorough and vetted resolution.
2. The project is continuously monitored to identify risks. These risks are logged in a Risk Register with an impact scale and mitigation plan. The Risk Register is part of MCNA's OPA repository on our secure document management system and exists as a Microsoft Excel® spreadsheet.
3. Issues may be identified during review of documentation provided as part of the project path. Such issues are brought to the attention of the stakeholders at the earliest possible time and a resolution is discussed and vetted.
4. Issues may be brought up during the weekly checkpoint call between the stakeholders and the project team. These are documented in the Risk Register and a mitigation plan is discussed with the PMO.
5. Issues may arise from lack of documentation or incomplete documentation related to the project. This usually tends to be more common during the initiation phase of a project. MCNA utilizes their PMO to go through newly initiated projects to vet their requirements to ensure documentation is completed prior to approving the project.
6. Potential issues may arise in completing a task based on resource availability. In the event that a project task remains unassigned, or an assigned owner is unable to take proper ownership, MCNA has several seasoned team members who are part of the project management team and are able to take charge of tasks and drive them through to completion.
7. "Scope creep" can occur when new or additional project demands are made known. This has the potential of causing several issues since it can delay full comprehension of project requirements, may cause a shift in the implementation timeline, or may require more resources than are currently allocated to the implementation effort.

Issue Identification

Implementation issues can be identified in a multitude of ways during the project cycle. MCNA's team is well versed with the mitigation strategies and processes that can be used to circumvent escalation. During the course of the implementation, the team holds weekly checkpoint calls with the stakeholders and bi-weekly project reviews with the PMO. These meetings combine to provide the opportunity for extensive analysis of the issue and the best course of action for its resolution. All issues are continually tracked and monitored as part of the Risk Register until resolved. Once resolved, they are moved to a closed status, but are kept as part of the Register for the lifetime of the project. The reason for documenting the resolved issue is to ensure the corrective actions can be reviewed should there be any concerns regarding the course of action taken.

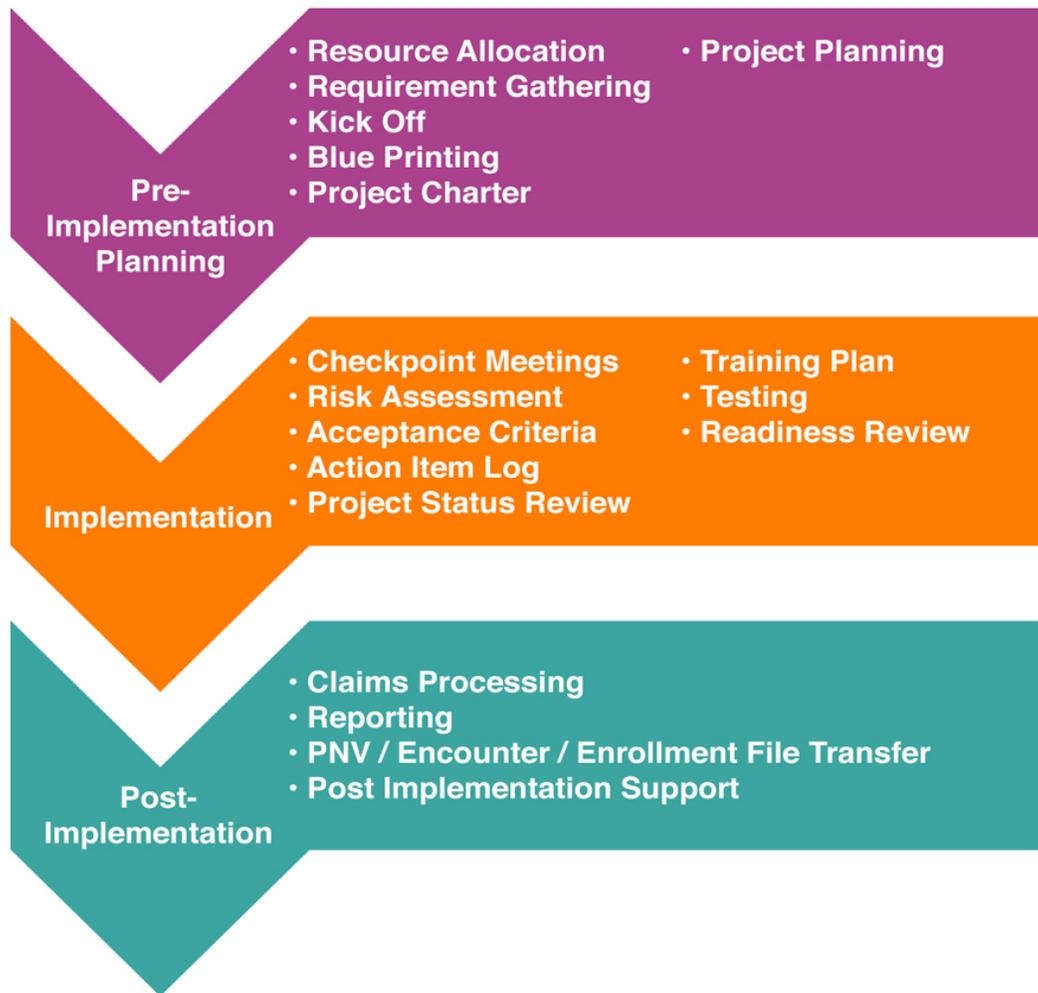
The bi-weekly PMO reviews not only focus on the project path, but also the effectiveness of the project team at keeping the implementation activities on track. Any additional resource allocation, key decision resolution, change management activities, fiscal requirements and project adjustments are also decided upon during these meetings. The meetings also serve to prepare an internal readiness review timeline and ensure all necessary activities are completed in time.

Resource Allocation, Project Manager, and Resource Deployment

We understand the importance of maintaining an **open channel of communication with DHH staff** assigned to monitor our transition. To this end, we have designated our Chief Information Officer, Daniel Salama to serve as the project lead and "Champion" as well as the Implementation Manager and company liaison with DHH, and any other party necessary for a successful implementation. Mr. Salama's experience with large-scale transitions and implementations coupled with his extensive knowledge of information technologies makes him the best and most logical choice as the Project Champion.

In addition to the importance of a dedicated project management team whose knowledge and skillset can enhance the implementation process, MCNA will assign a minimum of two dedicated PMs and six SMEs to liaise with DHH. These team members will be solely dedicated to the furtherance of the project and will be assigned in addition to the large team of executives and SMEs from all business units of the company. This team will coordinate and drive the project from the RFP stage to post-implementation. All PMs and SMEs have first-hand experience in the rollout and transition of Medicaid, CHIP, and other social service programs across our service areas.

A rollout strategy is utilized for the deployment of any implementation by MCNA. The strategy adheres to the processes and methodologies already put in place by the PMO and follows the below stages.



Pre-Implementation Planning Process

Resource Allocation

At the advent of any project, the PMO assigns a minimum of one (1) PM and two (2) SMEs to determine the scope and breadth of the same. These PM and SMEs provide a report of the project requirements and preliminary findings to the PMO to assess the needs of resource allocation for the project. Once the PMO is able to ascertain the needs, a set of team members is assigned to the project. These team members are brought in at various phases of the project in order to bring both expertise and skills to the table.

The phases include pre-implementation, implementation and post-implementation each of which require both a static team and a dynamic team.

- **Static Project Team**
 - Is assigned from the inception of the project
 - Remains with the project throughout its life cycle
 - Remains in place after the project has concluded to provide training and support

- **Dynamic Project Team**
 - Is brought in during the project kickoff
 - Remains with the project throughout its lifecycle
 - Are released from the project at its conclusion

Requirements Gathering

The PMO assigns a PM and SME during the RFP process to assist in the response phase. These same team members are responsible for gathering any and all information pertinent to the implementation efforts in order to conduct a kickoff and share the knowledge with the remaining project team members. All documents are gathered and stored as part of a project document repository in the secure document management system available through the PMO to the team members.

The SMEs are responsible for analyzing the data contained within the Contract, service level agreement (SLA) and any appendices, addendums or supporting documents. This is to ensure that all deliverables are extracted from said documents in order to chart them in the Project Plan and assign them to the project team members.

Kickoff

A kickoff meeting musters all project team members together for a comprehensive briefing on the particulars of the project. Prior to the kickoff meeting, the SMEs have gone through the Contract, Service Level Agreement and any additional supporting documentation provided to ascertain an in-depth knowledge of the implementation. This information is shared with all team members during the meeting. Questions, concerns and any clarifications are compiled during the kickoff event for further review and resolution. The team also charts out the schedule for the weekly internal checkpoints and the bi-weekly PMO project review meetings at this time.

All tools which will be utilized by the team are confirmed and OPAs are shared by all. Expectations of documentation requirements and timelines are also set.

Blueprinting

The blueprinting session is conducted by the PM and the SMEs in order to understand the full scope of the project. This assists with compiling the Project Charter to log all deliverables necessary at the conclusion of the implementation. During the blueprinting session, any deficiencies in information provided are identified and listed within the Action Log for further clarification. Issues found are logged within the Risk Register and assigned a Mitigation Plan. Both the log and the register are assigned a primary owner who ensures their continuous monitoring and status adjustments. The log and register are also made available to all team members in order to review items assigned to their ownership.

Project Charter

The Project Charter is a comprehensive document outlining all deliverables that must be met by the project team at the conclusion of the implementation. This document serves as a guideline in addition to the contract, SLA and supporting documents and is a culmination of all aspects pertaining to the deployment.

The development of the Project Charter is a Risk Management strategy that reduces the need for Change Management. Although these things are inevitable with any project, MCNA's experience has been that a robust Charter allows both the stakeholder and the project team to understand the requirements thoroughly and discuss and vet solutions prior to issues being encountered or the project being in an advanced stage.

Project Planning

The foundation of any well managed project lies in its planning. Even though all aspects of the implementation requirements may be understood, if a plan is not well developed, there is a greater chance of both Project Scope Creep and risks that would jeopardize its success. In order to have preventative measures against both, MCNA utilizes Microsoft Project®, PivotalTracker™ and Smartsheet for planning, tracking and collaboration respectively.

The plan is a detailed outline of all tasks and deliverables that need to be addressed by the project team. Some of the key attributes MCNA project plans track are:

- Baseline
- Key Tasks
- Milestones
- Resource Pool
- Resource Allocation
- Deliverable Dates
- Task Status
- Task Progress
- Time-per-task Allotment
- Fiscal Status
- Scope Creep
- Timeline
- Work Breakdown Structure (WBS)

The plan is meticulously maintained and all team members update the plan on a daily basis to ensure there is no impact to the planned timeline. MCNA maintains several distinct tasks within its project plans. Sub-plans may be developed for each department or stakeholder in order to expedite delivery and prevent confusion or mistakes.

Implementation Process

Checkpoint Meetings

A schedule of checkpoint calls is developed by the MCNA project team during the initiation of the implementation. These calls are both internal and external. The following sets of calls are scheduled.

- **Stakeholder Checkpoint Call**
 - The meeting is held weekly
 - Both DHH stakeholders and MCNA project teams attend
 - Project update is provided
 - Discussion on deliverables is held
 - Updates are provided on any issues or risks uncovered
 - Status of deliverables is provided
 - Documentation is shared (where required)
- **Internal Checkpoint Meeting**
 - The meeting is held weekly prior to the Stakeholder Checkpoint
 - Project plan updates are reviewed
 - Risk Register, Action Log and Change Requests are reviewed
 - Status of deliverables is confirmed
- **Project Status Checkpoint**
 - Meeting is held bi-weekly between PM, SMEs and PMO
 - Project Plan, Risk Register, Action Log and Change Requests are reviewed
 - Project Plan is reviewed and updated
 - Resource allocation and adequacy is assessed
 - Milestones and critical task status are assessed

Risk Assessment

MCNA maintains strict oversight of its Risk Assessment and Mitigation. With the knowledge that a blind eye to risk poses a serious threat to the integrity of the project, the PMO consistently monitors all issues and risks that could surface during the implementation. Each risk is assigned a mitigation plan that is vetted by both executives and SMEs. Best practices are applied and adhered to in order to ensure a meticulously executed resolution.

Acceptance Criteria

In order for the implementation to be successful, an Acceptance Criteria is drafted / confirmed for all stakeholders. These criteria address all deliverables that must be met including their standards. With the knowledge that the implementation must meet the needs and demands of the stakeholders, MCNA solicits advice from all stakeholders on their testing and acceptance requirements, and plans the implementation stages accordingly.

Action Log

In addition to the project plan, MCNA maintains an Action Log for items requiring attention from everyone involved in the project. These items can be as simple as scheduling a one-on-one call to

completing documentation approval. The purpose is to prevent the project plan from being inundated with tasks not critical for the implementation and yet maintaining a log of activities that must be performed in order for it to succeed. The log outlines the activity in detail, assigns ownership to a team member and allocates a due date by which it must be completed. The log is maintained in a Microsoft Excel® format and is housed in our secure document management system for accessibility and collaboration amongst the project team.

Project Status Review

The PMO convenes on a bi-weekly basis to assess the status of the project. During this meeting, a critical look is given to the Project Plan, Risk Register, Change Requests and Action Log. The meeting is held between the executives, PMs, SMEs and DEs. Any necessary communication which must be conducted with stakeholders is assessed and completed based on the discussion and review of the project status. Given that the PMO manages all changes, resource allocations, and project adjustments, the bi-weekly meetings are critical to the healthy life cycle of the project. In addition, it ensures open communication, inclusion of all project team members and knowledge sharing. This also prevents any confusion during the project execution as the PMO can make executive decisions during the status review.

Training Plan

Both an internal and external training plan are vital to a successful implementation. To ensure consistency, a training plan is developed in conjunction with department SMEs. A timetable is established and resources are assigned for training purposes. Although our staff is well trained and knowledgeable, training reinforces their knowledge and sets expectations within the timeline required for the successful implementation of the project.

Testing

Prior to the conclusion of the project, MCNA ensures that all acceptance criteria have been met by conducting testing. A test plan is developed during the acceptance criteria drafting phase to ensure stakeholders can confirm each deliverable has been adequately met as part of the implementation effort.

Readiness Review

To showcase our efforts applied during the implementation, MCNA plans and prepares for a readiness review by ensuring all of the deliverables have been met and project tasks achieved prior to the go-live date. MCNA's project plan includes key milestones and activities needed to be ready to assume plan operations on May 1, 2014. All timeframes including those for network development are included along with an estimate of person hours for the identified tasks.

Post-Implementation Process

Claims Processing

Utilizing the information provided in the RFP, MCNA will ensure proper claims processing by doing its due diligence in configuring all claim edits and criteria within its proprietary management information system (MIS). For further information about our post-implementation claims processing approach, please refer to Section P of this response.

Reporting

MCNA has a dedicated team of Reporting Analysts who develop and maintain over 500 complex reports which are utilized both internally and provided to the plans we serve.

Provider Network / Encounter / Enrollment File Transfer

A dedicated EDI team is part of the MCNA project team and serves to ensure timely and accurate electronic data exchange between DHH and MCNA. Our team members are able to generate and receive files in a multitude of formats. This flexibility puts us ahead of our competition and we are able to work with DHH to exceed their requirements while adhering to state compliance needs.

Post-Implementation Support

The static project team continues to monitor and provide assistance in all capacities once the project has drawn to a conclusion. This may include ensuring all necessary documents are closed and final copies shared with stakeholders, continuing training efforts where needed, providing project requirements to new staff or team members that are brought on post-implementation, and monitoring performance of the implemented solution by reviewing key performance indicators (KPIs).

Reporting of Status and Communications with DHH

If issues are identified during the TIP, checkpoint calls, or PMO review sessions, MCNA will assess the situation and determine the impact to the plan. We will utilize open lines of communication with DHH to ensure prompt resolution of any identified issues that could result in project plan changes. All issues with a potential impact will be documented individually into our project-tracking module. MCNA's project implementation team will update DHH twice per week, or more frequently if needed, about the status of the project. Each status report will contain updates on:

- Completed and pending deliverables
- Key milestones
- Upcoming activities
- Any items submitted for review and approval since the prior report
- Identified risks to scheduled deliverables that could impact the project

Responsible parties will be identified and any issues that could impact the project or critical timelines will be handled as follows:

- Response to general questions pertaining to activities will be directed to appropriate team members
- Resolution timeframe for issues is 24 hours or less
- Issues remaining unresolved after 24 hours must be escalated directly to the Implementation Manager
- Should the Implementation Manager be unable to resolve the issue within 24 hours, a risk mitigation plan is developed and submitted to MCNA Senior Management for approval

Automated Tools and Software

MCNA prides itself in being an early adopter of technological solutions and utilizing the tools necessary for success in both business and project needs. The project team utilizes several tools in order to keep the project on track and on time. Some of these are described below.

- **Microsoft Project**®

The project team uses this tool to develop extensive project plans. The plan keeps track of the baseline, all unique tasks associated with the implementation, the resources which are dedicated to it, the unique milestones which need to be achieved, the timeline allocated, task progress, fiscal status, scope creep and Work Breakdown Structure.



- **PivotalTracker**™

MCNA utilizes PivotalTracker™ for ticketing and development monitoring purposes. As project needs are made available, an “epic” is created in the system in order to track the various stories associated with the development effort.



- **DentalTrac**™

Our own in-house system excels at meeting all our business needs by providing a centralized repository where we can track, monitor, enter, maintain and export all our data needs.



- **Smartsheet**

This collaboration tool allows MCNA to share information and collaborate across multiple platforms and geographical areas.



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Section C.2

Provide a work plan for the implementation of the Louisiana Medicaid DBP Program. At a minimum the work plan should include the following:

- Tasks associated with your establishment of a “project office” or similar organization by which you will manage the implementation of the DBP Program;
- An itemization of activities that you will undertake during the period between the awarding of this procurement and the start date of the DBP Program. These activities shall have established deadlines and timeframes and as needed conform to the timelines established under this RFP for deliverables.
 - All activities to prepare for and participate in the Readiness Review Process; and
 - All activities necessary to obtain required contracts for mandatory dental care providers as specified in this RFP.
- An estimate of person-hours associated with each activity in the Work Plan;
- Identification of interdependencies between activities in the Work Plan; and
- Identification of your expectations regarding participation by DHH and/or its agents in the activities in the Work Plan and dependencies between these activities and implementation activities for which DHH will be responsible. (In responding the DBP shall understand DHH shall not be obligated to meet the DBP’s expectation.)

Project Management Office (PMO)

MCNA has a dedicated Project Management Office responsible for all projects which MCNA undertakes whether they are internal or external and regardless of scope. The responsibility of the PMO is to ensure the projects are planned properly, assigned necessary resources, and thoroughly documented. The PMO also ensures that all stakeholders are engaged and that the needs and outcomes are analyzed and assessed to ensure that the project is executed with precision. The following diagram shows a summary of the activities flow and administration within our PMO.

Please see our Project Management Methodology in Section C.1 for detailed information on our PMO and its processes.

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Section C.3

Describe your Risk Management Plan.

- At a minimum address the following contingency scenarios that could be encountered during implementation of the program:
 - Delays in building the appropriate Provider Network as stipulated in this RFP;
 - Delays in building and/or configuring and testing the information systems within your organization's Span of Control required to implement the DBP program;
 - Delays in hiring and training of the staff required to operate program functions;
 - Delays in the construction and/or acquisition of office space and the delivery of office equipment for staff required to operate program functions;
 - Delays in enrollment processing during the implementation of DBP; and
 - Delays in the publication of marketing and related materials and/or the delivery of these materials to DHH and/or its agents.
- For each contingency scenario identified in the Proposal, at a minimum the Risk Management Plan must include the following:
 - Risk identification and mitigation strategies;
 - Risk management implementation plans; and
 - Proposed or recommended monitoring and tracking tools.

Risk Assessment and Mitigation

Risk poses a serious threat to the integrity of any project. Proper Risk Management and Mitigation is one of the cornerstones of project management at MCNA. The MCNA PMO consistently monitors for all issues and risks that may arise during implementation of the DBPM implementation. The PMO utilizes a formal review and resolution process to prevent risks from being overlooked and causing the project disruption.

With an eye on industry standards and best practices, the PMO utilizes an agile risk management approach. The key facets of this approach are defined below.

1. Identify

- The project team must identify risks as they surface.
- The team must become aware of the risks involved as the project is planned.
- Daily standup meetings are held to assess status of projects and if any risks are on the horizon.
- A review of the project with a critical eye can often expose risks which were either not foreseen or have surfaced recently.
- Retrospective risk assessment is conducted based on the cause and effect of tasks identified for implementation.

- The project team is encouraged to bring up all risks when made aware of the possibility of their existence.

2. Assess

The project team must review the risk for its:

- Impacts on the project and implementation. How severe is the impact and can it be circumvented?
- Probability of the risk manifesting and causing disruption in the implementation.
- Frequency with which the risk could propagate itself and cause disruption.
- Urgency with which the risk needs to be addressed.
- Level of threat or disruption to the project and the steps that may be taken to mitigate its impact.

3. Respond

In order for the team to address the risk, the following steps could be taken:

- Try to avoid the risk. In certain cases and scenarios, this is possible. As such, the team applies all efforts to circumnavigate the threat or disruption.
- Mitigate the risk and diminish its impact on the overall scope of the project. With the extensive knowledge that our project team brings to the table, we are skilled at the methodologies that can be used in order to reduce the extent of exposure whenever a risk surfaces.
- Transfer the risk whenever possible by discussing the outcomes with the stakeholders.
- Accept “as is” if there is no viable resolution. At MCNA, this is usually the last course of action. Our PMs and SMEs have extensive knowledge about risk avoidance, transfer, and mitigation.

4. Review

MCNA utilizes a regular review of the Risk Register to keep potential risks at bay whenever a project is implemented. We understand that the key to risk identification and mitigation is communication. Therefore, we ensure that all lines of open and honest communication with the stakeholders are maintained.

Documenting and Classifying Risk

MCNA utilizes tools and processes to manage risks for all projects. Documenting risk in a well-designed Risk Register is the first step to managing it. Once the risk has been logged, its potential impact on the project and its likelihood of occurrence are ranked on a scale of High, Medium or Low. This allows the team to identify the mitigation plan appropriate to address the risk. The key items identified in the Risk Register are addressed below.

1. Identified Risk

This area defines the risk and all its associated causes. The risk may be identified through a multitude of ways and at any time before or during the implementation. The MCNA PMO is well versed in the identification of risks by using best practices and diligent monitoring.

2. Potential Impact Rank

Here, a High (H), Medium (M) or Low (L) rank is assigned to the risk based on how adversely it may affect the project and its delivery.

3. Likelihood of Occurrence Rank

Similar to the Impact Rank, the Likelihood of Occurrence is ranked on a High-to-Low scale based on the probability that it will occur and impact the project.

4. Mitigation Plan

The Mitigation Plan charts a series of steps and circumvention approaches that can be undertaken to eliminate or minimize the risk. Although all risks are given considerable attention, M/H and H/H ratios are scrutinized with extra care, and a separate Mitigation Risk Plan is developed in order to deal with its impact. The Risk Plan consists of:

- Top 3 reasons for occurrence
- Top 3 risk management approaches for mitigation, transfer or avoidance
- Mitigation strategy
- Mitigation ownership

A sample Risk Mitigation chart below illustrates our standard approach to registering risk and mitigation.

Risk Factor 1	Project Size (Duration or Effort)		
Low	Medium	High	Mitigation Ideas
< 4 Months < 1000 Hours	4-6 Months 1000 to 3000 Hours	> 6 Months > 3000 Hours	<ul style="list-style-type: none"> • Decomposition (Break into smaller phases) • Phased implementation

Risk Factor 2	Project Scope		
Low	Medium	High	Mitigation Ideas
Defined and Not Large or Complex	Somewhat Defined/ Large/Complex	Not Defined or Large/Complex	<ul style="list-style-type: none"> • Decomposition • Add another analysis phase • Detailed specifications • Early review of functionality • Add more time to the project schedule

Part Two: Technical Approach

Section C: Planned Approach to Project

Risk Factor 3	Project Decision-Making		
Low	Medium	High	Mitigation Ideas
One sponsor & One decision- maker	Sponsoring/ Decision making committee	No Clear Sponsor/Decision- maker	<ul style="list-style-type: none"> Specify decision-makers' role in project documentation Add tasks to the Project Plan for involving decision-makers and managing relationship with them

Risk Factor 4	Environmental State (Software/Hardware/Network)		
Low	Medium	High	Mitigation Ideas
Stable / Little Change Required	Transitional with Some Changes	Volatile or Yet to be Deployed	<ul style="list-style-type: none"> Additional testing, particularly stress testing Training on new environment Find other projects using a similar environment to compare notes

Risk Factor 5	Team's Experience (with environment/project size/scope)		
Low	Medium	High	Mitigation Ideas
Extensive (2 or more similar projects)	Moderate (at least one similar project)	Limited (No similar project completed)	<ul style="list-style-type: none"> Additional team training Cross-training Consider hiring consultant with additional experience for initial period

Risk Factor 6	Impact on other Operations		
Low	Medium	High	Mitigation Ideas
None or Very Little	Some Change	Extensive Changes	<ul style="list-style-type: none"> Additional User Training On-site assistance for cutover period Phased cutover Expose key stakeholders to prototype early

Risk Factor 7	Project Schedule created by:		
Low	Medium	High	Mitigation Ideas
Project team with standard estimation methods	Project team using some rough guesses based on limited info.	Mandate from an external source	<ul style="list-style-type: none"> Supplement resources (outside consultants, other groups) Try to reduce scope of deliverable Is there a minimum level of functionality for the mandated delivery date? Add time to the schedule to allow for slippage

Risk Management Strategy

MCNA's risk management approach does not stop after implementation. It includes the following processes for risk management throughout the life of the DBPM contract: planning, identification, analysis, monitoring and control. MCNA recognizes that new risks can be identified at any time during the contract and processes may need to be updated accordingly. MCNA's objective is to decrease the probability and impact of developments that could adversely affect the project.

MCNA's project management team will work to identify potential risks before the contract is initiated. When a risk is identified, it is first assessed to ascertain the probability of occurring, the degree of impact to the schedule, scope, cost, and quality of the project, and ultimately prioritized. Risk events may impact only one area while others may impact the project in multiple categories. The probability of occurrence, number of categories impacted and the degree (high, medium, low) to which they impact the project will be the basis for assigning the risk priority. All identifiable risks are entered into our Risk Register. As part of documenting a risk, two other important items are addressed:

- Mitigation strategies that will be taken by MCNA to lessen the probability of the event occurring
- Development of a contingency plan or a series of activities that will take place either prior to, or when the event occurs

Although many of the risks noted below have already been mitigated, the following are contingencies that MCNA may encounter during the implementation of the Louisiana Dental Benefits Program:

Delays in building the appropriate Provider Network as stipulated in this RFP		
Risk Identification	Risk Mitigation and Plan	Monitoring and Tracking
Loss of Provider	<ul style="list-style-type: none"> Assess network capacity Increase recruitment efforts Address root cause of provider attrition 	<ul style="list-style-type: none"> Geoaccess reports are reviewed to identify and address gaps Provider Relations and Network Development monitor and assess network deficiencies Document on Risk Register
Member and Provider Complaints	<ul style="list-style-type: none"> Assess network capacity Increase recruitment efforts Reach out to non-par providers Identify transportation resources to assist members with transportation to appointments 	<ul style="list-style-type: none"> Senior Director of Call Center Operations and Director of Provider Relations monitor all complaints logged into our MIS Geoaccess reports are reviewed to identify and address gaps Document on Risk Register
Providers offering services to members with special health care needs not available	<ul style="list-style-type: none"> Increase recruitment efforts Arrange transportation services for members to qualified providers in closest geographical area Enter into LOAs with non-par providers 	<ul style="list-style-type: none"> Geoaccess reports are reviewed to identify and address gaps Provider Relations and Network Development monitor and assess network deficiencies Member Services raises issue Document on Risk Register
Letter of Intent (LOI) does not materialize into signed contract	<ul style="list-style-type: none"> Identify root cause of provider disinterest Increase volume of LOIs received Reach out to providers to ensure commitment Enhance outreach program to stay in communication with providers and assess any change in their commitment Identify supply of non-participating providers to address gaps 	<ul style="list-style-type: none"> Provider Relations and Network Development monitor and assess network deficiencies Provider Relations reviews commercial issues affecting recruitment with senior management Document on Risk Register

Delays in building and/or configuring and testing the information systems within your organization’s Span of Control required to implement the DBP program

Risk Identification	Risk Mitigation and Plan	Monitoring and Tracking
<p>Delayed delivery of hardware</p>	<ul style="list-style-type: none"> Establish relationships with local vendors including Veteran and Hudson Initiative vendors Maintain an abundant supply of hardware at corporate office location to be shipped “on demand” 	<ul style="list-style-type: none"> Infrastructure Team monitors procurement process and communicates updates to PM Document on Risk Register
<p>Delayed delivery of applications</p>	<ul style="list-style-type: none"> MCNA’s proprietary software, DentalTrac™, is web based, which allows the flexibility to access anywhere there is an Internet connection Leverage pre-existing systems and software for deployment needs 	<ul style="list-style-type: none"> Infrastructure Team monitors the availability of DentalTrac™ Development Team delivers system enhancements timely Development Team and Infrastructure Team communicate updates to PM Document on Risk Register
<p>Delayed delivery of the connectivity to the local office</p>	<ul style="list-style-type: none"> Deploy resources in Texas and Florida until connectivity established Evaluate alternative vendors 	<ul style="list-style-type: none"> Infrastructure Team monitors and tests connection activities prior to go-live Document on Risk Register
<p>Delayed delivery of data from DHH or its FI</p>	<ul style="list-style-type: none"> Identify root cause with DHH Leverage existing data in DentalTrac™ if applicable Establish workaround Create and get approval of scripting for Member and Provider Hotline in the event calls related to the missing data are received Update DHH daily on mitigation activity 	<ul style="list-style-type: none"> EDI Team monitors and updates PM Nightly system update report is generated and reviewed by EDI and Development teams for inconsistencies Document on Risk Register

Delays in hiring and training of the staff required to operate program functions		
Risk Identification	Risk Mitigation and Plan	Monitoring and Tracking
Recruiting efforts are not yielding qualified candidates	<ul style="list-style-type: none"> Revise job descriptions Conduct job fairs to increase visibility Consider candidate referral incentive program 	<ul style="list-style-type: none"> Monitor Key Performance Indicators Document on Risk Register
Inability to hire and thoroughly train staff in the Louisiana based office before the May 1, 2014 go-live date	<ul style="list-style-type: none"> Utilize cross-trained staff in regional and corporate offices (Texas and Florida) until staffing requirements are met 	<ul style="list-style-type: none"> Monitor Key Performance Indicators Document on Risk Register
Work load exceeds office space	<ul style="list-style-type: none"> Utilize cross-trained staff in regional and corporate offices (Texas and Florida) for overflow until staffing requirements are met Identify additional office space 	<ul style="list-style-type: none"> Monitor Key Performance Indicators Document on Risk Register

Delays in the Construction and/or Acquisition of Office Space and the Delivery of Office Equipment for Staff required to Operate Program Functions		
Risk Identification	Risk Mitigation and Plan	Monitoring and Tracking
Unable to locate facility that meets expectations for space and amenities	<ul style="list-style-type: none"> • Space options are being considered- Project Team in close contact with realtor and facility management • Utilize Texas and Florida staff until facility is occupied • Identify alternate locations 	<ul style="list-style-type: none"> • Hold daily meetings with realtor and facility management to gauge progress • Document on Risk Register
Construction vendor behind schedule	<ul style="list-style-type: none"> • Project Lead in daily contact with construction supervisor • Utilize Texas and Florida staff until facility is occupied • Identify alternate locations 	<ul style="list-style-type: none"> • Hold daily meetings or conference calls with construction supervisor • Document on Risk Register
Furniture vendor behind schedule	<ul style="list-style-type: none"> • Rent furniture until order arrives • Project Lead in daily contact with furniture vendor • Change vendors or order details if delays cannot be sustained 	<ul style="list-style-type: none"> • Hold daily meetings or conference calls with furniture vendor • Document on Risk Register
Installation of alarm, cameras, sound masking and access control behind schedule	<ul style="list-style-type: none"> • Identify alternate vendors • Project Lead in daily contact with vendors 	<ul style="list-style-type: none"> • Hold daily meetings or conference calls with vendors • Document on Risk Register

Delays in Enrollment Processing During the Implementation of the DBP		
Risk Identification	Risk Mitigation and Plan	Monitoring and Tracking
Failure to load enrollment files from DHH in a timely manner	<ul style="list-style-type: none"> Identify and fix root cause of failure Enter member file manually Review denied claims and reprocess those affected by eligibility file Verify eligibility using DHH system Update DHH daily on mitigation activity 	<ul style="list-style-type: none"> EDI team reviews daily / weekly / monthly logs Monitor Provider and Member Complaints log Document on Risk Register
Inability to open or process enrollment file	<ul style="list-style-type: none"> Request replacement file or alternate file format from FI Identify and fix root cause Update DHH daily on mitigation activity 	<ul style="list-style-type: none"> EDI team reviews daily / weekly / monthly logs System processing error logs reviewed daily Document on Risk Register
Corrupted file provided	<ul style="list-style-type: none"> Request replacement file or alternate file format from FI Identify and fix root cause Update DHH daily on mitigation activity 	<ul style="list-style-type: none"> EDI team reviews daily / weekly / monthly logs System processing error logs reviewed daily Document on Risk Register
SFTP server not accessible or reachable	<ul style="list-style-type: none"> Review access credentials Attempt FTP access Check to ensure SFTP is not offline Check internal network and Internet connectivity Update DHH daily on mitigation activity 	<ul style="list-style-type: none"> EDI team reviews daily / weekly / monthly logs System alerts monitored by NOC are escalated to Development and EDI teams Document on Risk Register
Internal network is offline	<ul style="list-style-type: none"> Alert Infrastructure team for resolution Reach out to host maintainer, if applicable Update DHH daily on mitigation activity 	<ul style="list-style-type: none"> System alerts monitored by NOC are escalated to Development and EDI teams Document on Risk Register
Enrollment file not received	<ul style="list-style-type: none"> Verify with DHH or FI Review expected delivery date of file Check connectivity Check authorization credentials 	<ul style="list-style-type: none"> EDI team reviews daily / weekly / monthly logs System alerts monitored by NOC are escalated to Development and EDI teams Document on Risk Register

Delays in the Publication of Marketing and Related Materials and/or the Delivery of these Materials to DHH and/or its agents		
Risk Identification	Risk Mitigation and Plan	Monitoring and Tracking
Delay with developing member or provider materials	<ul style="list-style-type: none"> Project Lead meets with Communications Committee to review materials Leverage existing materials if applicable Develop materials prior to contract award when possible Leverage additional resources to assist in developing materials 	<ul style="list-style-type: none"> List all materials in Project Plan Daily conference calls and meetings with Communications Committee Document on Risk Register
Printing vendor behind schedule	<ul style="list-style-type: none"> Identify alternate printing vendor Print in-house Project Lead meets with Printing Company Liaison Pre-print materials for stock inventory Utilize delivery of materials electronically where permitted Leverage online Portals for distribution of materials Update DHH daily on mitigation activity 	<ul style="list-style-type: none"> Setup task in Project Plan for time delay evaluation (acceptable vs. not-acceptable) Daily conference calls and meetings with marketing team Document on Risk Register
Distribution vendor behind schedule	<ul style="list-style-type: none"> Identify alternate distribution vendor Project Lead meets with Distribution vendor liaison Update DHH daily on mitigation activity 	<ul style="list-style-type: none"> Delivery timeline assessed during meetings with distribution vendors Daily conference calls and meetings with marketing team Document on Risk Register

Potential Risks based on Implementation experience		
Risk Identification	Risk Mitigation and Plan	Monitoring and Tracking
Project scope creep	<ul style="list-style-type: none"> Review documentation including contract and charter to correct project path Assign additional resources to make up for delayed tasks Correct expectations with stakeholders for deliverables 	<ul style="list-style-type: none"> Project Charter review Daily Project Plan review Weekly / bi-weekly checkpoint calls Document on Risk Register
Narrowed implementation timeline	<ul style="list-style-type: none"> Assign more resources to accomplish tasks and deliverables Compare work completed against remaining tasks and adjust number of hours required to complete implementation Update DHH daily on mitigation activity 	<ul style="list-style-type: none"> Daily Project Plan review Weekly / bi-weekly checkpoint calls Document on Risk Register
Call center problems	<ul style="list-style-type: none"> Re-route calls to Texas and Florida call centers Determine root cause and resolve Contact phone line provider / phone company to resolve technical issues Update DHH daily on mitigation activity 	<ul style="list-style-type: none"> Senior Director of Call Center Operations and Director of Provider Relations monitor all complaints logged into our MIS Senior Director of Call Center Operations monitors call center KPIs Infrastructure team monitoring Document on Risk Register
Missed deliverables / tasks	<ul style="list-style-type: none"> Review project charter, contract and SLA for clarification Update DHH daily on mitigation activity 	<ul style="list-style-type: none"> Project Plan review Checkpoint call discussion PMO project status review Document on Risk Register
Incomplete deliverables / tasks	<ul style="list-style-type: none"> Assign additional resources Re-schedule existing resource hours 	<ul style="list-style-type: none"> Checkpoint call discussion PMO project status review Project Plan review Document on Risk Register
Miscommunication on deliverables	<ul style="list-style-type: none"> Schedule weekly checkpoint meetings with stakeholders Periodically review contract and Project Charter to ensure on target approach 	<ul style="list-style-type: none"> Checkpoint call discussion Project contract and charter review Document on Risk Register
Natural disaster causes office closure	<ul style="list-style-type: none"> Transfer operations to other center (Florida or Texas) Update DHH daily on mitigation activity 	<ul style="list-style-type: none"> National weather monitoring systems Monitor State / County / City alerts Document on Risk Register

Section C.4

Provide a copy of the work plan, generated in Microsoft Project or similar software product that includes the aforementioned implementation activities along with the timeframes, person-hours, and dependencies associated with this activities.

Work Plan

MCNA is pleased to submit a detailed Work Plan for implementation and associated activities for the Louisiana DBP. **We have thoroughly researched the project requirements and guarantee a seamless implementation by May 1, 2014.**

Please see the following Work Plan, generated in Microsoft Project® and formatted through Smartsheet for the purposes of this RFP. Listed are the implementation activities, timeframes, person-hours, responsible parties, and dependencies as applicable.



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Section C.5

Provide a roster of the members of the proposed implementation team including the group that will be responsible for finalizing the provider network.

REDACTED

REDACTED

Section C.6

Provide the resume of the Implementation Manager (the primary person responsible for coordinating implementation activities and for allocating implementation team resources).

REDACTED

REDACTED

Section D.1

Describe how you will ensure that you will coordinate with DHH and its Agent to transmit and obtain files sent by the Fiscal Intermediary.

MCNA's **experienced** Eligibility and Enrollment department and Electronic Data Interchange (EDI) department currently exchange data through proprietary and HIPAA file format transmissions with over 75 trading partners. Our EDI team currently exchanges enrollment files and information records with 12 health plans and state agencies, their enrollment brokers and Fiscal Intermediaries (FI).

Our proprietary management information system (MIS), DentalTrac™ is a fully integrated MIS that unifies all of our business operations and processes. DentalTrac™'s EDI module ensures our **seamless and flawless exchange of transaction files** with our trading partners. The module exchanges encounter data, enrollment updates, eligibility inquiries, and payment acknowledgements.

In 2013, the MCNA EDI module processed over 25 million enrollment transactions for almost 3 million members with an average turn around time of 21.3 hours from the time the transaction file was received.

Coordination with the DHH and the Medicaid Fiscal Intermediary (FI)

MCNA's **Enrollment Manager** (EM) will work directly with the DHH's Medicaid Fiscal Intermediary (FI) to establish an open line of communication regarding member file transfers. We believe that having a dedicated resource for this key contract component is critical to the effective management of the enrollment process.

The EM will be responsible for:

- Ensuring that enrollment files received are processed within 24 hours from the time of receipt
- Reconciling the enrollment data
- Reviewing enrollments and disenrollments to identify potential issues, and ensuring each member's eligibility status is accurate
- Notifying the FI within 10 days of receipt of the enrollment file if any issues are identified during processing of the file
- Providing DHH information on the number of Medicaid member linkages and network capacity for each PCD on a quarterly basis

MCNA will receive the member files from the state's FI and ensure that all enrollments are effective at 12:01 a.m. on the 1st calendar day of the month of assignment.

We currently process enrollment files daily and have the ability to process on any frequency desired by DHH. MCNA will receive full member files on a weekly basis, and incremental member file updates daily from the FI in the format specified in the Systems Companion Guide. MCNA will notify the FI in writing within ten (10) calendar days of receipt of the enrollment file if any inconsistencies are identified in the data.

Business Rules and Reports

MCNA's MIS is configured with hundreds of business rules developed **using industry best practices** for ensuring the information in enrollment transaction files is accurate prior to affecting our production systems. Additionally, our business analysts and implementation team will ensure that any DHH-specific rule is put in place no later than 30 days prior to the operational start date. Our Business Rules Processing Engine allows us to define triggers that alert the EM when irregular increases or decreases of enrollment data are transmitted.

The MIS also generates enrollment reports and automatically updates our enrollment dashboards which are monitored by our EM on a daily basis. These reports and dashboards assist in ensuring the validity of the enrollment transaction file and allow us to better track new membership, member changes, PCD assignments and re-assignments, and terminated membership. Our EDI subsystem also produces a summary report of the information received in the enrollment transaction file and the impact the file will have in our production system. When coupled with the operational and business rules defined in our MIS, the EM is alerted about inconsistencies with the enrollment transaction file prior to loading it into our production system.

Secure Reliable Data Management and Reconciliation

All data received from the FI is stored in our Relational Database Management System (RDBMS) for easy access and archived for a period of no less than ten years. DentalTrac™ utilizes an **automated reconciliation process** to verify that the residential address for each enrollee in the enrollment file matches the address listed in our records. All addresses provided in the enrollment files are **validated** against the National Change of Address (NCOA) database as well as geocoded in order to better assist our members in obtaining a conveniently located provider.



We will report in writing to DHH's Medicaid Customer Service Unit any changes in contact information or living arrangements for families or individual members within five (5) business days of identification, including changes in mailing address, residential address if outside Louisiana, email address, telephone number and insurance coverage. To meet the security and encryption requirements stated in this RFP, notices to DHH or the FI can be transmitted using:

Part Two: Technical Approach

Section D: Member Enrollment and Disenrollment



- Secure email
- PGP-encrypted email
- MCNA's secure portal
- DHH or FI's secure portal
- Virtual Private Networks (VPN) and secure tunnels

DentalTrac™ adheres to the Medicaid Information Technology Architecture (MITA) alignment standard as prescribed by CMS. MITA promotes a centralized system with modularity, scalability, and interoperability. This system architecture limits the risks associated with vendors who use multiple systems to perform tasks such as enrollment. DentalTrac™'s development is based on these standards and conditions. By keeping all data aggregated in our interoperable MIS, DentalTrac™, **MCNA minimizes the possibility of file transfer and processing errors.**

Our Eligibility and Enrollment module is completely interoperable with all other aspects of DentalTrac™. This allows for Medicaid and CHIP members to be identified uniquely across multiple populations housed in our system. Duplicate records for a single member can be identified and resolved to where enrollment, claims, prior authorizations, grievances and appeals, and all other member interactions with our plan can be merged into a single, linked member history and record.

Once eligibility information is processed and available in DentalTrac™, it is then automatically available to providers to verify member eligibility via our toll-free hotline, automated Interactive Voice Response (IVR) system, or online Provider Portal.

The following flowchart illustrates our current enrollment and eligibility process for handling electronic and ad-hoc requests. The flexibility of DentalTrac™ allows us to incorporate changes to our business processes to meet the notification requirements of DHH.

Part Two: Technical Approach

Section D: Member Enrollment and Disenrollment



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Section D.2

Describe the steps you will take to assign a member to a different Provider in the event a Primary Care Dentist requests the Member be assigned elsewhere.

Member Primary Care Dentist Reassignment

MCNA encourages our providers to foster professional relationships with their assigned members and their caregivers. We also inform members and/or their caregivers about their rights and responsibilities with respect to the dentist/patient relationship via the MCNA Member Handbook and through interactions with our Member Services department. Members are expected to follow their dental provider's treatment instructions and office visit requirements. We make every effort to ensure members continue to receive the treatment and dental services they need.

In our experience, involuntary member reassignments are extremely rare. Although it is uncommon, we recognize that there may be situations where the provider chooses to request that a member be reassigned to another PCD such as:

- Continuous non-compliance with appointments or treatment plans
- Inappropriate or disruptive behavior at a level that impairs the ability of the dentist to render services
- Suspected fraud

The reassignment process begins with a written request including all supporting documentation from the provider to reassign the member. Upon receipt of the request and supporting documentation, MCNA's Case Management department updates the member eligibility record in the Case Management module of DentalTrac™. All of the facts gathered from the member and provider, as well as the notes produced by the MCNA Case Management Coordinator are logged into the member's profile. A case number is automatically assigned to the request for tracking purposes.

MCNA's Case Management department makes every effort to resolve issues that undermine the relationship between our members and providers. A reassignment request will be granted by Case Management if the issues between the provider and member cannot be resolved. MCNA requires the provider to document the member's behavior and any verbal warnings. Reassignment is only permitted after the member has been educated about the issue and given at least one (1) verbal warning by the provider.

When a reassignment request is granted, MCNA's Case Management department will reach out to the member to provide counseling on behavioral expectations, the reassignment process and the importance of receiving dental care. The Case Management Coordinator informs the member of the reason for the reassignment request, and explains why MCNA is requesting that they select a new Primary Care Dentist (PCD). If the member declines to select a new PCD, one will be assigned using a

Part Two: Technical Approach

Section D: Member Enrollment and Disenrollment



DHH-approved auto-assignment methodology. For additional information about MCNA's auto assignment process, please see Section F.6 of this response.

MCNA's Dental Provider Agreement (provider contract) requires that providers not discriminate on the basis of the member's health history, health status, need for healthcare services or adverse change in health status; or on the basis of age, religious belief, sex/gender, handicap, race, color, national origin or sexual orientation. Reassignment requests for any of the aforementioned reasons will not be permitted, and any attempts by the provider to discriminate against a member will result in immediate corrective action and review by MCNA's Credentialing Committee.

Building positive relationships between our dentists and the members they serve is a fundamental element of our business plan. **The numerous fiscal, social and professional challenges associated with the delivery of dental health services to vulnerable populations are surmountable so long as the expectations of providers, members, and their parents or guardians are managed properly and proactively.** MCNA's strategy in this area is simple but effective. We promote healthy dentist and patient relationships through well developed training and educational techniques, and superb customer service.

Section E.1

DHH intends to provide DBPs with two years of historic claims data for members enrolled in the DBP effective the start date of operations. Describe how you will ensure the continuation of all active prior authorized services for members effective the start date of operations. The description should include:

- How you will identify these enrollees, and how you will use this information to identify these enrollees;
- What additional information you will request from DHH, if any, to assist you in ensuring continuation of services;
- How you will ensure continuation of services and use of non-contract providers;
- What information, education, and training you will provide to your providers to ensure continuation of services; and
- What information you will provide your members to assist with the transition of care.

Enrollee (Member) Identification

MCNA is **committed to providing continuity of care** for our new Louisiana members transitioning from fee-for-service Medicaid and Bayou Health programs. We have successfully administered large-scale managed care program implementations in Texas, Florida and Kentucky, and are intimately familiar with the challenges that transitions present to continuity of care for members with existing treatment plans.

MCNA will process all DHH historical claims data for the two years prior to the go-live date. Dental claims data does not routinely contain diagnosis codes so our evaluation focuses on services that required prior authorization and those services that routinely require more than one visit to complete treatment. Our proprietary management information system, DentalTrac™, and our Data Analysis Team can flag all members receiving the following services that indicate active treatment and therefore the need for continuity of care:

- Members in active orthodontia
- Members who have received an endodontic procedure with no follow-up restoration
- Members who received services that required prior authorization under the fee-for-service program
- Members who have received periodontal care

Additionally, in order to identify members that would benefit from **MCNA's case management services**, MCNA will also analyze the DHH data to identify the treatment histories of members who have received the following procedures:

- Biopsies
- Recent surgical procedures
- Hospital call procedure codes
- Intravenous sedation services

- Behavior management services

The claims data for these procedures is of particular interest to us because these CDT codes can indicate severe or chronic oral health conditions such as periodontal disease, cancer in the oral cavity, abscesses, malocclusions, and behavioral issues that complicate the delivery of dental services. Given that preventive dental care and competent case management are a proven means of reducing the likelihood that conditions such as these will manifest in children and adults, we can use the data to ensure that these members receive the high touch assistance they need. Our Case Management Coordinators will work with members to coordinate transportation and other available community based services to ensure that members are able to complete their treatment.

Additional Information Needed

We know that the **exchange of meaningful information and extensive coordination with key stakeholders** are essential ingredients for the effective continuation of a member's prior authorized services.

In addition to encounter data, MCNA will request that DHH provide the following information:

- Two years of prior authorization history to include open and closed authorizations. Data should include:
 - Member ID
 - Rendering Provider Name
 - Rendering Provider NPI
 - Dental Facility Name
 - Dental Facility NPI
 - Dental Facility Address
 - CDT Codes of Services Approved
 - Quantities Approved
 - Quantities Remaining
 - Dollars Approved
 - Date of Approval
 - Expiration Date of Prior Authorization
- Demographic information that would allow us to identify members with special health care needs such as:
 - Pregnant women
 - Autistic children
 - Children with developmental disabilities
 - Members currently enrolled in their health plan's case management program
 - Members with conditions (such as craniofacial anomalies) that require special care arrangements

We will work closely with DHH to identify additional members requiring continuity of care. MCNA will also notify providers of their need to submit completed continuity of care forms along with proof of

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Informing Members

MCNA has included in our draft Louisiana Member Handbook information about our continuity of care and coordination of care processes. Members can also call MCNA's Member Services department via our toll-free Member Hotline for any questions about continuation of services, assistance in obtaining services, scheduling an appointment, or general inquiries about their benefits. Additionally, continuity of care information will be provided in our welcome calls, and members can seek assistance from MCNA's MAOS should the members have questions or need assistance with continuity of care. Below is an excerpt from our draft Louisiana Member Handbook:

What if my Primary Care Dentist is not in MCNA's network?

When MCNA's plan begins in Louisiana on May 1, 2014, we will allow you to see your current Primary Care Dentist for up to 30 days during the transition. If you have special health care needs, this time period may be extended.

Please call our toll-free Member Services Hotline at 1-855-702-6262 for more information about continuing care with your current Primary Care Dentist and to request information about MCNA's Case Management Program.

What if my Primary Care Dentist leaves MCNA's network?

We will send you a letter if your Primary Care Dentist is no longer part of our network. If that happens MCNA will assign you to a new Primary Care Dentist. In some cases we may allow your old Primary Care Dentist to keep treating you for up to 30 days after they leave our network, or until your care is done. We may do this if you are being treated for a serious dental problem.

Please call our toll-free Member Services Hotline at 1-855-702-6262 if you want to change the Primary Care Dentist we assign for you. Do you have a favorite dentist that is not an MCNA plan dentist? Please let us know. We can try to get them to join the plan.

Excerpt from MCNA's Draft Louisiana Member Handbook

Section E.2

Provide your communication plans with the Bayou Health Plans and Medicaid fee-for-service in coordinating the following services which will continue to be provided by the Medicaid fee-for-service and Bayou Health programs:

- Outpatient facility fees for dental services
- Fluoride Varnish performed by Primary Care Physician
- Current Procedural Terminology (CPT) codes billed by Oral Surgeons

MCNA routinely coordinates a wide variety of carved-out services, including Medicaid services that continue to be provided through the fee-for-service (FFS) program or through the member's medical managed care plan. This includes dental services at outpatient facilities, fluoride varnish performed by a primary care physician (PCP), and services that are provided by oral surgeons and billed under CPT codes rather than CDT codes.

For example, in our Texas Medicaid and CHIP plan MCNA coordinates with the Texas Health and Human Services Commission's (HHSC) claims administrator or the member's medical plan to ensure coverage for the following treatment services which are carved-out when rendered in a hospital or ambulatory surgical center:

- Dislocated jaw
- Traumatic damage to teeth
- Removal of cysts
- Oral abscess of tooth or gum origin
- Craniofacial anomalies

MCNA's approach to carved-out services focuses on ensuring the member receives all needed care in a timely manner. We ensure that the member's family is not burdened by the coordination of benefits effort because we work directly with the Health Plans' staff and providers. Our Member Services Representatives, Case Management Coordinators, and Member Advocate and Outreach Specialists (MAOS) are trained to provide members education and assistance about obtaining all needed services, regardless of whether those services are MCNA covered benefits.

Our Case Management Coordinators work with Health Plan Case Managers, Utilization Management and Claims staff, as well as state agencies, other government programs such as Medicare, and various provider types to ensure coordination of care. Additionally, our Claims and Utilization Management departments coordinate with the member's Health Plan or fee-for-service Medicaid to determine who is responsible for the coverage of carved-out service benefits.

Please see the following excerpt from our current Texas Medicaid and CHIP Provider Manual regarding Coordination of Non-Capitated (carved-out) Services.

Excerpt from MCNA’s Texas Medicaid and CHIP Provider Manual [1/2]

Provider Manual: Texas Medicaid and CHIP 

Coordination of Non-Capitated Services

Medicaid Services Not Covered by MCNA

The following Texas Medicaid programs and services are paid for by HHSC’s claims administrator instead of MCNA. Medicaid Members can get these services from Texas Medicaid Providers.

- Early Childhood Intervention (ECI) case management/service coordination;
- DSHS case management for Children and Pregnant Women;
- Texas School Health and Related Services (SHARS); and
- Health and Human Services Commission’s Medical Transportation.

Either the Member’s medical plan or HHSC’s claims administrator will pay for devices for craniofacial anomalies, and for emergency dental services that a Member gets in a hospital or ambulatory surgical center. This includes hospital, physician, and related medical services (e.g., anesthesia and drugs) for:

- Treatment of a dislocated jaw, traumatic damage to teeth, and removal of cysts;
- Treatment of oral abscess of tooth or gum origin; and
- Treatment of craniofacial anomalies.

CHIP Services Not Covered by MCNA

Some services are paid by CHIP medical plans instead of MCNA. These services include devices for craniofacial anomalies, and emergency dental services that a Member gets in a hospital or ambulatory surgical center. This includes hospital, physician, and related medical services (e.g., anesthesia and drugs) for:

- Treatment of a dislocated jaw, traumatic damage to teeth, and removal of cysts;
- Treatment of oral abscess of tooth or gum origin; and
- Treatment craniofacial anomalies.

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Excerpt from MCNA’s Texas Medicaid and CHIP Provider Manual [2/2]

Provider Manual: Texas Medicaid and CHIP 

Emergency Dental Services

MCNA is not responsible for coverage or payment of Non-Capitated Services, including emergency dental services provided to Members in a hospital or ambulatory surgical center setting. These Non-Capitated Services are part of the medical benefit provided by the medical health plans.

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Service Specific Processes

Our approach to coordinating all carved-out services that will continue to be provided by the fee-for-service Medicaid program and/or Bayou Health plans will include:

Outpatient facility fees for dental services

When members require services in an outpatient facility, MCNA covers the claims from the dental provider, and Bayou Health plans or fee-for-service Medicaid pays the facility fees. MCNA welcomes the ability to assist Bayou Health plans or fee-for-service Medicaid in verifying any needed information about the member's dental condition and treatment to ensure claims are paid accurately and timely for the outpatient facility. Additionally, if Bayou Health plans or fee-for-service Medicaid notice any outliers or trends in the use of certain outpatient facilities, our Special Investigations Unit (SIU) will cooperate and assist them with their investigative efforts.

Fluoride Varnish performed by Primary Care Physician

We will make every effort to keep members compliant with the Louisiana EPDST periodicity schedule. The member's assigned Primary Care Dentist is the preferred provider of preventive dental services because their expertise allows for a more comprehensive oral evaluation and treatment of other potential dental issues. However, MCNA supports members accessing fluoride varnish from Primary Care Physicians so long as the application of the varnish is performed in accordance with ADA and AAPD standards of care and periodicity. Too much fluoride can be toxic and have adverse health effects on our members.

MCNA recommends that the DHH provide, or require the Bayou Health plans to provide monthly encounter data to ensure that our members' treatment records reflect the fluoride service and to prevent its overutilization.

Current Procedural Terminology (CPT) codes billed by Oral Surgeons

Should the member require services by an oral surgeon that are then billed on the proper HCFA CMS-1500 or UB-04 claim form using the appropriate CPT codes, Bayou Health plans or fee-for-service Medicaid would pay these claims. If oral surgery services are provided and billed using the most recent ADA claim form and appropriate CDT codes, MCNA will provide coverage so long as plan benefits and exclusions have been followed and the services rendered are covered benefits under the Louisiana dental benefits program.

In all care coordination situations, MCNA welcomes the opportunity to discuss the patient's condition with other treating providers to ensure all aspects of care are coordinated. This **comprehensive care coordination process** provides access to coverage and care for the member while ensuring both the member's other insurers, providers, and MCNA facilitate coverage and appropriate payment.

Section E.3

What specific measures will you take to ensure that members in rural parishes are able to access specialty care? Also address specifically how will you ensure members with disabilities have access?

Caring for Members in Rural Areas

MCNA's founder and CEO, Jeffrey Feingold, D.D.S., M.S.D., has made finding ways to reach out and treat children and adults in underserved areas a priority throughout his career. In his early years as a practicing Periodontist in rural areas of Florida, Dr. Feingold observed first-hand the impact poor access to dental care had on migrant farm workers and local communities. These "lessons learned" about quality dental care in his early practice have greatly influenced our dental managed care approach to administering rural dentistry programs.

Our markets in Texas, Florida and Kentucky have vast rural areas with sparsely populated communities and limited access to dental care services. **Ensuring patient access** in rural areas of the states we serve has required a comprehensive multi-pronged approach. It starts with **stable and geographically distributed networks of providers and specialists**, and continues with **creative initiatives** that leverage our own financial and operational resources and resources contributed by other stakeholders. We place a special emphasis on ensuring the availability of participating specialists with pediatric expertise. MCNA's commitment to ensure access to members through our statewide provider network, including rural areas, has allowed us to become the premier dental plan in Texas and Florida.

Qualified Network of General Dentists and Specialists

MCNA is proud to provide our members with access to a highly qualified network of participating general dentists and specialists throughout the State of Louisiana. We have recruited a comprehensive network of primary and specialty providers. Our network has been actively recruited since 2012 and contains 1,074 access points throughout the state including Health Professional Shortage Area (HPSA) parishes. For more information, please see the geoaccess maps and provider roster attached to Section F.1 of this response.

Circumstances may arise where it will be necessary for a member to obtain treatment from an out-of-network provider ("non-par provider"). This is most likely to occur in rural areas or areas where there are no licensed dental practitioners. The need to see a non-par provider can also occur when a member requires exceptional services that address uncommon and unique dental needs. MCNA will meet the distance requirements of the RFP with both participating and non-participating providers because the oral health needs of our **members are our first priority**. In the event that a member must access care outside of these distance limitations, MCNA will arrange for the member to receive treatment from the nearest available specialty provider in accordance with the requirements in the RFP.

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Serving Persons with Disabilities and Special Needs

MCNA ensures access to care by contracting with providers who meet our credentialing criteria for participation. The credentialing process is designed to assess the capacity of each provider to meet the needs of members with special physical and behavioral health care needs. We ensure providers comply with the ADA accessibility standards by conducting site audits. Our Provider Relations Representative visits the office and evaluates the following for accessibility and accommodation compliance:

- Walkways, sidewalks, and parking facilities
- Entrance ramps, handrails, and hallways
- Adequate space around doors to maneuver a wheelchair
- Accessibility of elevators
- Operatory design allowing for wheelchair transfer or treatment in wheelchair

Additionally, MCNA reviews enrollment files to identify members with special health care needs. We cross-reference the member information against our provider network to identify special needs access measures and locate any gaps that may exist. MCNA's Network Development team continuously strives to identify and recruit providers who treat members with special health care needs.

The MCNA provider contract adheres to all state and federal requirements. It expressly **prohibits discrimination** against our members regardless of race, religion, national origin, sex, sexual orientation, or health status including disabilities. Additionally, our contracted providers must comply with all Americans with Disabilities Act (ADA) requirements.

MCNA is focused on being a culturally competent organization. Our staff is drawn from the many cultures we serve, and they embody MCNA's strong commitment to recognizing and appreciating all cultures. As evidence of our commitment, we have built mechanisms into the daily business processes of MCNA to foster continual learning to ensure that our services are responsive to the needs of all members and providers. We are committed to perform according to the U.S. Department of Health and Human Services, Office of Minority Health, Culturally and Linguistically Appropriate Services (CLAS) standards and to the elimination of disparities in dental care between diverse populations.

Our Director of Quality Improvement is responsible for the creation and administration of MCNA's Cultural Competency Program and ensures that we meet our own internal cultural competency goals and externally mandated objectives. Cultural training is an essential component of our extensive training programs throughout our company including training of all new employees within 30 days of hire and annually thereafter. MCNA also has a Zero Tolerance policy for any hotline interactions that contain discriminatory or derogatory language.

By engaging each level of management in our training program, we ensure that culturally competent services are delivered to people of all cultures, races, ethnic backgrounds, religions and individuals with disabilities in a manner that recognizes the **worth and dignity** of each individual. MCNA uses only "person first" language and we educate our providers on the use of this approach when speaking with our members and their families.

Part Two: Technical Approach

Section E: Service Coordination



Our Provider Network is comprised of diverse dental practitioners who value people of all races, ethnicities, and socioeconomic backgrounds. We actively monitor our providers' ability to communicate in different languages to ensure all members are well served. **All network providers are required to comply with MCNA's Cultural Competency Program, as well as ADA requirements.**

MCNA accommodates the preferences of members whose primary language is not English by maintaining staff fluent in French and other predominant regional languages such as Spanish, Creole, and Vietnamese. With an emphasis on cultural competence, MCNA has engaged a translation service for those members with language preferences not available from MCNA staff. A TTY line is in place for the hearing impaired. Our Member Handbook is available in English, French, Creole, Spanish, Braille, and large print. All member materials can be translated into other languages.

Section E.4

Detail the strategies you will use to influence the behavior of members to access oral health care resources appropriately and adapt healthier lifestyles. Include examples from your other Medicaid/CHIP managed care contracts as well as your plan for Louisiana Medicaid DBP members.

Influencing Member Behavior

Preventive care is vital to cultivating and maintaining good oral hygiene outcomes and cost savings for the Medicaid and CHIP programs. MCNA believes that communication and education are the most important tools we have to influence member behavior. **We seek to empower members and their caregivers to take responsibility for their oral health.**

The first opportunity we have to influence member behavior occurs upon enrollment. Newly enrolled members receive a welcome packet that contains an extensive array of information about the importance of accessing their dental care benefits and the importance of good oral health. A complete description of the new member welcome packet is included in Section J of this response.

MCNA's Outreach Goals
Promote early preventive dental visits
Ensure dental needs are identified and addressed
Increase routine preventive care services
Decrease oral diseases
Decrease the number of cancelled or no-show appointments
Increase provider access and availability

After the initial enrollment period, we continue to influence member behavior through a variety of **targeted strategies** including outbound call campaigns. Our outbound call campaign harnesses the advanced capabilities of the DentalTrac™ system to automatically call members using the number included in their enrollment file. The call received by the member delivers a message that encourages them to set up a dental appointment with their provider. It also allows the member to request assistance from an MSR by simply prompting the system. If we are unable to reach a member due to a disconnected or invalid telephone number, we send a postcard to the member with the information they need to access care.

MCNA also employs social media communication strategies to communicate our oral health message to our members. The public's massive migration from traditional land based telephony to online and mobile communications has exponentially increased our ability to target our message. Online and mobile communications present new and unique opportunities for us to influence our members, especially teenage members, about the benefits of good oral health. Online communication has the unique ability to reach others within a member's social network. This means that our messaging capabilities are increased geometrically among members and non-members.

Member education materials are another component of MCNA's strategy to influence member behavior and increase access to oral health care resources. We deliver educational materials directly to

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Please see the following outbound call script for our Texas Medicaid members:

New Members “Welcome to MCNA Dental” automated call:

The purpose of this script is to contact new Class* members to encourage them to make an appointment for a dental checkup as soon as possible.

Call frequency to encourage **newly enrolled** members to receive a dental checkup within 90 days of enrollment; initial enrollment, then in 45 days, and lastly in 75 days.

Automated Call Opening:

Hello, this is MCNA Dental calling to welcome you to our plan. (for Spanish Press 1)

You have recently enrolled with MCNA Dental through Texas Medicaid.

Good dental health is important to us.

We ask that you schedule a dental visit soon.

If you would like help scheduling a visit, press 1 now. [Call disposition is to route to MSR for scheduling]

If you do not want help scheduling a visit, press 2 now. [Call disposition is to be tracked in DentalTrac™ for reporting refusals and implementing additional follow-up outreach]

Thank you for being a valued member of MCNA Dental.

Existing Members Follow-Up call:

The purpose of this script is to contact existing Class* members that have not had a dental checkup in 6 months.

Call frequency to encourage existing members to receive a dental checkup; at 6 months from last claim encounter.

Automated Call Opening:

Hello, this is MCNA Dental calling to welcome you to our plan. (for Spanish Press 1)

Thank you for being a valued member of MCNA Dental through Texas Medicaid.

We have noticed that you have not been to the dentist in the past 6 months.

Good dental health is important to us.

We ask that you schedule a dental visit soon.

If you would like help scheduling a visit, press 1 now. [Call disposition is to route to MSR for scheduling]

If you do not want help scheduling a visit, press 2 now. [Call disposition is to be tracked in DentalTrac™ for reporting refusals and implementing additional follow-up outreach]

Again, thank you for being a valued member of MCNA Dental.

**Class members are Medicaid beneficiaries.*

Page 1 of 1

For the Florida Healthy Kids Corporation, the CHIP program in Florida, MCNA coupled the outbound call process with the postcard shown below:



Sample Florida Healthy Kids Member Reminder Postcard

MCNA's Plan for Louisiana

MCNA's member outreach efforts have yielded positive results for our members and our clients. For Louisiana we will implement a combination of targeted member communication including outbound call campaigns, direct mail, text messages, and in-person outreach. For an example of our Louisiana specific member mailings, please see our member reminder postcard on the next page. The sample postcard has been translated into the Vietnamese language to illustrate bilingual content.

In Texas, MCNA employs experienced Member Advocate and Outreach Specialists (MAOS) to ensure members receive appointment reminders, assistance with scheduling dental appointments, transportation assistance, oral health education, and one-on-one assistance with submitting grievances and appeals and understanding plan benefits. MAOS also participate in community outreach events where they focus on educating members, their parents, and members of the public about the benefits of adhering to the EPSDT periodicity schedule and improving overall oral health outcomes. To facilitate

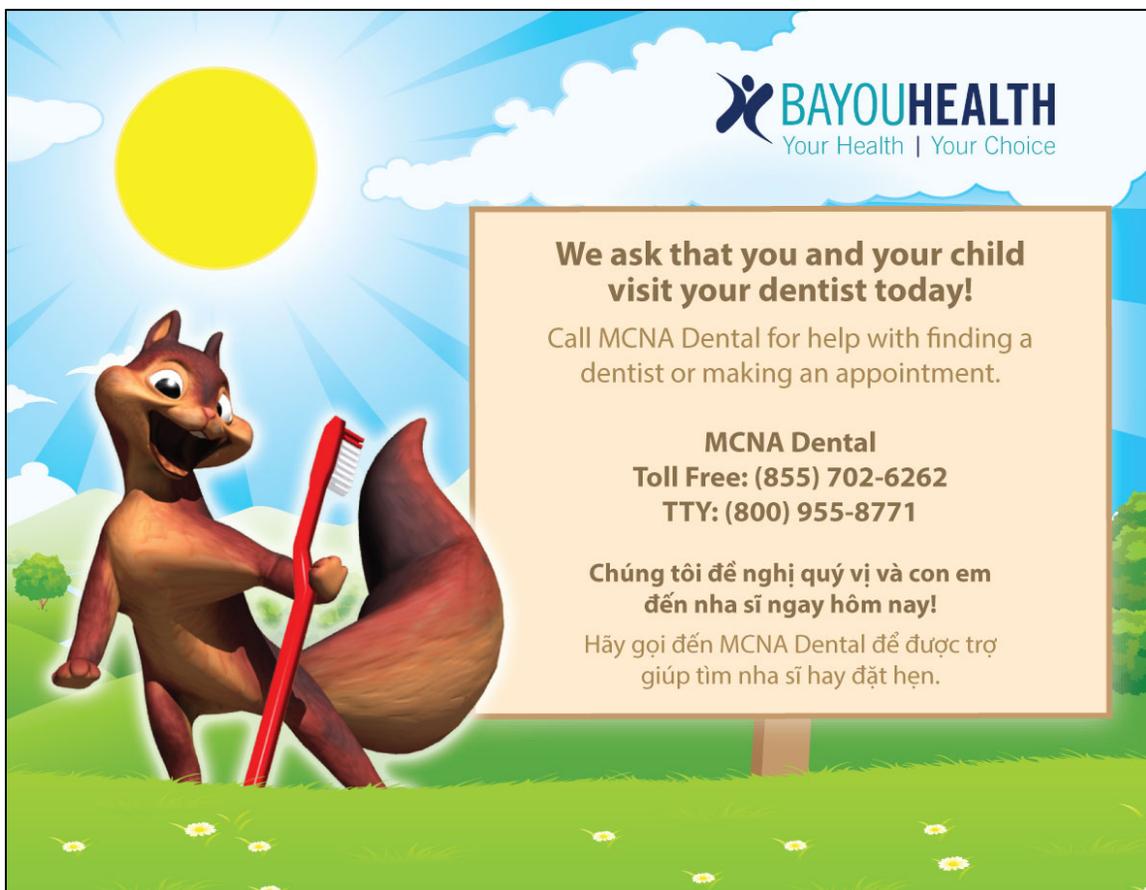
Part Two: Technical Approach

Section E: Service Coordination



continuity of care, network providers can inform MAOS of members who continuously break appointments so that MAOS can conduct outreach to the members and ensure they receive dental care in an appropriate and timely manner. MAOS also work closely with special populations like the children of migrant farmworkers to ensure that services are obtained and to reduce health care disparities.

Given the success of the MAOS approach, we will employ Louisiana based MAOS to work with our Louisiana members and their families. The MAOS will be located throughout the state in order to be close to the populations they serve. MAOS will attend health fairs and work with community partners such as faith based groups, community action agencies, and other organizations who are devoted to improving the health and lives of our members.



Sample Dental Visit Reminder Postcard to be Mailed to Louisiana Members (with Vietnamese translation)

Section E.5

Much faith based, social and civic groups, resident associations, and other community-based organizations now feature health education and outreach activities, incorporate health education in their events, and provide direct oral health services. Describe what specific ways would you leverage these resources to support the oral health and wellness of your members.

Partnering to Provide Outreach

MCNA has a long history of reaching out to the underserved by cooperating with social and civic groups, resident associations, faith based groups, and other community-based organizations. MCNA proactively deploys Member Advocate and Outreach Specialists (MAOS) to educate families throughout the communities we serve by organizing and supporting local health fairs.

Over the past year, our Quality Improvement and Case Management staff has actively participated in over **370 health fairs and outreach events**.

These health fairs are organized in coordination with county health departments, Head Start programs, public school systems, civic organizations, dental centers, health plans, and faith based organizations. In addition to attending outreach events, our Quality Improvement staff and MAOS organize “Dental Health Day” events within elementary schools located in low-income areas and conduct interactive oral health presentations to large groups of students and faculty. Families and children attending these events receive free dental kits (toothbrushes, toothpaste, floss), oral health literature, and other giveaway items such as water bottles, backpacks, MCNA wristbands, and hand sanitizer.



During outreach events, MCNA’s Quality Improvement staff and MAOS:

- Discuss the techniques to maintain good oral hygiene and encourage following the EPSDT/AAPD periodicity schedule for continuity of care
- Demonstrate the correct way to brush teeth, floss, and the type of toothbrush to use
- Discuss the importance of fluoride
- Encourage attendees and parents to visit the dentist regularly for a checkup
- Display a binder containing pictures of tooth decay, fillings, sealants, gingivitis, and stages of periodontal disease

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Part Two: Technical Approach

Section E: Service Coordination



MCNA's outreach efforts are **valued by our community partners**. We will continue to reach out to additional organizations throughout Louisiana for more partnership opportunities.

Please see the following examples of appreciation certificates and letters in response to recent outreach efforts with other members of what we like to call, "**The Caring Community.**"

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Part Two: Technical Approach

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Section F.1

Provide a listing of the proposed provider network using the List of Required In- Network and Allowable Out-of-Network Providers as described in this RFP, including only those providers with whom you have obtained a signed LOI or executed subcontract. LOIs and signed subcontracts will receive equal consideration. LOIs and subcontracts should NOT be submitted with the proposal. DHH may verify any or all referenced LOIs or contracts. Along with the provider listing, provide the number of potential linkages per primary care dentist.

Using providers, with whom you have signed letters of intent or executed contracts, provide individual maps and coding by parish. You should provide individual maps as well as overlay maps to demonstrate distance relationships between provider types, if applicable (i.e., pediatrics, general dentist and orthodontist).

The DBP should provide an Excel spreadsheet of their proposed provider network and include the following information: (Sample spreadsheet is available in the Procurement Library)

1. Practitioner Last Name, First Name and Title - For types of service such as primary care dentist and specialist, list the practitioner's name and practitioner title such as DDS, DMD, etc.
2. Practice Name/Provider Name - - Indicate the name of the provider. For practitioners indicate the professional association/group name, if applicable.
3. Business Location Address - Indicate the business location address where services are provided including but not limited to, 1st line of address, 2nd line of address, City, State, Postal Code
4. Provider Type and Specialty Code - Indicate the practitioner's specialty using Medicaid Provider Type and Specialty Codes.
5. New Patient - Indicate whether or not the provider is accepting new patients.
6. Age Restriction - Indicate any age restrictions for the provider's practice. For instance, if a provider only sees patients up to age 19, indicate < 19; if a provider only sees patients age 13 or above, indicate > 13.
7. Primary Care Dentist - the number of potential linkages.
8. If LOI or contract executed.
9. Designate if Significant Traditional Provider.
10. Maps for this location.

REDACTED

REDACTED

Attestation of Provider Network Submission (Appendix CC)



Attestation of Provider Network Submission

March 1, 2014

I, Carlos A. Lacasa, Esq. as Senior Vice President and General Counsel for MCNA, do hereby attest that the information provided concerning our proposed network letters of intent and subcontracts are accurate, true, and complete.

I attest that the necessary information for these providers will be loaded into our organization's system prior to providing services to Louisiana Medicaid/CHIP members. Additionally, I attest that the following requirements will be met:

- All provider files will contain a list of group practice members.

In addition to the services provided through its subcontracted network, MCNA will provide access consistent with the Contract with DHH.

I understand that should DHH determine at a later date that the submitted information is inaccurate, untrue, or incomplete, MCNA may be subject to sanctions and/or fines as outlined in the Contract with DHH.

Signature/Title

Date

200 West Cypress Creek Road • Suite 500 • Fort Lauderdale, Florida 33309
(954) 730-7131 • (800) 494-6262 • Fax (954) 730-7875 • www.mena.net

REDACTED

Section F.2

Describe how you will handle the potential loss (i.e., contract termination, closure) in a parish of all providers within a certain specialty.

MCNA is proud to provide our members with access to our highly qualified network of participating general dentists and specialists throughout the state. MCNA has a proven track record of establishing and maintaining networks of qualified dental providers across every state in which we operate. We will address material changes in the network that may negatively affect the ability of members to access services from specialty providers.

Our Network Development department **proactively assesses our network** to ensure members have access to the care they need. Utilizing the advanced geoaccess analytic capabilities of the Network Management module of DentalTrac™, the Network Management team can quickly define, model, and implement effective provider networks based on product-specific criteria. The Network Management team reviews monthly geoaccess reports to identify any specific areas where capacity should be enhanced. Our Network Management Director and Quality Improvement Director will review these reports to verify that we have a sufficient number of specialists, pediatric and general dentists to ensure our members have the appropriate access to quality dental services.

Should MCNA lose all specialists within a parish, our Network Development department will conduct an analysis of the network to **identify any gaps, and develop interventions** to bring the network into compliance with contractual requirements as appropriate. Losing all providers in a parish within a certain specialty may or may not have a material effect on network access for our members. Access may be available in neighboring parishes within the time and distance requirements of the RFP.

MCNA is committed to providing Medicaid members in Louisiana with statewide access to primary and specialty dental providers.

If the loss of all specialists in a parish impacts our access to care standards, MCNA will treat the situation as a material network change. **We will communicate the issue to DHH within seven (7) business days.** MCNA will also notify DHH within one (1) business day of any unexpected changes that would impair our provider network as outlined in 42 CFR 438.207(c) and this RFP. The notification will include information about how the provider network change will impact the delivery of covered services and MCNA's plan for maintaining the quality of member care if the provider network change is likely to affect the delivery of covered services. Our documentation of compliance with access requirements will be provided to DHH at any time there has been a significant change in MCNA's operations that would affect adequate capacity and services.

MCNA's Executive Director will submit to DHH a notice of the material change to the network. The notice will 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. The notice will also include a draft notification to be sent to affected members sixty (60) days prior to the expected implementation of the change.

MCNA provider agreements include a provision requiring providers to give a 90 day advance written notification to request contract termination. Upon receipt of the provider's termination notice, MCNA's Provider Relations team immediately reaches out to the provider to understand the root cause of their desire to dissolve the relationship. Once the reasons are ascertained, MCNA will work with the provider to resolve issues in order to maintain network participation. In the event the provider cannot be retained, MCNA's Director of Network Management will review geoaccess reports and identify other network and non-network specialists who meet the time and distance standards of the RFP.

The next step is member communication. MCNA will give notice to our members within 15 days of the termination and ensure that the terminating provider completes treatment for members in active care. We understand the impact of contract terminations and how they can potentially affect our members. To ease the transition, MCNA's DHH-approved notification to affected members will include information about contacting MCNA's Member Services Hotline for assistance with selecting a new specialist. Members with special health care needs or those who may be undergoing active treatment plans are assured of our commitment to continuity of care.

Access issues can occur in rural areas or areas where there are no licensed dental practitioners, or when a member requires exceptional services that address uncommon and unique dental needs. In addition to voluntary terminations, access issues may also occur following the death, injury, illness, or involuntary relocation of a provider, in natural disaster situations, or when the provider must be terminated immediately due to quality of care issues.

For example, in the case of a rural parish where the office of the only specialty provider is temporarily or permanently closed due to a natural disaster, we would work with other dental or health care providers in the community to arrange for the use of their office space to allow the displaced provider to continue serving their patients.

To address access challenges, our Network Management department monitors the performance of our network continuously to ensure that our members have an adequate number of providers accepting new Medicaid patients, and maintains a database of non-participating providers for when such services are required. **MCNA's network of providers is continually growing.**



If there are areas where specialty coverage is still not available, MCNA will ensure that all members in the identified area can access non-participating specialists by entering into member specific Letters of Agreement (LOAs) for the provision of care. Our Provider Relations department is skilled in identifying suitable providers from our PPO network or from our list of non-participating providers with whom we have had previous LOAs. Provider Relations may also identify providers from secondary sources such as the practitioner rosters of the Louisiana Dental Association, DHH's Medicaid provider list, and member requests.

REDACTED

Section F.3

The DBP is encouraged to offer to contract with Significant Traditional Providers (STPs) who meet your credentialing standards and all the requirements in the DBP's subcontract. DHH will make available on www.MakingMedicaidBetter.com a listing of STPs by provider type by parish.

Describe how you will encourage the enrollment of STPs into your network; and indicate on a copy of the listing which of the providers included in your listing of network providers (See F.1) are STPs.

REDACTED

REDACTED

Section F.4

Based on discussions with providers in obtaining Letters of Intent and executed subcontracts as well as other activities you have undertaken to understand the delivery system and enrollee population in the parish(es) for which a proposal is being submitted, discuss your observations and the challenges you have identified in terms of developing and maintaining a provider network. Provide a response tailored to each parish of the following provider types/services:

- Primary Care
- Specialty Care
- FQHC/RHC

REDACTED

Section F.5

Describe your process for monitoring and ensuring adherence to DHH's requirements regarding appointments and wait times.

Monitoring Adherence to DHH's Requirements Regarding Appointment and Wait Times

The ability of our members to access care from our network providers is affected by the level of provider compliance with our prescribed appointment and wait times. MCNA's providers will be contractually required to meet the appointment availability and wait time standards set forth in our contract with DHH. MCNA will **assure** our Louisiana DBP members that primary care dental services and referrals to participating specialists will be available on a timely basis as follows:

- **Emergent or Emergency Visits** – available at all times
- **Urgent Care** – within 24 hours, 7 days a week
- **Routine, non-urgent or preventive care visits** – within six (6) weeks

We ensure Primary Care Dentist (PCD) compliance with after-hours access and telephone coverage standards. To ensure these standards are met, our Senior Director of Call Center Operations monitors member complaints about appointment access on a daily basis to **identify and address trends** in collaboration with our Quality Improvement and Provider Relations departments. MCNA's Provider Relations department monitors compliance with appointment standards through "**secret shopper**" **calls**, feedback from member satisfaction surveys, and complaints.

Our Network Management staff conducts unannounced site visits on a quarterly basis to at least 10% of the total provider network. A statistically valid random sample of Primary Care Dentists are selected in order to test their compliance with MCNA appointment and access standards, cultural competency requirements, and after-hours availability.

MCNA also analyzes the rate at which members change PCDs. If any trends are noted for a particular provider, MCNA seeks more detailed feedback from previously assigned members. The Provider Relations Representative assigned to the office then educates the provider on the importance of maintaining **strong and ongoing relationships** with assigned members, shares the de-identified feedback, and educates the provider on retention strategies.

Our Experience

In Texas for 2013, MCNA has the following Appointment Availability survey results:

MCNA's 2013 Appointment Availability for Texas Medicaid				
Appointment Type	Texas Medicaid Standard	MCNA's Compliance		
		Total Surveys	Affirmative	Percentage
Emergency Visit	Within 24 Hours	1,046	1,011	98.44%
Routine Symptomatic	Within 14 Days	1,046	1,001	95.70%
Routine Asymptomatic	Within 30 Days	1,046	968	92.54%

As indicated by the results above, MCNA is very successful in ensuring provider compliance with appointment availability timeframes. Our dedicated Provider Relations department provides ongoing education and outreach to our PCD community regarding their responsibilities. If providers are found to be non-compliant with the contractual standards regarding appointment and availability timeframes, our Provider Relations and Quality Improvement departments will develop a corrective action plan (CAP) in conjunction with the non-compliant provider.

The CAP will be reviewed and agreed to with the provider to ensure “buy in” and increase the likelihood that it will be successfully completed. The Provider Relations department will audit the provider’s performance of the CAP within 30 days of execution. Provider Relations staff will share the results of the reviews with the provider and address any compliance issues. If the provider is non-compliant, the provider will be reviewed again in 30 days. If the provider passes the initial 30-day review, a final review will occur in six (6) months to ensure ongoing compliance. A provider’s continued failure to adhere to appointment and wait time standards may result in suspension or termination. All results are reported to the Quality Improvement Committee (QIC) on a quarterly basis.

Our effort to ensure access and availability for our members is more than a core contract compliance measure; it is a means of reducing the unnecessary use of alternative methods of access to dental care such as emergency room visits.

Section F.6

Describe your primary care dentist assignment process and the measures taken to ensure that every member in your DBP is assigned in a timely manner. Include your process for permitting members with chronic conditions to select a specialist as their primary care dentist and whether you allow specialists to be credentialed to act as primary care dentists.

Primary Care Dentist Assignment

MCNA's Primary Care Dentist (PCD) auto-assignment process begins with the loading and processing of the eligibility and enrollment file from the Fiscal Intermediary (FI). DentalTrac™, our fully integrated and proprietary management information system (MIS), has a comprehensive module for loading and processing enrollment data using Electronic Data Interchange (EDI) HIPAA ASC X12N 834 formatted files as well as other proprietary formats.

DentalTrac™'s Eligibility and Enrollment module contains extensive business rules that control the processing and loading of the eligibility and enrollment data. As described further in Section Q of this response, DentalTrac™ will load and process all eligibility and enrollment files within 24 hours of receipt from the FI, including performing any PCD auto assignments as described in this section.

The business process and business rules DentalTrac™ applies can be configured depending on the needs and requirements of each state and contract. Our standard PCD auto-assignment process begins with a verification of the member's records from DHH for previous DBP eligibility. If there is a PCD assignment or selection from the member's previous eligibility and enrollment file (including a specific STP to which the member was previously assigned), DentalTrac™ will assign the member to that same PCD. If multiple members of the same family are enrolled with MCNA, every attempt will be made to assign them to the same PCD. Members of the same family always have the right to select their preferred PCD from MCNA's network of providers.

MCNA will contact the member within 10 business days of receiving the Member File from the FI to assist the member in selecting a PCD; this is part of our welcome process and is noted in our Member Handbook. For members who do not select a PCD or have selected a PCD with restrictions/limitations that prevent assignment, MCNA will assign a PCD utilizing the DHH-approved methodology that takes into account the member's geographic location, treatment history, family treatment history, age, language, and other demographic indicators. For members who are new to the DBPM and have no record available, MCNA will check for records from DHH and the member's family or guardian. If the member has any family members currently eligible with MCNA and there is a PCD assignment for those family members, the new member will be assigned to that PCD, if appropriate. MCNA will provide PCD automatic assignment methodology to DHH within 30 days of the date the contract is signed with DHH.

Members with chronic conditions requiring a course of treatment or regular care monitoring are allowed direct access to a specialist through a standing referral or an approved number of visits as appropriate for the member's condition and identified needs. Members who need a course of treatment or regular

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care monitoring may require a specialist to act as their PCD. MCNA will credential specialists as a PCD on a case-by-case basis and the treatment of these members will be closely monitored by our Case Management department. **MCNA always allows pediatric specialists (pedodontists) to serve as PCDs for our members.**

Please see the following flowchart outlining MCNA's current PCD assignment process.

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Section F.7

Describe how you will monitor providers and ensure compliance with provider subcontracts. In addition to a general description of your approach, address each of the following:

- Compliance with cost sharing requirements;
- Compliance with dental record documentation standards;
- Compliance with conflict of interest requirements;
- Compliance with lobbying requirements;
- Compliance with disclosure requirements; and
- Compliance with member education requirements.

The MCNA Provider Relations department is primarily responsible for ensuring that our participating network providers are properly trained and fully understand their rights and responsibilities under the MCNA Dental Provider Agreement (DPA). The DPA is designed to be comprehensive but readable. Federally mandated and Louisiana state requirements are incorporated into the DPA and into our Provider Manual which is incorporated by reference into the DPA.

MCNA's Provider Relations staff continuously monitors our providers' compliance with the requirements of the DPA. Our most effective tool for monitoring provider performance is DentalTrac™'s provider profiling system functionality which flags providers based on claims data. The system continually analyzes claims data to identify over and under-utilization of certain CDT codes, and it alerts our Special Investigations Unit (SIU) when a provider's claims indicate outlying behavior. A more comprehensive description of MCNA's provider profiling capabilities is contained in Sections F.11 and N of this response.

The algorithm used by DentalTrac™ to identify outliers is set to a level of sensitivity designed to cast a wide net. When coupled with the efforts of our Member Services, Provider Relations, and Quality Improvement departments to monitor satisfaction surveys, member complaints, and provider office audits, our strategy for detecting provider non-compliance has proven to be efficient and effective.

Compliance with Cost-Sharing Requirements

There are no cost-sharing requirements for Louisiana Medicaid's core benefits and services. Providers have a provision in the DPA and Provider Manual that prohibits balance billing or otherwise seeking payment from Louisiana Medicaid members for covered services rendered. Our Senior Director of Call Center Operations and Director of Grievances and Appeals review weekly reports on member complaints, grievances, and appeals documented in the DentalTrac™ system to identify provider patterns of behavior over time and determine if the prohibitions against cost sharing in the DPA have been violated. Additionally, MCNA monitors claims data to identify any appearance of cost sharing on the part of the member such as comments related to copayments or other member payments.

Compliance with Dental Record Documentation Standards

Provider dental records are a vital component of a high quality and trustworthy dental practice. MCNA conducts routine dental record reviews to ensure that our participating general dentists and specialists provide high quality dental care that is documented according to established national standards, DHH requirements, and state and federal law. MCNA's dental record documentation requirements will be distributed to providers via their DPA, Provider Manual and MCNA's Provider Portal.

MCNA requires that member dental records be maintained on paper or in electronic format. MCNA's dental record policies are in compliance with state, federal and HIPAA guidelines and procedures that include standards for proper storage and retrieval of our member's dental records at the provider's office.

MCNA will ensure that member dental records are maintained in a timely manner, legible, current, and that records are detailed and organized to permit effective and confidential patient care and quality review. Documentation of each member visit must include:

- Date and begin/end times of service
- Chief complaint or purpose of the visit
- Diagnoses or medical impression
- Objective findings
- Patient assessment findings
- Studies ordered and results of those studies (e.g. labs and x-rays)
- Medications prescribed
- Dental health education provided
- Name and credentials of the provider rendering services and the signature or initials of the provider
- Initials of providers must be identified with correlating signatures

In addition to the documentation required for each member visit, the dental record must include, without limitation, the following:

- Member identifying information
- Primary language spoken by the member and translation needs if any
- Medical history
- Referrals
- Signed and dated consent forms
- Documentation of advance directives

The reviews will be conducted at all primary care practice sites that include both individual offices and large group facilities. Each practice site is reviewed at least once every three years per DHH requirements. MCNA shall review a minimum of five (5) to ten (10) records at each provider facility to determine compliance. Larger file samples will be reviewed for large group practices given the more intricate administrative characteristics of this type of practice.

The Quality Improvement Director will develop an audit strategy and tools for submission to DHH for written approval, and maintain a written policy and procedure outlining the dental record review process. This Louisiana process shall include:

- Dental record reviews conducted by registered dental hygienists
- The number of files to be reviewed for each practice site is determined by practice size
- All files are randomly selected
- A DHH approved Audit Tool is used to document the review
- The Audit Tool captures the degree to which providers are complying with dental record guidelines adopted by MCNA
- This process allows for the tracking and trending of individual and plan-wide provider performance over time and includes the following:
 - Mechanisms and processes that allow for the identification, investigation and resolution of quality of care concerns
 - Mechanisms for detecting instances of over-utilization, under-utilization, and inappropriate utilization

The results of all dental record reviews are maintained in the DentalTrac™ system. If a provider fails to meet our contractually required dental record standards, MCNA will institute a corrective action plan (CAP) and conduct routine follow-up visits to the provider's office to monitor the provider's progress under the CAP and ensure ongoing compliance with MCNA's established dental record keeping standards.

Our Provider Relations and QI staff educate non-compliant providers on all issues found during the dental record review. All non-compliant providers will be re-audited by QI within 30 days and again in six (6) months to ensure adherence to all record keeping requirements. Continued failure to adhere to dental record requirements may result in provider termination. All results of MCNA's dental record reviews are reported to the Quality Improvement Committee (QIC) on a quarterly basis.

MCNA will report the results of all record reviews to DHH quarterly and also provide an annual summary as required by the RFP.

Compliance with Conflict of Interest Requirements

MCNA does not have any conflicts of interest that would interfere with our contract to administer the Dental Benefit Program for DHH. MCNA will hold our subcontracted providers to the same standards and require immediate notification if a conflict of interest arises that may interfere with their ability to meet the obligations of their agreement with MCNA. Conflict of interest compliance will be monitored through complaints and audits.

Compliance with Lobbying Requirements

The MCNA Dental Provider Agreement requires that our contracted providers comply with all federal and state lobbying laws. MCNA does not allow contracted providers to use federal funds to pay a person or employee or organization to influence or attempt to influence an officer or employee of any federal agency, member, or employee of a member of Congress, to obtain any federal contract, grant or award. MCNA requires that all contracted providers disclose their lobbying activities utilizing non-federal funds for the purpose of obtaining any federal award as required by state and federal law.

Compliance with Disclosure Requirements

MCNA and all its participating providers shall comply with state and federal disclosure requirements including, without limitation, the obligation to disclose any of the required disclosures identified in the RFP.

MCNA monitors our subcontractors' compliance with the HIPAA Privacy Rule, state and federal laws, and the provisions of this contract with respect to the use and disclosure of medical records, and all other health and enrollment information relating to members or potential members which comes into the possession of a provider as a result of the provider's performance under this contract. MCNA will also comply with the provisions of 42 CFR §438.102(a)(1)(ii) concerning the integrity of professional advice to members, including interference with provider's advice to members and information disclosure requirements related to Provider Incentive Plans.

Our Provider Relations Representatives are responsible for visiting provider offices at least once per year to meet with staff, conduct audits and educate providers about their contractual requirements.

Compliance with Member Education and Marketing Requirements

MCNA has never been sanctioned or placed under corrective action for any prohibited marketing practice related to the delivery of dental products by any state or federal government agency.

With respect to the Louisiana DBPM, MCNA does not anticipate engaging in "marketing activities" (as that term is defined in the RFP) directly, or through our network of participating providers. We will not produce, publish, or distribute to our providers for publication, materials designed to influence DHH enrollees to join MCNA. However, we do anticipate producing member materials to be used in our outreach activities to encourage enrolled members to utilize their covered benefits and educate them about the importance of good oral health. We also anticipate that our member materials may be distributed to members of the public that attend health fairs and other public events where MCNA conducts outreach.

All of our member materials and marketing materials, if any, will be submitted to DHH for approval prior to publication. MCNA will ensure that all member and marketing materials fully comply with the

requirements set forth in 42 CFR 438.10 regarding the dissemination of information to enrollees and the requirements set forth in the RFP. All of our materials will comply with state and federal marketing requirements, including state insurance laws and Louisiana Department of Insurance (LDI) regulations regarding marketing, and all DHH rules and regulations including prior approval of marketing materials by DHH.

MCNA ensures that all participating providers are educated and oriented on DHH marketing guidelines contained in the DPA, the Provider Manual, and state and federal law. To ensure compliance, MCNA monitors complaints from members, providers, event sponsors and participants, and will cooperate with DHH with respect to the disclosure of discovered marketing violations.

Ongoing Monitoring Through Credentialing and Recredentialing

MCNA's NCQA-certified Credentialing department monitors sanctions, formal reprimands, and quality of care complaints with respect to providers to identify quality deficiencies that may result in a restriction, suspension, termination, or sanctioning of the provider. The Credentialing Department takes appropriate actions when quality of care or safety concerns are identified between credentialing cycles. This action includes re-review of the provider by MCNA's Credentialing Committee.

Provider Site Audits

MCNA's Provider Relations department conducts provider site audits for credentialing and recredentialing, and to assist in responding to complaints, grievances, and quality of care concerns about the provider. Site audits are conducted to ensure providers are compliant with acceptable professional standards for quality dental care services as determined by MCNA, DHH and the Centers for Medicare and Medicaid Services (CMS).

Non-compliant providers will be re-trained and placed on a corrective action plan. A follow-up audit will be conducted to ensure compliance with the corrective action plan. Continued failure to adhere to site audit requirements will result in provider termination.

Section F.8

Provide an example from your previous experience of how you have handled provider noncompliance with contract requirements.

Provider Noncompliance with Contract Requirements

MCNA is proud of the strong relationships we have with our providers. We use a proactive education and training approach to minimize network disruption.

When MCNA has experienced challenges with providers who are not in compliance with any specific aspect of our contract, we immediately contact them to discuss the issue and work together to come to a mutually agreed upon resolution. The following are recent examples of our experience with contract non-compliance and provider education:

Issue	Resolution
A provider who failed to submit their dental records for a member when requested.	Our Director of Provider Relations contacted the provider and explained the contractual provision and business need for the record. MCNA requested their cooperation. Once the provider understood the importance of submitting the dental records and recognized our spirit of partnership, they immediately complied with the request.
A provider who balance billed a member for covered services.	MCNA immediately contacted this provider, educated them about proper billing practices, and referred them to the appropriate clause in their Dental Provider Agreement prohibiting this practice. The provider received a thorough re-training and now understands that he is not allowed to bill Medicaid members. We followed up with the member and learned the provider had reached out to them to apologize and advise them to disregard the bill.
A provider group refused to accept and comply with clinical criteria regarding medical necessity of third molar extractions.	MCNA Provider Services and Utilization Management supplied the clinical criteria to the provider and followed up with emails and phone calls to ensure an understanding of MCNA's clinical criteria. The provider group adamantly disagreed with MCNA's position on the extraction of asymptomatic third molars (wisdom teeth). MCNA was unable to gain agreement with the provider group. Therefore, a decision was made by MCNA's Provider Services, UM, and Senior Leadership to terminate this provider group's contract. The provider asked our State Regulator to review the dispute. Our Regulator confirmed MCNA's decision to terminate the provider after investigating the matter.
A provider's office was in violation of marketing rules.	MCNA re-educated the provider multiple times and emphasized the consequences of violating the marketing rules. The provider was advised that repeated offenses could lead to corrective action, up to and including contract termination. MCNA reported the violation to the appropriate state agencies. The provider corrected the behavior, but remains under close scrutiny to ensure compliance.

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<p>A provider refused to supply updated licensure during the re-credentialing process.</p>	<p>MCNA's Credentialing department attempted to contact the provider's office several times without a response. MCNA's Provider Relations department also reached out to the provider without success. Due to lack of response and provider non-compliance with their contractual obligation regarding credentialing, the provider was recommended for termination to MCNA's Credentialing Committee. The Committee unanimously agreed to terminate the provider contract for failure to submit active licenses.</p>
<p>A provider failed to comply with appropriate record keeping and documentation guidelines.</p>	<p>After thorough review of a random sample of patient records, multiple record keeping and documentation deficiencies, as well as numerous billing discrepancies were identified. The provider was re-educated on appropriate record keeping and appropriate billing. MCNA initiated a recoupment for inappropriately billed claims.</p>
<p>A provider repeatedly submitted claims with both D9230 (Analgesia, Anxiolysis, Inhalation of Nitrous Oxide) and D9248 (Non-Intravenous Conscious Sedation) together on behalf of members on one date of service, in violation of MCNA's Covered Services, Fee Schedules, and Guidelines.</p>	<p>A Provider Relations Representative visited the office and thoroughly retrained the provider on appropriate billing for sedation, specifically code D9230 will be denied if submitted with D9248 as explained in our Provider Manual:</p> <ul style="list-style-type: none"> • D9230 (Analgesia, anxiolysis, inhalation of nitrous oxide): May not be submitted more than one per client, per day. <u>Denied if submitted with D9248.</u> Ages 1-20. • D9248 (Non-intravenous conscious sedation): May be submitted twice within a 12-month period. Must comply with all TSBDE rules and AAPD guidelines, including maintaining a current permit to provide non-intravenous (IV) conscious sedation. Ages 1-20. <p>The provider agreed to follow MCNA's guidelines and has had no further incidents.</p>
<p>A provider refused to adhere to MCNA's clinical guidelines by including recovery time in the billing of sedation codes. The provider also did not include sedation start and stop times in the patient records.</p>	<p>The provider was educated on multiple occasions by the Provider Relations Representative, the Provider Relations Director and MCNA's Dental Director. After continued refusal to comply with MCNA's clinical guidelines, the provider was offered a Corrective Action Plan. The provider refused to sign the Corrective Action Plan and reconcile his billing and record keeping practices to comply with MCNA's clinical guidelines for sedation and clinically appropriate record keeping standards. MCNA is terminating this provider for non-compliance.</p>

Education, training, and communication are all key factors that have contributed to MCNA's ability to maintain a provider network that is compliant with our contract, and state and federal law. MCNA is prepared to take action toward providers who are not receptive to this approach by placing them on corrective action plans, up to and including termination. We will ensure that our network providers will adhere to all DHH requirements.

Section F.9

Describe in detail how you will educate and train providers about billing requirements, including both initial education and training prior to the start date of operations and ongoing education and training for current and new providers.

Initial and Ongoing Provider Education and Training

MCNA understands the Louisiana provider community may have some apprehension about the transition from state-operated fee-for-service programs to Medicaid managed care. Our past experience in successful transitions allows us to proactively address the concerns of our providers, specifically with respect to provider claims processing, reimbursements and their options. MCNA believes the key to our previous successes can be attributed to the strong relationships we have built with our provider communities. Experience tells us the most effective way to build relationships is by establishing trust. MCNA establishes trust with our provider communities using the following five essential elements:

- **Mutual Concern:** MCNA demonstrates shared concern with our providers about the oral health of our members
- **Keeping Commitments:** MCNA exhibits integrity, ability and character in keeping commitments to our providers and members
- **Open Communication:** MCNA fosters an open communication environment with customers, employees, providers and members
- **Active Collaboration:** MCNA actively collaborates with community partners, providers and members to promote good oral health
- **Long Term Perspective:** MCNA invests in provider education and training to contribute to overall provider and member satisfaction



Building trust with the Louisiana provider community is a top network development priority.

With this long-term perspective in mind, MCNA will conduct initial and ongoing provider orientations and webinars and provide a wealth of information through the Provider Portal and Provider Manual. MCNA’s Provider Portal and Provider Manual educate providers on a wide spectrum of topics, and include our procedures for claims submissions, requirements for clean claims, payment and reimbursement options, submission of electronic and paper claims, and a complete user guide explaining the functionality of our Provider Portal.

Providers can find informational and educational materials on our web-based Provider Portal. These materials include provider manuals, program descriptions, claim submission guidelines, video tutorials, ADA claim form completion instructions, and claim coding and processing guidelines. Providers are notified of any changes to these materials at least ninety (90) days prior to their effective date. We make all efforts possible to maintain our provider network's awareness of changes in regulations, program administration, benefits, and other requirements that may impact their reimbursement or ability to treat our members.

Prior to Go-Live

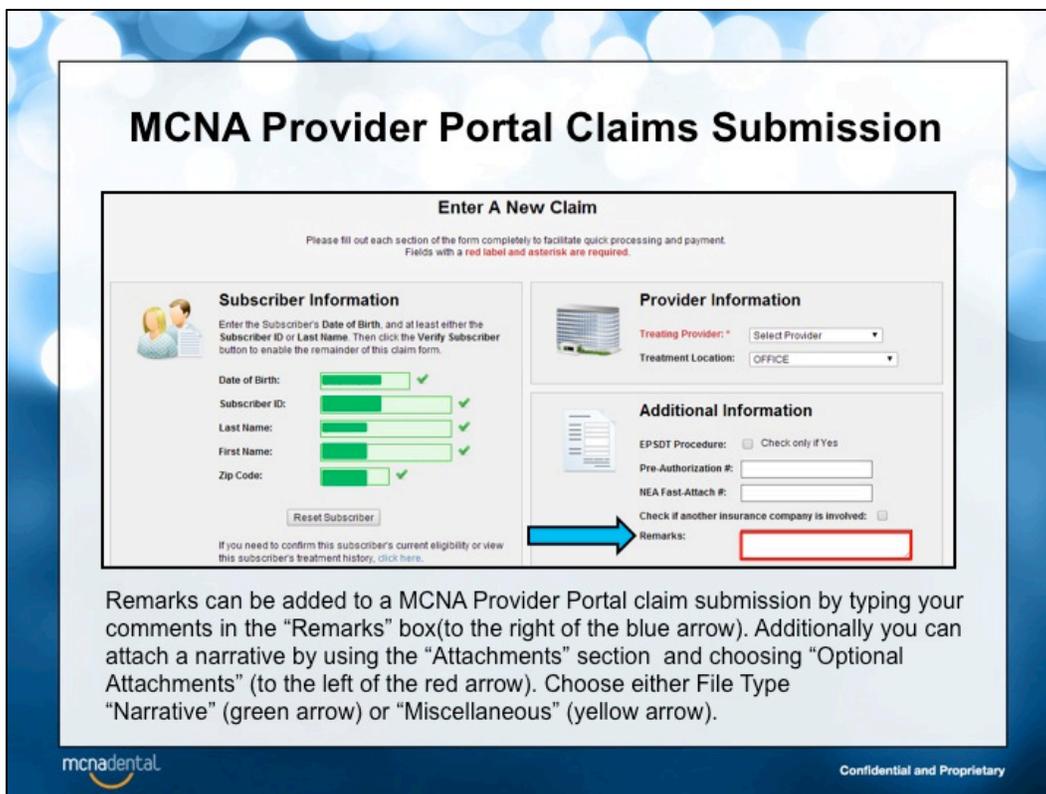
MCNA will conduct regional training workshops prior to the operation start date to ensure a smooth transition from fee-for-service Medicaid to managed care. These workshops will be the building blocks for establishing trust through **open communication** and **active collaboration**. Content covered in these workshops will also be available via a series of webinars. This dual approach to educational programming will allow providers multiple opportunities to receive training on MCNA's billing requirements and learn about the operational aspects of the Louisiana plan.

Training topics specific to billing include:

- Member eligibility verification resources
 - Provider Portal
 - MCNA's Call Center - Provider Hotline
 - MCNA's 24/7 automated eligibility IVR
- Covered services
 - Using MCNA's Provider Manual
- Prior authorizations and referrals
 - Services requiring a preauthorization or referral
 - Processing timeframes
 - Submission of required documentation
- Payment and reimbursement options
 - EFT set up
 - Paper checks
- How to submit claims
 - Provider Portal
 - Paper claims
 - Third party clearinghouses
- Claims submission guidelines
 - Definition of a "clean" claim
 - Processing timeframes
- Notification of "unclean" claims
 - Portal notification: active portal users
 - Letters: non-active portal users
- Payment disputes
 - Claims reconsideration
 - Complaints
 - Appeals

- Processes and timeframes
- MCNA's Provider Portal demonstration
 - Accessing provider tools
 - Submitting a claim
 - EOPs/RAs
 - Checking the status
 - Claim payments
 - Reconsideration requests
 - Appeals
- Fraud, waste and abuse (FWA)
 - Examples of FWA
 - Reporting FWA
- Coordination of benefits and third-party liability (COB/TPL)
 - Examples of COB/TPL
 - Reporting COB/TPL

The following slide is an excerpt from MCNA's orientation training on Provider Portal claims submission:



MCNA Provider Portal Claims Submission

Enter A New Claim

Please fill out each section of the form completely to facilitate quick processing and payment.
Fields with a red label and asterisk are required.

Subscriber Information
Enter the Subscriber's Date of Birth, and at least either the Subscriber ID or Last Name. Then click the Verify Subscriber button to enable the remainder of this claim form.

Date of Birth: ✓
Subscriber ID: ✓
Last Name: ✓
First Name: ✓
Zip Code: ✓

[Reset Subscriber](#)

If you need to confirm this subscriber's current eligibility or view this subscriber's treatment history, [click here](#).

Provider Information

Treating Provider: * Selected Provider
Treatment Location: OFFICE

Additional Information

EPST Procedure: Check only if Yes
Pre-Authorization #:
NEA Fast-Attach #:
Check if another insurance company is involved:

Remarks:

Remarks can be added to a MCNA Provider Portal claim submission by typing your comments in the "Remarks" box (to the right of the blue arrow). Additionally you can attach a narrative by using the "Attachments" section and choosing "Optional Attachments" (to the left of the red arrow). Choose either File Type "Narrative" (green arrow) or "Miscellaneous" (yellow arrow).

mcnadental Confidential and Proprietary

The following is a proposed regional training schedule for our Louisiana providers prior to the go-live date of May 1, 2014:

Proposed Regional Training Schedule [1/2]

mcnadental

MCNA Regional Provider Recruiting and Training Seminars

DRAFT ONLY



See next page for seminar details. Visit us online at www.MCNALA.net for more information.

Proposed Regional Training Schedule [2/2]

2014 Regional Training Seminars			
1	Baton Rouge	April 2, 15, 28	Location TBD
2	Slidell	April 3, 16	Location TBD
3	New Orleans	April 4, 17, 29	Location TBD
4	Lafayette	April 7, 18	Location TBD
5	Lake Charles	April 8, 21	Location TBD
6	Shreveport	April 9, 22	Location TBD
7	Monroe	April 10, 23	Location TBD
8	Alexandria	April 11, 24	Location TBD

All Regional Training Seminars are available in a morning session from **9:30 am - 11:30 am** and an afternoon session from **3:30 pm - 5:30 pm**. Snacks and refreshments will be provided.

2014 Online Webinars	
Online at http://mcnadental.webex.com	April 3, 7, 9, 11, 14, 16, 24, 30

All Online Webinars are available in an afternoon session from **12:00 pm - 2:00 pm** and an evening session from **5:00 pm - 7:00 pm**. Webinar access information will emailed to you upon your RSVP.

To RSVP, email LouisianaSeminars@MCNA.net with your name, contact information, and desired date, time, and location.

For more information about these seminars, please contact the MCNA Provider Relations Department at 1-855-854-6262. Note that dates and locations are subject to change. Please visit our website <http://www.mcnala.net> regularly to check for schedule updates.

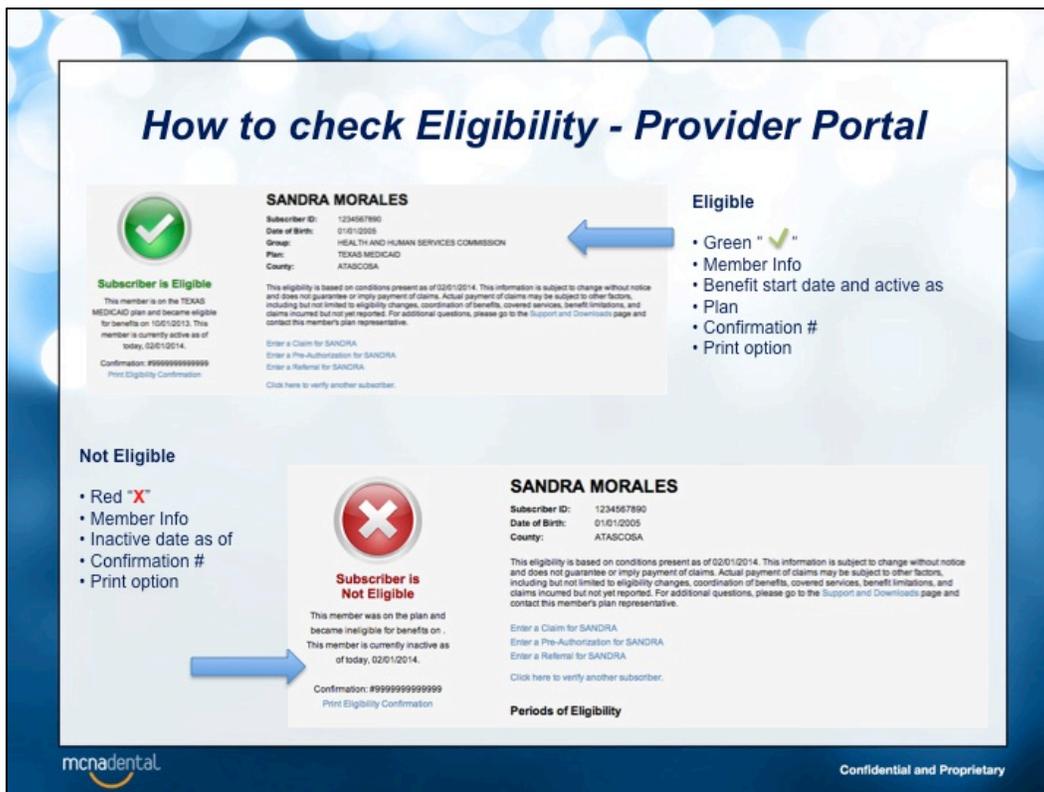
After Go-Live

MCNA will provide on-going education for current and new providers through a variety of methods:

Monthly Training Webinars

MCNA will host monthly training webinars for all network providers to address training gaps identified through frequently asked questions received on the Provider Hotline and feedback from our Provider Relations Representatives. We will also solicit suggestions from our provider community. The monthly webinar training schedule will be posted on the Provider Portal. In addition, providers will be notified by fax and email of the training dates and topics.

The following slide represents a sample of a recent monthly workshop held for our Texas Medicaid and CHIP Providers covering the importance of verifying member eligibility prior to rendering services.



Regional Quarterly Workshops

Workshops will be conducted each quarter on a regional basis and are designed to keep providers abreast of any changes to MCNA's policies and procedures, and DHH or federal requirements. The same content will again be available via webinars for providers and their office staff. Ongoing provider education can also be initiated by:

- Results from surveys and audits

- Identified trends from:
 - Claim and authorization submissions
 - Provider grievances or inquiries
 - Member complaints and grievances

Face-to-face training sessions will be used when there are specific issues to address stemming from complaints, provider profiling results, quality improvement activities, re-orientations for offices that may have staffing changes over time, or other opportunities that may arise where individual training is ideal.

MCNA will use the Provider Portal, provider bulletins and newsletters as ongoing training tools. Updates will be made to the Provider Manual on an as needed basis.

Section F.10

Describe how you will educate and train providers that join your network after program implementation. Identify the key requirements that will be addressed.

In 2013, our dedicated team of Provider Relations Representatives **trained over 5,500** Texas and Florida Medicaid and CHIP providers and facilities. MCNA educates our network of providers using a multi-faceted approach to information dissemination. After go-live we will continue to offer training in-person in large regional locations, on-site at individual offices, and remotely via monthly conference calls and webinars. All training sessions are supplemented by printed instructional materials and content will be available on our Provider Portal. Supplementary training seminars and webinars are scheduled as necessary to address specific topics. MCNA will also conduct outreach to non-participating providers.

Providers will have our Louisiana specific Provider Manual as a supplement to their contract. The Provider Manual contains key program information and is updated as needed to ensure complete, current information. In addition to our comprehensive Provider Manual, MCNA also produces and makes available newsletters, bulletins, quick reference guides, and other publications on clinical and operational items of interest. Our monthly provider newsletter, *Dental Details*, will be customized for our Louisiana network.

Please see the following sample from our Texas Medicaid and CHIP program.

Sample *Dental Details* Monthly Provider Newsletter

Topics in This Issue: Change to CDT Code D7111 • Update to Your Provider Manual • Change to Appeals Process • The Texas Meeting

dental**details**
for texas dental providers • may 2013

mcnadental

We Listen to You

Relationship-building is an important part of the continued success of our partnership with you. Our team in San Antonio actively listens to your questions and concerns. We examine the issues that you bring to our attention to make sound decisions about what steps to take going forward. We hear your voice and we take your concerns seriously. Please continue to reach out to us.

Change to CDT Code D7111

Upon examination of the compensation for CDT codes D7111 Extraction of Coronal Remnants-Deciduous Tooth and D7140 Extraction, Erupted Tooth or Exposed Root, we have decided to raise the amount we will pay for D7111. **We have raised the reimbursement rate from \$11.46 to \$30.00.** This amount was chosen after consultation with industry professionals. The new rate went into effect on **April 15, 2013.**

When a claim is received for D7140, if the tooth in question is within the average exfoliation period for the child, an x-ray is requested for review. Please be advised that if the tooth's root structure is not clearly visible in bone on the x-ray, you may also submit a photo if you feel that will assist the dentist reviewing the case in making a clinical determination. All determinations with respect to whether an extraction meets the CDT definition of D7140 or D7111 are made by Texas licensed dentists.

CDT	Description	Benefit Limitations	Fee
D7111	Extraction, coronal remnants - deciduous tooth	TIDs #A-T and AS-TS. A Birth-20	\$30.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	Replaces procedure codes D7110, D7120, and D7130. A Birth-20All primary teeth require an x-ray (or intraoral photo if the tooth cannot be seen radiographically), and rationale.	\$65.70

Update to Your Provider Manual

We are in the process of completing important updates to the Provider Manual. We have posted a 30-day notification of our intent to implement the changes to the Manual. You may preview the newest edition by accessing your Provider Portal account.

Change to Appeals Process

MCNA providers can now file an appeal using the Provider Portal. Take advantage of this new function and much more by logging on to the Portal!

The Texas Meeting

Get ready for the annual session of the Texas Dental Association (TDA)! The 2013 Texas Meeting will be hosted in San Antonio, May 2-4, at the Henry B. Gonzalez Convention Center.

MCNA will be there; come visit us at booth #4076! We look forward to seeing all of you at the conference. If you would like more information, visit the TDA 2013 conference website at <http://www.texasmeeting.com/>.

Need to Reach Us?

Contact MCNA's Provider Hotline at **1-855-PRO-MCNA (1-855-776-6262)**. We welcome all of your questions and comments!

MCNA uses multiple channels to deliver training to new and existing network providers in order to maximize the quality of a provider's services to our members and increase contract compliance. MCNA will provide initial training to all providers and their staff within thirty (30) days of placing the practice on active status.

New Provider Training

The initial training of all contracted providers will cover at a minimum:

- Overview of the Louisiana Dental Benefits Program
- Covered services
- EPSDT
- Provider roles and responsibilities
- Continuity of care
- After-hours on-call coverage requirements, appointment availability standards, and other provider responsibilities with regards to access to care for our members
- Linguistic access for members that need an interpreter or have special physical or hearing needs and anti-discrimination
- Referral and pre-authorization requirements
- Claims submission and processing
- Prohibitions on balance-billing members for covered services
- MCNA's Quality Assurance and Performance Improvement program (QAPI) and the provider's role in participating in surveys and audits, including dental chart review, access to care, provider satisfaction surveys
- HIPAA compliance
- Fraud, waste, and abuse
- Provider dispute resolution process
- Member eligibility and enrollment
- Accessing the Provider Portal

MCNA will keep providers informed of any changes to DHH requirements and MCNA policies and procedures.

REDACTED

Sample Training Evaluation Form

MCNA Provider Training Evaluation Form

We welcome your feedback on our Provider Training program! Please fill out this form and return it to the MCNA Representative. If you have any questions or would like to contact MCNA, please call our Provider Relations Hotline at 1-855-PRO-MCNA (1-855-776-6262).

Workshop Information

Workshop Title	Workshop Date
Workshop Trainer	Workshop Location

Training Evaluation

Please rate the following items on a scale of one to ten, with one being abysmal, five being acceptable, and ten being perfect.

Training Content	1 2 3 4 5 6 7 8 9 10
Usefulness of the Material	1 2 3 4 5 6 7 8 9 10
Trainer's Delivery and Expertise	1 2 3 4 5 6 7 8 9 10
Overall Satisfaction	1 2 3 4 5 6 7 8 9 10

Would you recommend this course to others? YES NO

Why or why not?: _____

Other thoughts you would like to share with us?

Provider Satisfaction

MCNA's Provider Relations team also conducts Provider Satisfaction Surveys to evaluate MCNA's training efforts and other key performance indicators. These surveys are typically conducted through outbound call campaigns, but may also be incorporated into site visits as a means to generate productive conversations with the office staff. The survey results are entered into DentalTrac™, MCNA's proprietary management information system. The results are compiled and appropriately addressed by the Provider Relations team.

A sample of the Provider Satisfaction survey which includes an assessment of training follows.

Sample Provider Satisfaction Survey

MCNA Provider Satisfaction Survey



We welcome your feedback on MCNA's level of provider service! Please fill out this form and return it to MCNA. If you have any questions or would like to contact MCNA, please call our Provider Relations Hotline at 1-855-PRO-MCNA (1-855-776-6262).

Survey Information

Provider Name	Facility ID Number
Date (MM/DD/YYYY)	Your Name

Survey Questions

Please rate the following items on a scale of one to five, with one being unacceptable and five being fantastic.

Timeliness of Claims Payment	1 2 3 4 5	Ease of Submitting Electronic Claims	1 2 3 4 5
Accuracy of Claims Payment	1 2 3 4 5	Resolution of Unpaid/Rejected Claims	1 2 3 4 5
Knowledge/Accuracy of Response to Telephone Inquiries	1 2 3 4 5	Representative Provided Courteous Service	1 2 3 4 5
Responded to Your Inquiry Promptly	1 2 3 4 5	Accuracy of Remittance Advice (EOB)	1 2 3 4 5
Resolved Inquiry in a Timely Manner	1 2 3 4 5	Timeliness of Pre-Authorization Process	1 2 3 4 5
Representative was Knowledgeable	1 2 3 4 5	Accessibility of MCNA's Dental Director	1 2 3 4 5
MCNA Provided Accurate, Complete Information on the Plan	1 2 3 4 5	Your Staff Received Adequate Orientation to MCNA Procedures	1 2 3 4 5
Your Staff Received Ongoing Training That is Effective and Useful	1 2 3 4 5	MCNA Provides Accurate Eligibility on the Phone	1 2 3 4 5
Timeliness of Appeal Process	1 2 3 4 5	Overall Experience with MCNA	1 2 3 4 5
I Would Recommend MCNA to Other Providers	1 2 3 4 5		

Additional Comments or Suggestions:

RFP # 305PUR-DHHRFP-DENTAL-PAHP-MVA
Prepared for the State of Louisiana Department of Health and Hospitals

Part Two, Page F-206

Section F.11

Describe your practice of profiling the quality of care delivered by network general dentists, and any other acute care providers including the methodology for determining which and how many Providers will be profiled.

- Submit sample quality profile reports used by you, or proposed for future use (identify which).
- Describe the rationale for selecting the performance measures presented in the sample profile reports.
- Describe the proposed frequency with which you will distribute such reports to network providers, and identify which providers will receive such profile reports.

Provider Profiling

We know that a successful provider profiling scorecard program must produce reliable data in order to obtain “buy-in” from the provider community. Our provider profiling techniques use large member and performance measure sample sizes, robust differentiators between providers, and audit methods to reduce measurement error. MCNA uses claims data, grievance and appeal details, results from dental record reviews, and information from our team of Clinical Reviewers to develop provider profiles. This data is analyzed to identify practice patterns that deviate from the mean, including providers who are excelling in the provision of preventive care to our members.

Establishing a Statistical Mean

MCNA uses encounter data to establish a mean based on the average rate of service delivery in accordance with clinically accepted practice guidelines and takes into consideration the geographic and demographic variations of our service areas.

The reports we generate also include monitoring member satisfaction, tracking and trending clinical studies, and monitoring appointment availability and after-hours access. Our proprietary management information system, DentalTrac™, uses a combination of business intelligence and powerful analytics to aggregate data for reliable provider profiling reports. MCNA creates profiling reports to identify aberrant practice patterns and fraud, waste, and abuse. For additional details about our provider profiling approach, please see Section N of this response.

When we evaluate providers and their practice patterns, we look at their compliance with:

- MCNA’s contractual requirements
- Availability as a measure of access to care
- EPSDT periodicity schedule adherence

Any reports of dissatisfaction with the provider are also reviewed to determine the need for additional provider education regarding particular aspects of the program. Our Provider Relations department

contacts providers who have abnormal rates of dissatisfaction and requests one-on-one training sessions to target the root cause of member concerns.

The metric for “Access Standards - Wait Times” was selected as a critical indicator of our **provider profiling algorithm** in order to ensure members are receiving the right care, in the right place, at the right time, and in accordance with state requirements. Please see the following sample “**PDP Wait Time Scorecard**” which illustrates a provider’s wait time score individually and in comparison with other PDPs in the selected service area.

The second type of scorecard that we will use in Louisiana illustrates a comparison of a particular service rate to the other providers in a peer grouping. This report looks at the provider’s use of sedation. Sedation was selected for the sample scorecard because it represents the most likely dental service to result in an adverse patient outcome if inappropriately administered. High rates of sedation can also indicate fraud and abuse. Providers are profiled on this measure and those falling outside of the acceptable standard deviation from the mean are targeted for peer-to-peer education by the Dental Director or a peer Clinical Reviewer. Please see the following sample “**Sedation Cluster Scorecard.**”

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Distribution Criteria and Frequency

For both scorecard approaches, providers are scored individually and then compared to their peers. This peer-to-peer comparison has proven highly effective in altering unfavorable practice patterns. Dentists are scientists as well as providers and their inclination is to perform within the expected mean for their peer grouping. Profiling reports are created on a quarterly basis with an annual summary that is made available to providers via MCNA's Provider Portal.

Using Profiling for Quality Improvement

Best practices identified through any of the above profiling assessments will be shared with all network providers. This will be done through multiple mechanisms including newsletters, direct correspondence via email, and through quarterly face-to-face network meetings facilitated by MCNA. Providers who demonstrate best practices will be invited to showcase their efforts in articles published on our website or through provider newsletters.

It is imperative that providers working with MCNA contribute to achieving our QAPI goals. Those providers who fail to demonstrate improvement or continuously lag behind our performance goals will be referred to our Quality Improvement and Credentialing Committees for further action. These committees work in tandem with one another to conduct peer review as appropriate and direct reasonable corrective actions when necessary. MCNA will report cases involving non-compliant providers to the National Practitioner Data Bank and the Louisiana State Board of Dentistry as appropriate.

Example of Provider Quality Profiling

In addition to our targeted profiling efforts, MCNA also seeks to identify and recognize providers who engage in best practices. Participating general and pediatric dentists are considered to be primary care providers for the members we serve. These providers are evaluated based on their compliance with best practices in the delivery of preventive care. MCNA would like to explore a quality initiative with our Louisiana providers after gaining some baseline experience in the state.

The following details our quality profiling efforts in Texas as an example of an approach that could be used in Louisiana to identify "preferred providers." Preferred providers are those who consistently demonstrate their commitment to the delivery of preventive care to our members. High scoring Louisiana providers would be eligible to receive non-monetary rewards such as preferred status in our PCD auto-assignment process, reduced prior authorization requirements, and reduced need to submit clinical documentation with claims for selected procedures.

Our Texas Experience

MCNA's Stellar Treatment and Recognition Reward (STARR) program was designed by MCNA to increase the provision of key preventive care services by our participating General and Pediatric Dentists and reward stellar performance. Our quality profiling approach was a natural evolutionary step

for the Medicaid and CHIP dental program in Texas. It is targeted to substantially increase provider satisfaction with the Medicaid plan, ensure enhanced clinical outcomes for our members, and serve as an excellent indication of the state's commitment to meet and exceed quality and access-to-care goals.

Targeted Provider Types and Rationale

The provider types targeted in the STARR program are Main Dental Home (MDH) providers (either general dentists or pediatric dentists). MDH providers were selected because these are the providers that perform preventive care services for the Medicaid and CHIP members served by MCNA.

Targeted Service Types and Rationale

Our STARR program targets the following preventive care services (the "Targeted Service Category(s)") for enhanced utilization:

- Prophylaxis Treatment
- Fluoride Application
- Sealant Application
- Recall Visits
- First Dental Home Visits

These preventive services were selected by a workgroup of MCNA and independent dentists based on evidence based, best practices in the field of dentistry. Preventive care promotes positive oral health outcomes and results in lower costs over time, as more costly restorative care becomes unnecessary for the member. The selected categories are also congruent with the efforts of the Dental Quality Alliance (DQA) and recently adopted DQA target metrics.

Specific Quality Improvements Targeted and Rationale

To qualify for participation in STARR during year one of the program, a provider must have treated at least 150 MCNA members between March 1, 2012 and May 31, 2013, and conducted an initial comprehensive examination on at least 40% of the MCNA members they treated within 210 days of enrollment. The first year of the program is inclusive of all qualified providers.

Qualified Providers were scored from zero (0) to three (3) stars based on the level of each Targeted Service Category provided to MCNA members. Providers are able to achieve a maximum score of 15 stars. If over 5% of the MCNA members treated by a provider have re-treatment (multiple restorative services on the same tooth/same surface), the provider would lose two stars. Any provider with re-treatment in excess of 10% would lose eligibility for the STARR program.

A qualifying provider's cumulative star total is illustrated in the Provider Scorecard as follows:

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Part Two: Technical Approach

Section F: Provider Network



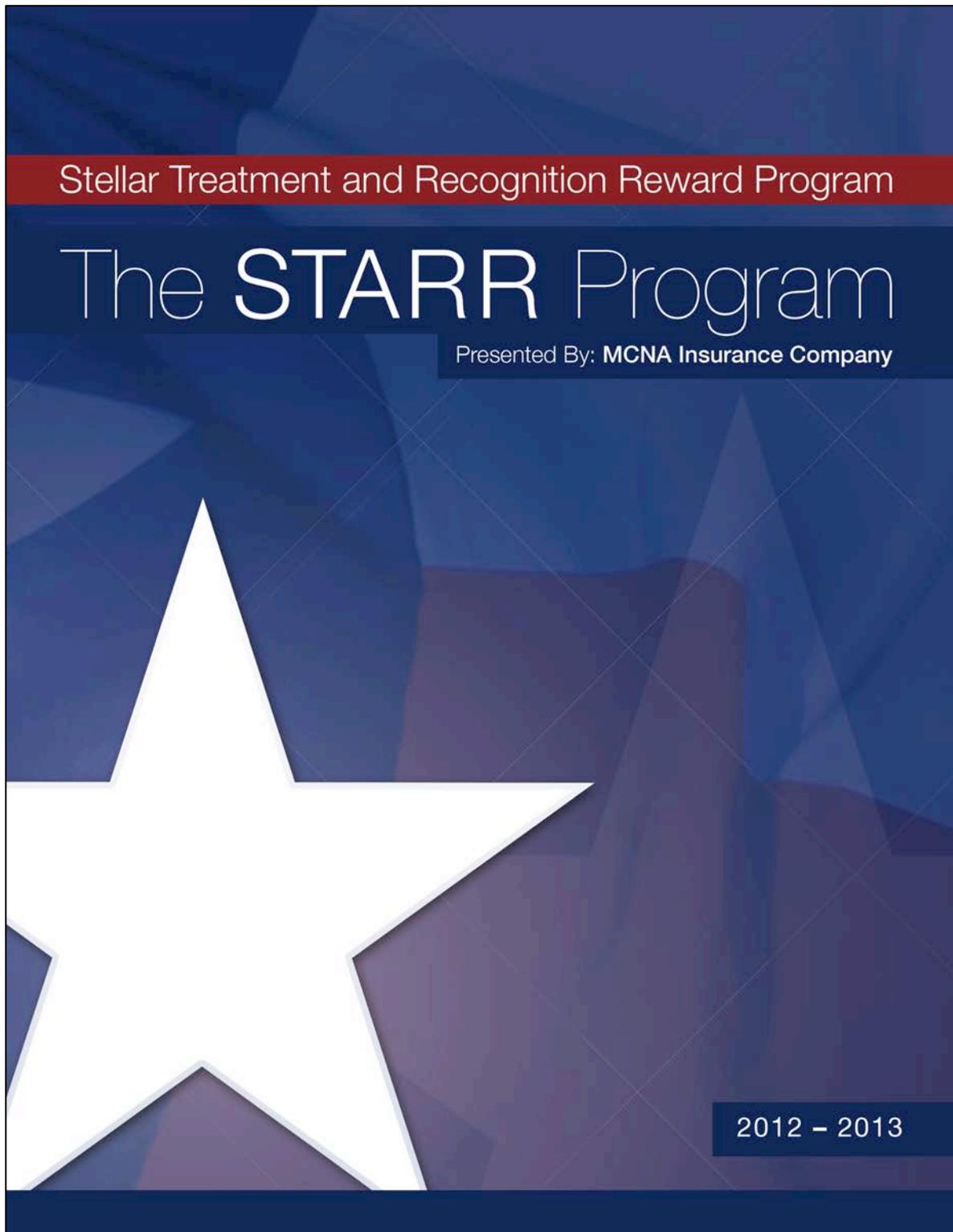
such as sealants on 1st and 2nd permanent molars. If applied properly, dental sealants are 100% effective at preventing caries. This should reduce the need for restorative services such as fillings and crowns. Fluoride application also remineralizes teeth and prevents decay. Although not as effective as sealant application, similar outcomes should be seen.

The annual dental visit measure and 6-month recall visits are geared toward identifying risks early and being able to treat any dental disease with the most conservative restorative treatment available as a result of early detection. The D0145 metric is a Texas preventive code geared to incentivize early oral health intervention through a program known as the “First Dental Home Initiative.” For this reason, the First Dental Home Initiative is a STARR metric that should result in cost savings by decreasing the number of children needing hospital care with general anesthesia to treat their severe caries.

Claims data will be used to measure the impact of the STARR program on preventive care rates and resulting cost savings calculations. Savings will be based on a reduction in restorative care that will result from the use of proper preventive services such as sealants.

MCNA is eager to work with DHH to explore provider quality profiling options for Louisiana.

MCNA's Stellar Treatment and Recognition Reward (STARR) Program [1/5]



MCNA’s Stellar Treatment and Recognition Reward (STARR) Program [2/5]



Dear Colleague,

MCNA Insurance Company is pleased to announce our **Stellar Treatment and Recognition Reward (STARR) Program** for our Texas Main Dental Home Providers. Over the course of the past year, we have enjoyed getting to know you as Providers and working to enhance the oral health care of the children of Texas.

As former President of the American Academy of Pediatric Dentistry (AAPD) and the Texas Academy of Pediatric Dentistry (TAPD), I had the opportunity to lead the development of the AAPD’s clinical guidelines emphasizing the importance of oral health intervention and the dental home model of care. As the Texas President for MCNA Dental, I am committed to maintaining an emphasis on improving the oral health outcomes of our Texas children and reducing their risk for dental disease.

MCNA’s innovative STARR Program is designed to recognize our Providers who render stellar treatment. The program rewards Main Dental Home Providers who perform a high volume of five select preventive services. These services were selected based on AAPD guidelines and the emerging quality of care indicators from the Dental Quality Alliance.

All Main Dental Home Providers are eligible for program participation once they meet the defined qualifying criteria. Stars are awarded in each of the five preventive service categories, and Providers are placed into tiers based on their cumulative number of stars. Scorecards will be posted in their Provider Portal account that identify their star total and recognition tier.

MCNA values your participation in our Provider Network. This program is designed to reward your hard work and dedication. Together we can build a foundation for a lifetime of positive oral health outcomes for the children of Texas!

Sincerely,

Philip H. Hunke, D.D.S., M.S.D.
President



MCNA’s Stellar Treatment and Recognition Reward (STARR) Program [3/5]

Star Allocation Service Categories

Once a Provider meets MCNA’s qualifying criteria, their practice patterns are evaluated and scored based on the number of MCNA members receiving the following five recommended preventive services:

- **Prophylaxis Treatments**

Microbial plaque is the primary etiological factor in caries and periodontal disease. According to the AAPD Guideline on the Role of Dental Prophylaxis in Pediatric Dentistry, professional prophylaxis is necessary to provide long-term inhibition of gingivitis. Although it may be possible to remove most plaque using mechanical oral hygiene aids, many patients do not have the motivation or skill to maintain a plaque-free state for extended periods of time.
- **Fluoride Application**

The AAPD affirms that fluoride is a safe and effective measure for reducing the risk of caries. According to the current AAPD Guideline on Fluoride Therapy, use of fluorides for the prevention and control of caries is documented to be both safe and highly effective. Fluoride has several caries-protective mechanisms of action, including enamel remineralization and altering bacterial metabolism to help prevent caries.
- **Sealant Application**

The AAPD recommends the use of sealants after the eruption of the first and second permanent molars. Sealants are 100 percent effective if they are fully retained on the tooth. According to the Surgeon General’s 2000 report on oral health, sealants have been shown to reduce decay by more than 70 percent. The combination of sealants and fluoride has the potential to nearly eliminate tooth decay in school age children.
- **Recall Visits**

Professional care is necessary to maintain oral health. The AAPD emphasizes the importance of initiating professional oral health intervention in infancy and continuing through adolescence and beyond. The periodicity of professional oral health intervention and services is based on a patient’s individual needs and risk assessment. Minimum guidelines include a comprehensive or periodic oral evaluation once every six months.
- **First Dental Home Visit (D0145)**

Establishment of the First Dental Home sets the stage for an ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. It begins as early as 6 months of age and includes referral to dental specialists when appropriate.

MCNA’s Stellar Treatment and Recognition Reward (STARR) Program [4/5]

Qualifying Criteria

In order to qualify as a STARR Provider:

- You must have been an active **MCNA Main Dental Home Provider** at the end of the plan year (March 1, 2012 – May 31, 2013).
- You must have treated at least **150 MCNA Members** in your practice over the course of the plan year.
- **At least 40% of the members** treated had to receive a comprehensive oral examination (D0120, D0150, or D0145 as applicable) within 210 days of assignment to you.
- You must have been in **good standing** with MCNA and all federal and state agencies throughout the measurement period.
- Your **office must be active** with MCNA on the date of Recognition Reward payment.

150
MCNA Members Treated

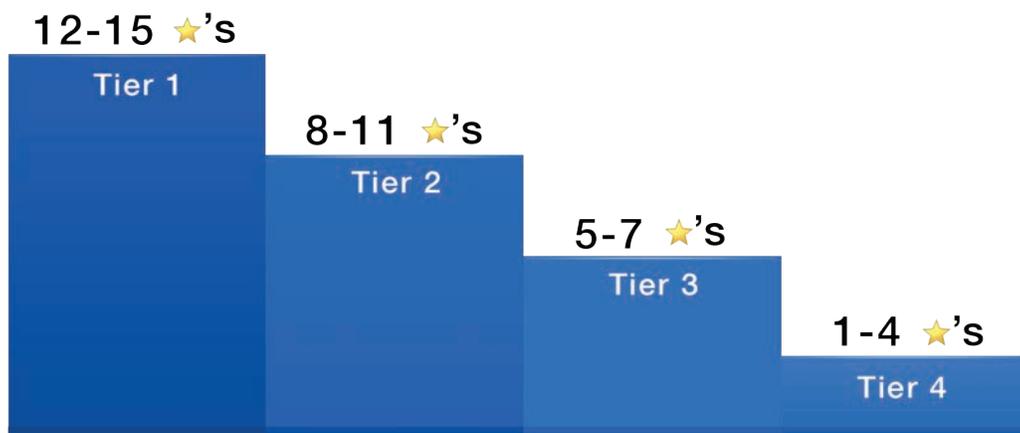
40%
Oral Exam Within 210 Days

Quality of Care Concerns

MCNA reviews dental practice patterns that indicate inappropriate or substandard treatment. “Re-treatment” or the use of multiple restorations on the same surface and tooth can indicate a poor quality of initial work. Two stars will be deducted in the event Re-treatment exceeds 5% for all MCNA Members treated. A Provider with a re-treatment rate in excess of 10% for all MCNA Members treated is not eligible for this program.

Recognition Tiers

MCNA has established four recognition tiers and scored each of the five categories from zero to three stars, based on the percentage of members treated by you that receive each service. **The maximum number of stars available is 15.** Your cumulative star total determines your qualifying tier as follows:



MCNA’s Stellar Treatment and Recognition Reward (STARR) Program [5/5]

2012-2013 Year in Review

At the end of the 2012-2013 measurement period, over 90% of MCNA’s Main Dental Home Providers who qualified for the STARR Program were in Tier 1 or Tier 2.



STARR Scorecard

You will have access to a scorecard in your Provider Portal account that details your star allocation, cumulative star total, and corresponding tier achievement for your facility and each provider at your facility. The scorecard will reflect the score for services performed at that facility only.

Recognition Rewards

A Main Dental Home Provider who qualified for Recognition Tiers 1 through 4 shall receive a cash Recognition Reward from MCNA. The total amount of the cash Recognition Reward available for any given year is subject to Texas Health and Human Services Commission (HHSC) approval. Each facility that has a Qualifying Main Dental Home Provider will receive a personalized letter detailing the Recognition Tier achieved by the Provider, and a check for the dollar amount of their Recognition Reward.



Section F.12

Describe the process for accepting and managing provider inquiries, complaints, and requests for information that are received outside the provider grievance and appeal process.

Accepting and Managing Provider Inquiries, Complaints, and Requests for Information

MCNA maintains a provider complaint process for in and out-of-network providers in Louisiana to dispute MCNA's policies, procedures, or any aspect of our administrative functions. The complaint process will be outlined in MCNA's Provider Manual and available online via MCNA's Provider Portal.

We have a toll-free Provider Hotline that is available for providers to ask questions about the program, file a complaint, request information or seek resolution of a problem. The Provider Hotline is available 7:00 a.m. until 7:00 p.m. CST throughout the State of Louisiana, Monday through Friday, excluding state-approved holidays.

To ensure providers are aware of MCNA's provider complaint process, we will feature the toll-free number prominently on our website, in the Provider Manual, in the Provider Portal, in provider education materials, and for non-network providers the information will be available on our remittance advices. The information will include specific information such as details about the Provider Hotline, how to contact your Provider Relations Representative, and specific email and mail contact information for how to submit a complaint via email, surface mail, or for the provider to request a face-to-face meeting to present his or her case to MCNA. Providers are permitted to file a written complaint with MCNA within 30 calendar days of the event that is the basis of the complaint. MCNA will respond to the complaint within 30 calendar days of receipt.

MCNA's Provider Hotline

The Provider Hotline is typically the first point of contact for our providers. When providers call, MCNA's Interactive Voice Response (IVR) system answers within 3 rings and offers a series of prompts to ensure calls are routed correctly. A provider's primary source of information from the hotline is the Provider Hotline Representative. We have implemented an "Auto Answer" mechanism by which the call is automatically answered by the next available Provider Hotline Representative to reduce wait time and call abandonment rates.

To accommodate providers who need assistance outside normal business hours, our hotline will be answered by the automated IVR system after-hours, on weekends, and on state-approved holidays. The automated IVR system informs providers of our Hotline's normal operating hours and allows them to check a member's eligibility for services. These features on the IVR can be accessed by the provider upon entering his or her identifying information, and the member's ID and date of birth. The IVR will then confirm the member's eligibility for services.

When an MCNA Provider Hotline Representative receives a call from a provider, the representative documents and categorizes the call in DentalTrac™ and utilizes the system to assist the provider. DentalTrac™ provides the representative the ability to search for information and accurately answer questions about:

- Member enrollment status and benefits
- Claims, referrals, and authorization submissions
- Provider enrollment status
- Fee schedule(s)

Providers can register complaints, inquiries, request information, or seek information about covered benefits. The Provider Hotline Representative will also utilize other reference materials such as the Provider Manual, the DHH contract, the Dental Provider Agreement, and policies and procedures to assist them in addressing the provider's issue. Any documentation that is requested by the provider will be logged in DentalTrac™ and submitted to the provider via fax, email or mail within 1 business day. All materials containing member protected health information is handled in a secure manner.

All provider inquiries and complaints are logged into DentalTrac™ for tracking purposes. The Senior Director of Call Center Operations, in conjunction with the Director of Provider Relations, analyzes reports to identify any operational issues and implement intervention strategies that may include re-educating providers on policies and procedures, and inter-departmental collaboration to improve internal processes. As part of our continuous quality improvement process and to ensure participating providers are given consistent and accurate information, the Provider Hotline staff's calls are monitored. Any inconsistencies identified are immediately addressed with the employee.

Provider Hotline Staff Training

To ensure our Provider Hotline staff is fully knowledgeable about DHH Dental Benefit Program requirements, MCNA will provide comprehensive training on topics such as service goals, performance standards, and medically necessary covered dental benefits. Training consists of both classroom time and on-the-job training. The course curriculum supports DHH's performance standards and will be delivered using established training methods. The Senior Director of Call Center Operations is responsible for the daily management and establishment of the goals and objectives of our Provider Hotline staff. The staff is trained in the dental claims and service authorization processes so they can quickly and accurately answer providers' questions regarding claims payment and prior authorization status. The training includes a review of Provider Relations policies and procedures, telephone etiquette, the Provider Grievances and Appeals process, accessibility and availability standards, site survey audit tools, and the Provider Satisfaction Survey.

Our team is trained on the process of assisting providers needing help with enrollment, claims submission, or credentialing. The representatives receive training on the technical aspects of the position and their job description, as well as MCNA's Mission, Quality Improvement Program, Compliance Program, Risk Management Program, incident reporting protocols, and Disaster Recovery and Business Continuity Plan. All MCNA employees receive a training manual covering our policies and procedures as well as other reference material.

Escalation and Investigation Process

MCNA's Provider Relations department offers our dental professionals timely and accurate responses to all inquiries, questions and concerns. Our Provider Relations Representatives are committed to providing prompt and accurate information to providers and their staff regarding their contract, covered benefits, fee schedules, prior authorization requests, referrals, claims, and the MCNA Provider Portal. Provider Relations Representatives are also trained to handle any dissatisfaction expressed by a provider.

Should the Provider Hotline Representative be unable to resolve a provider's issue, the complaint will be forwarded to MCNA's Provider Relations department. MCNA's Provider Relations department maintains representatives throughout the State of Louisiana. Our Provider Relations (PR) Representatives will research and resolve the issue. The PR Representative will then notify the provider of the outcome.

Complaint Resolution Process

MCNA's Provider Hotline Representatives and Provider Relations Representatives investigate each complaint. Their thorough review includes review of applicable statutory, regulatory, contract and provider subcontract provisions, and application of MCNA's written policies and procedures. The needed facts are gathered from all involved parties. Should the complaint require corrective action, an MCNA executive with the authority to require such action will be the final point of escalation. All information pertaining to the complaint, including documents gathered during the investigation, will be maintained in the DentalTrac™ system to provide a complete and thorough audit trail and enable reports to be generated based on the nature of the complaint.

Provider Relations Representatives are trained to distinguish between provider complaints and member grievances or appeals. All member grievances and appeals, whether submitted by the member or by the member's provider on behalf of the member, are handled by MCNA's Grievances and Appeals department. Additionally, to streamline the complaint process, MCNA allows providers to consolidate complaints of multiple claims that involve the same or similar payment or coverage issues.

MCNA will maintain and implement written policies and procedures that detail the operation of the provider complaint process. These policies and procedures will be submitted to DHH for review and approval within 30 calendar days of the date the Contract with DHH is signed, or not later than prior to the Readiness Review. MCNA's provider complaint process will comply with all RFP requirements and the status of all provider complaints and their resolution will be provided to DHH on a monthly basis in the format required by DHH.

Section F.13

If the Department receives written or verbal complaints on behalf of any provider in regards to excessive, unwarranted, and/or aggressive attempts to require any information to fulfill network adequacy requirements during the RFP process.

MCNA is aware of and understands this requirement. While building our network, all providers were treated with dignity and respect.

Section G.1

Describe how you will ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope as specified in the Louisiana Medicaid State Plan.

Ensuring Appropriate Services

MCNA has proven experience in managing state mandated, covered dental services for almost 3 million children and adults in the Medicaid and CHIP plans of Texas, Florida, and Kentucky. Our Louisiana members will have access to the full spectrum of dental care services required in this RFP, including diagnostic, preventive, restorative, pediatric, endodontic, periodontic, prosthodontic (including adult dentures), orthodontic, emergency, and oral and maxillofacial surgery. MCNA understands and shares the desire of the Department of Health and Hospitals (DHH) to increase access to appropriate, quality dental care and improve oral health outcomes for its Medicaid and CHIP populations. **We have extensive experience delivering the quality dental care services required by the DHH for its enrollees.**

Key Facts About MCNA

- ❖ MCNA employs **31 licensed general and specialty care dentists** to review all utilization management cases that require medical necessity review.
- ❖ 2013 processing time for UM cases in Texas: **1.3 business days**
- ❖ 2013 processing time for UM cases in Florida: **1.8 business days**
- ❖ 2013 processing time for UM cases in Kentucky: **Less than 1 business day**

We are committed to **ensuring** our dental services are accessible, appropriate, cost effective, and meet or exceed regulatory and contractual requirements. We accomplish this through the application of MCNA's Utilization Review Criteria and Guidelines by our Dental Directors and Clinical Reviewers. Additionally, our state-of-the-art management information system, DentalTrac™, prevents inappropriate and duplicate use of dental services through customized edits that are based on benefit plan design, service frequency limitations, and clinical guidelines. We strive to ensure members receive the right care, at the right time, in the right place.

MCNA will **ensure** that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope as specified in the Louisiana Medicaid State Plan. By tailoring our Utilization Management (UM) program to meet the needs of Louisiana, MCNA ensures that the provision of dental care services are high quality, cost-effective and provided in the most appropriate setting consistent with 42 CFR Chapter 456.

Designed and guided by dentists, MCNA's UM program follows generally accepted dental standards of care and review criteria developed in conjunction with the guidelines of the American Academy of Pediatric Dentistry, the American Dental Association, the American Association of Oral and Maxillofacial Surgeons, the American Association of Endodontics, the American Academy of

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MCNA's utilization management protocols ensure that covered services shall not be any more restrictive than what is covered in the Medicaid fee-for-service program. For example, our utilization review and referral management policies ensure that state eligibility criteria for oral and maxillofacial surgery services, treatment in a facility setting, and orthodontic services must be met in order for those specialty services to be covered. Additionally, our providers understand that members cannot be charged copayments for covered services, and each participating provider agreement contains a provision prohibiting balance billing. MCNA will comply with all DHH requirements with respect to provider reimbursement and timely claims payment.

UM Committee

MCNA's Board of Directors has ultimate responsibility to establish, maintain and support the Utilization Management Program. The Board charters state specific Utilization Management Committees (UM) as sub-committees of the Quality Improvement Committee (QIC), and appoints its members. Each UM sub-committee is chaired by the Dental Director of its state. Annually, the Board receives a written summary and evaluation of the Utilization Management Program and proposed plan amendments from the QIC. The UM Committee meets on a quarterly basis and conducts the following activities:

- Monitor the medical appropriateness and necessity of dental services delivered for the quarter by reviewing provider quality and utilization profiling data including out of network referrals
- Develop strategies to safeguard against inappropriate and/or unnecessary dental services
- Monitor consistent application of medical necessity criteria and guidelines by UM staff
- Review the effectiveness of the utilization review process and recommend changes
- Approve policies and procedures for UM that conform to industry standards, including methodology and timeliness
- Establish and analyze internal performance goals where benchmarks are not available, or when current performance exceeds benchmark data
- Monitor over and underutilization of preventive and restorative services by providers
- Assess member and provider satisfaction with the UM Program

The activities and functions of the UM Committee are conducted in compliance with HIPAA privacy regulations and in a manner that protects the confidentiality of all committee proceedings and member information used in committee deliberations.

Monitoring Consistent Application of Utilization Review Guidelines and Management of Criteria

MCNA's UM Committee is responsible for the review of our utilization management procedures and for ensuring that our Clinical Reviewers and support staff adhere to our qualitative clinical review standards. The UM Committee reports quarterly on these efforts to the QIC who then reports all results to the Board of Directors. **MCNA's Dental Directors ensure that clinical criteria are being utilized appropriately and consistently by our Clinical Reviewers by conducting comprehensive inter-rater reliability audits on an annual basis and unscheduled random audits as needed.** The Dental Director will assess Clinical Reviewer performance, ensure accuracy, verify adherence to qualifying criteria, and ensure general and specialty services are rendered in the amount, duration and scope as specified in the Louisiana Medicaid State Plan.

Evaluation of the UM Program

Our UM Program is evaluated on an annual basis by the QIC and any recommended modifications to the program are submitted to the Board of Directors. Our annual review process is designed to evaluate the continued appropriateness of our dental criteria and the program's overall effectiveness. The UM Committee reviews and analyzes the following reports to identify opportunities for improvement:

- Call tracking reports from member and provider services to analyze complaints about the UM program
- Information gathered from member and provider satisfaction surveys regarding member and provider satisfaction with the UM program
- Results from clinical staff inter-rater reliability audits
- Turnaround time (TAT) reports
- Medical necessity approval and denial reports
- Administrative approval and denial reports
- Member and provider medical necessity appeals
- UM and Case Management non-clinical staff key performance indicator reports

Amendments to the UM Program adopted by the MCNA Board Directors will be submitted to DHH for approval before implementation.

New Technologies For Better Outcomes

We acknowledge the vast contributions of technological breakthroughs to the health care field. Advances in management information systems, dental sealants, new orthodontia techniques, and the emerging prospect of digitally printed dental appliances are prime examples of innovative ways that our industry seeks to improve the oral health services our members may access.

The Chief Dental Officer (CDO) and our state Dental Directors are responsible for identifying opportunities for quality improvement through new technologies. They access government publications, the Hayes Directory, scientific journals and consultations with practicing dental providers to identify technology related opportunities to improve covered services.

When an opportunity is identified, the CDO presents the information to the UM Committee to review and consider any necessary clinical guideline updates to ensure that state-of-the-art procedures are covered for our members. The UM Committee will make recommendations to the QIC who reports results and recommendations to the Board of Directors for final approval and implementation. Our Chief Dental Officer encourages and maintains open communication and collaboration with participating providers and the DHH on any identified new technologies that could benefit the Medicaid and CHIP members we serve.

Our Pre-Authorization (Prior Authorization, Pre-Certification) Process

From a continuity of care perspective, the success of a member's dental care is entirely dependent on the ability of a treating dentist to complete the treatment plan. Every new enrollee in active treatment transitioning into MCNA will be allowed to continue medically necessary covered services with an in-network or out-of-network provider, without prior approval from MCNA. For tracking purposes, MCNA encourages providers to submit a continuity of care (COC) form to ensure members receive services during the transitional period. MCNA's UM department requires written documentation of pre-authorization for ongoing covered services for a period of 30 calendar days after the effective date of enrollment.

We have a proven track record in continuing dental services for members transitioning from fee-for-service to dental managed care programs in Texas, Florida, and Kentucky. We are dedicated to ensuring that all DHH enrollees will complete their treatment plans seamlessly as the Louisiana Medicaid dental program transitions to the DBPM.

MCNA ensures that our members have access to emergency dental care services without any delay or hindrance. Our members have access to emergency care without the need to obtain a pre-authorization and can receive services through any emergency facility or provider, regardless of whether the facility is in or out-of-network. MCNA's pre-authorization process complies with 42 CFR 438.210.

Part Two: Technical Approach

Section G: Utilization Management



MCNA accepts pre-authorization requests submitted by providers **electronically**, via our easy to use online **Provider Portal**, or on **paper**. Paper requests are manually entered into our DentalTrac™ system and electronic requests are received in either HIPAA compliant 837D files or real-time through our online Provider Portal submission process. MCNA's Provider Portal allows dentists to attach x-rays, narrative, and other supporting documentation electronically. Providers using a clearinghouse to submit prior authorizations electronically can use **NEA FastAttach®** for all submissions of x-rays, narratives, and supporting documentation.



DentalTrac™ adjudicates the pre-authorization request using the National Correct Coding Initiative edits as well as our customized edits to verify member eligibility, provider status, and plan benefit coverage. DentalTrac™ reviews the CDT code against the member's prior dental history to manage the benefit limitations of dental services according to the contractual agreement. A provider's pre-authorization request must include any related radiographs, photos, charting, models, and narratives as outlined in the Provider Manual.

Providers prefer the ease of MCNA's Provider Portal for submitting prior authorization requests. In 2013, 9 out of 10 prior authorizations were submitted via the MCNA Online Provider Portal.

Upon receipt of a pre-authorization request, the Utilization Management Coordinator (UMC) verifies the member's eligibility and benefits as well as the requesting provider's network affiliation. All pre-authorizations requiring medical necessity determinations are routed through our state-of-the-art management information system, DentalTrac™ to a Clinical Reviewer. Requests for services are reviewed to determine that the service is a medically necessary covered benefit and that the service is being delivered **consistent with established criteria and guidelines**.

Our Clinical Reviewers examine each case and relate the existing conditions to the qualifying criteria to determine approval. Our clinical staff uses criteria and clinical evidence such as x-rays, models, narratives, and chart notes to determine the medical necessity of requested procedures. Additional information will be sought as needed from the requesting dentist. The requesting provider is notified of the UM determination via MCNA's online Provider Portal. If a provider does not have access to the Provider Portal, a determination letter will be mailed. The provider will also receive telephonic notification of MCNA's determination for any urgent or emergent requests.

MCNA notifies our members in writing of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested within the timeframes outlined by DHH. Member notices are written at or below a 6th grade reading level to ensure ease of understanding and are in compliance with 42 CFR 438.404(b) and 42 CFR 438.210(c). **MCNA fully complies with all language requirements** including translation of member notifications.

Member and provider notifications explain, at a minimum the:

- Action MCNA has taken or intends to take
- Reasons for the action
- Member's or the provider's right to file a grievance or appeal

- Member's right to request a State Fair Hearing

The notice also explains circumstances under which expedited resolution is available and how to request it, as well as the member's right to request that benefits continue pending the resolution of the appeal. A decision to authorize, modify, or deny a dental treatment shall be made within two (2) business days, but no later than 14 calendar days after receipt of the request for authorization of services for all standard requests. Urgent or emergency determinations will be completed as expeditiously as the member's health or dental condition requires, but no later than 72 hours after receipt of the request.

MCNA will make retrospective review determinations within 180 days from the date of service. All retrospective review determinations will be made within 30 calendar days of receipt of all needed dental or medical information. MCNA will not subsequently retract its authorization after services have been provided, or reduce payment for an item or services furnished in reliance upon a previous authorization approval, unless the approval was based upon a material omission or misrepresentation about the member's health or dental condition made by the provider.

When appropriate, our Dental Director and Clinical Reviewers consult with a member's treating dentist or specialist via a **peer-to-peer consultation** concerning utilization management decisions. MCNA offers an informal reconsideration process as part of our appeal process. Within one (1) business day after we receive a request for reconsideration, the Grievances and Appeals Administrator arranges for a peer-to-peer consultation with the Clinical Reviewer that made the adverse determination or a peer designated by the Dental Director if the initial reviewer is not available.

Please see the following flowchart, which illustrates our pre-authorization process.

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Section G.2

If the UM guidelines were developed internally, describe the process by which they were developed and when they were developed or last revised.

Jeffrey P. Feingold, D.D.S., M.S.D., a Florida-licensed Periodontist since 1971 and Diplomate of the American Board of Periodontology, founded MCNA and serves as the Chairman of the Board and Chief Executive Officer. He believes that the best way to run a successful dental program is by partnering with general dentists and specialists, and making them part of the policy-making process. This led Dr. Feingold to form MCNA, a plan focused on preventive services as the means to establish a healthier population.

Clinical Practice Guidelines

Our Utilization Review Criteria and Guidelines are based on the needs of our enrolled membership and state and contracted health plan requirements. The clinical guidelines address the provision of acute and chronic dental care services. The Dental Director presides over a panel of participating primary care dentists (which will include participating dentists from the State of Louisiana) and board-certified specialists, and ensures that the panel includes representatives of each dental specialty involved in MCNA's criteria development and review process. Our Criteria and Guidelines are developed taking into account the following considerations:

- Reasonable, sound, scientific dental and medical evidence
- Prevalence of acute and chronic dental conditions
- Extent of variation present in current clinical practice patterns
- Magnitude of quality of care issues based on existing patterns of clinical practice
- Ability to impact practice patterns
- Feedback from participating providers
- The needs of the members
- The strength of the evidence to support best clinical practice management strategies

MCNA's Dental Director ensures that the Utilization Review Criteria and Guidelines are objective, transparent, consistent and flexible enough to allow a deviation from the norm when justified on an individual case-by-case basis.

Our Process

Each state's Utilization Management (UM) Committee is presided over by the Dental Director and includes licensed primary and specialty care dental providers. The committee is responsible for the development, adoption, and annual update of MCNA's Utilization Review Criteria and Guidelines.

MCNA develops its clinical guidelines for preventive and therapeutic services based upon guidelines for appropriateness of care from the:

- American Academy of Pediatric Dentistry
- American Dental Association
- American Association of Oral and Maxillofacial Surgeons
- American Association of Endodontics
- American Academy of Periodontology
- American College of Prosthodontists

As President of the American Academy of Pediatric Dentistry, Dr. Philip Hunke, MCNA's President, led the development of the Academy's clinical guidelines emphasizing the importance of oral health intervention and the dental home model of care. Preventive education and early intervention provide a foundation for a lifetime of positive dental outcomes.

On an annual basis, our Utilization Review Criteria and Guidelines are reviewed to ensure they are current with industry best practice standards and comply with our contractual agreements. A key part of the

review process involves research and consultation with UM clinical staff, participating general dentists and specialists, and when necessary, expert consultants engaged by MCNA. The research results and recommendations are presented to the UM Committee, then to the Quality Improvement Committee (QIC) for final consideration and approval by the Board of Directors. **MCNA's clinical guidelines were last approved on November 11, 2013.**

MCNA recognizes that in our pursuit of the best oral health outcomes, situations may arise that warrant unscheduled reviews of our clinical criteria. The need to develop or revise dental criteria may be triggered by:

- Frequent provider requests for services for which screening criteria are not available
- Results of inter-rater reliability audits for Clinical Reviewers
- Frequent provider requests for reconsideration of adverse determinations for specific procedures
- The consistent overturning of certain denied claims or authorizations
- A thorough review of current literature pertaining to the appropriateness and efficacy of treatment

MCNA's Louisiana Plan President

Dr. Philip Hunke

serves as President of MCNA Insurance Company. He is the former President of the American Academy of Pediatric Dentistry (AAPD) and the Texas Academy of Pediatric Dentistry (TAPD).



- A result of changes in dental policy
- Account specific benefits

Below is a sample of the Oral and Maxillofacial Surgery criteria and guidelines adopted by MCNA:

Criteria and Guidelines for Oral Surgery

Uncomplicated extractions, removal of soft tissue impactions or minor surgical procedures are considered basic services and are the responsibility of the Primary Care Dentist. The member may be referred to a contracted MCNA Oral Surgeon when the treatment is beyond the scope of the Primary Care Dentist.

Criteria

- A tooth fractured below the crestal bone height
- Supernumerary tooth
- Dentigerous cyst
- Untreatable Periodontal disease
- Pathology not treatable by other means
- Recurrent pericoronitis
- Non-restorable carious lesion
- Pain and/or swelling due to impeded eruption
- Orthodontic extractions (requires approval)
- Exfoliation of a deciduous tooth not anticipated within six months
- No extractions of third molars if roots are not substantially formed
- Alveoplasty (7310) in conjunction with four or more extractions in the same quadrant
- There is no benefit for the extraction of asymptomatic teeth
- Extractions are not payable for deciduous teeth when normal loss is imminent

Documentation Required for Authorization

- Submit appropriate radiographs with authorization request: bitewings, periapical or panorex
- Narrative demonstrating medical necessity

MCNA Utilization Review Criteria and Guidelines Distribution

MCNA Utilization Review Criteria and Guidelines are made available to providers and members at their request. The clinical guidelines are published to our network providers in the MCNA Provider Manual and online in the Provider Portal. Periodic updates and notices related to the guidelines are included in new provider orientation materials, and published in provider newsletters and mailings.

Guidelines Approved by MCNA's State and Health Plan Partners

Once the clinical criteria are approved internally, they are forwarded to appropriate state regulatory agencies for final approval and implementation. MCNA will submit all UM criteria and guidelines to DHH for review and approval during the Readiness Review Process. In addition, our Utilization Management department will coordinate with our Provider Relations department to make training available to participating providers.

Provider Adherence to Clinical Guidelines

MCNA continuously uses the advanced auditing functions of DentalTrac™ to analyze our providers' utilization patterns for adherence to our approved criteria and clinical guidelines. We will encourage compliance by educating our providers via the Provider Manual, provider newsletters, postings to the online Provider Portal, and during site visits, orientations and provider webinars.

Our process will ensure that dental providers are consistently in compliance with the Utilization Management requirements of this RFP. Outlying providers will be administratively reviewed for compliance. When outliers are identified by Utilization Management Coordinators or Clinical Reviewers, MCNA's Quality Improvement department may perform dental record reviews on a statistically significant sample of the provider's dental charts. If the provider is found to be non-compliant, the provider will be placed on corrective action beginning with re-education efforts. If the provider shows continued non-compliance after a subsequent six (6) month review, he or she may be subject to termination from MCNA's network. Should suspected fraud or abuse be identified during the dental record review process, the case will be forwarded to MCNA's Special Investigation Unit (SIU) for additional review. For more information on MCNA's efforts to combat fraud and abuse, please refer to Section N of this RFP response.

Section G.3

Regarding your utilization management (UM) staff:

- Provide a detailed description of the training you provide your UM staff;
- Describe any differences between your UM phone line and your provider services line with respect to bullets (2) through (7) in item K.1;
- If your UM phone line will handle both Louisiana DBP and non- Louisiana DBP calls,
 - explain how you will track DBP calls separately; and
 - how you will ensure that applicable DHH timeframes for prior authorization decisions are met.

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- Adverse determination and medical necessity appeals
- MCNA’s Special Investigations Unit
- Claims – prepayment review and guidelines

MCNA educates our Clinical Reviewers on both the terminology and qualifying criteria defining the amount, duration and scope of treatment specified in the Louisiana Medicaid State Plan. MCNA Clinical Reviewers and participating providers must agree on the plain meaning of the terminology and resolve any ambiguities, so that they share a common understanding of the qualifying criteria. The Clinical Reviewers are trained to examine cases utilizing their experience as dental practitioners in addition to relating the existing conditions to the qualifying criteria to determine whether the requested service should be approved. **The result is that services that should be approved will be approved.**

Sample Training Completion Certificate



Inter-Rater Reliability

MCNA ensures that our Clinical Reviewers and Specialty Reviewers utilize our clinical criteria and guidelines appropriately and consistently. To accomplish this, an Inter-Rater Reliability audit is completed on an annual basis (or more frequently as needed). The Dental Director reviews ten (10) de-identified cases to create the standard approach against which the Clinical Reviewer's performance will be measured. Clinical Reviewers are then given the de-identified cases and asked to complete a comprehensive review of each case documenting all findings in a tool prepared by the Dental Director. Each Clinical Reviewer's response is graded against the standard to ensure accuracy, verify adherence to qualifying criteria, and ensure general and specialty services are rendered in an amount, duration and scope specified by the Louisiana Medicaid State Plan.

If the rate of agreement between the Clinical Reviewer and Dental Director standard is less than 90%, the findings of the original reviewer are examined in more detail. Based on the results, the Dental Director may recommend a corrective action plan to include re-training, re-measurement, increased supervision of decision making, and possible removal from medical necessity determinations. The assessment methodology and results of the audits are reported to the UM Committee, the Quality Improvement Committee (QIC) and ultimately, the Board of Directors.

The following chart illustrates how MCNA's inter-rater reliability scores are reported for each reviewer:

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- Department staff member roles and responsibilities
- Overview of Louisiana plan benefits, including exclusions and limitations
- Utilization management system in DentalTrac™
- Data entry and adjudication of referrals, pre-authorizations, second opinion requests, and continuity of care requests
- Overview of clinical criteria and guidelines utilized by Clinical Reviewers
- Case Management procedures
- Inter-departmental communications and collaborations
- Quality Improvement Program
- Performance standards, quality monitoring, and productivity goals
- Grievances and appeals
- Customer service and telephone etiquette, performance and expectations

MCNA's Director of UM monitors the job performance of all non-clinical staff by conducting a monthly Performance Measurement. A sample of five (5) cases (pre-authorization, referrals, and data entry) are randomly selected and audited for each staff member respectively to assess whether the correct processes are being completed and the desired results are achieved.

The Director of UM utilizes the results of this monitoring to identify what changes are required with the goal of improving performance and the quality of service provided to our members and providers. The compliance target for UM Coordinators and Referral Specialists is 95%. The performance goal for Data Entry Specialists is 100%.

The Performance Measures are presented to the UM Committee and reported up to the Quality Improvement Committee quarterly. The results are also reviewed with individual staff members, and overall with UM staff on a monthly basis. The Performance Measurement reports are taken into consideration during each staff member's annual performance appraisal. If a staff member does not meet the performance goals, remedial actions are put into place that may include re-training, setting goals and objectives, additional monitoring, re-evaluation and a corrective action plan if needed. Every effort is made to work with staff members to remediate performance issues. Annually, the Performance Measures are reviewed to determine if changes, revisions or updates are required to keep the audit process relevant, continue to adequately measure performance, and achieve the intended impact in targeted areas.

The following chart illustrates how MCNA's utilization management staff is scored for performance:

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Dedicated Louisiana Phone Numbers

MCNA has established the following dedicated toll-free phone numbers for the Louisiana DBPM, and they are currently active.

Member Services: 1-855-702-6262

Provider Services: 1-855-854-6262

The calls are organized into member and provider queues which are used to monitor performance and contractual compliance while also keeping separate statistics based on caller type. **The dedicated numbers listed above will enable us to separately track all phone calls received for the Louisiana DBPM, and ensure that applicable DHH timeframes for prior authorization decisions are met.**



Utilization Management Phone Calls

At MCNA, we believe in addressing all of our callers' needs on the first contact with us. Our rigorous call center training program ensures the staff handling calls are thoroughly trained to address the most relevant issues for our members and providers. In 2013, our call center staff achieved a first-call-resolution (FCR) rate of 99.42% out of more than 1.3 million calls handled.

Our Member Services and Provider Hotline staff are supported by our proprietary, state-of-the-art, management information system (MIS), DentalTrac™. DentalTrac™'s fully integrated functionality allows our hotline staff to access all relevant information related to the member or provider calling. The quality and quantity of information MCNA's **highly trained hotline staff** has at its fingertips ensures that each call is handled accurately and efficiently, and promotes satisfaction with our services.

MCNA's telephone system has a built-in Interactive Voice Response (IVR) module that allows us to implement customized call flows to direct our callers more efficiently depending on their needs and our contractual requirements. The telephone system is available 24x7x365 and the caller has various options to speak with a live person during our normal business hours.

Utilization Management calls are handled through our Member and Provider Hotlines. The hotline representatives are thoroughly trained to provide assistance to members and providers regarding the status of all UM requests and pre-authorization submission requirements. Should the call center staff be unable to address a particular UM-related issue, the call is routed to the UM department via "warm transfer" to ensure it is immediately answered by a UM staff member. Likewise, any provider requesting a peer-to-peer discussion is routed to a UM Supervisor or Manager who will coordinate the peer-to-peer request with one of MCNA's licensed Clinical Reviewers. In the event of an emergency or natural

disaster, member and provider calls will be routed according to the specifications in our Disaster Recovery and Business Continuity Plan (please refer to section L of this response).

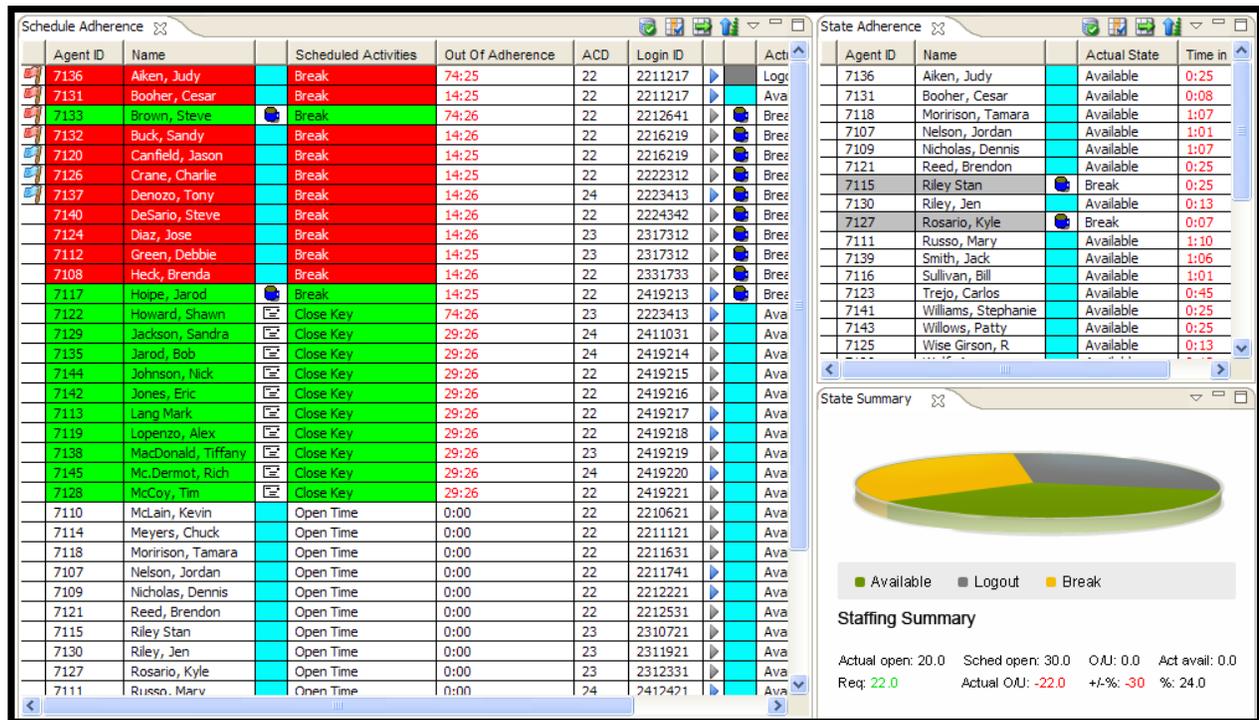
UM department staff is available to respond to utilization management and dental review inquiries Monday through Friday, between the hours of 7:00 am to 7:00 pm, CST. **MCNA's thorough utilization management processes (detailed in H.1) and technology resources ensure that all applicable DHH timeframes for prior authorizations are met and exceeded.** Calls received by our UM department after normal business hours will be answered by our Interactive Voice Response (IVR) system and callers will be prompted to leave a voicemail message. UM staff members are required to retrieve all voicemails immediately upon arrival to work and respond to callers within one (1) business day. Providers have the ability to check the status of an authorization through our online Provider Portal, 24x7x365.

The advanced technology in our Automated Call Distribution (ACD) system coupled with dedicated Louisiana phone numbers, allows us to **track the performance** of the Louisiana UM-specific calls while leveraging economies of scale. Leveraging the production capabilities of our Member and Provider Hotlines ensures that we meet and exceed the call handling performance objectives specified in this RFP and deliver immediate resolution and satisfaction to our callers.

When a member or provider dials one of our dedicated Louisiana phone numbers, our ACD immediately tags the call record with information that allows us to track the call as a Louisiana call. As the caller navigates through the IVR system making selections and optionally speaking with a live person, the tracking information attached to the call record provides us with a detailed audit trail of the caller's selections and the performance metrics within each step of their navigation through the IVR system. If the Member or Provider Hotline representative needs to transfer or escalate the call to a UM specialist, our ACD system tracks those events separately such that we can produce reports and reporting metrics that are specific to UM-related requests.

The interactive dashboards throughout our call centers show real-time performance metrics that alert MCNA management if a decline in any of our performance metrics could compromise our minimum performance standards. This allows our call center management team to proactively address any deficiencies before they affect the quality of our call center services. On a daily basis, our Senior Director of Call Center Operations reviews our call performance dashboards to ensure we are constantly **meeting and exceeding** our performance goals, and leverages the integration of our telephone system with our **sophisticated NICE IEX Workforce Management System** to develop staffing models to ensure we remain in compliance with our contractual performance standards.





Screenshot of Sample NICE IEX Workforce Management System

The Senior Director of Call Center Operations and Director of UM monitor calls to ensure that response time and abandonment rate goals are compliant in addition to ensuring the quality of staff encounters with members, providers and facility staff. A primary goal of the UM department is that all encounters with members and providers will be positive, productive, accurate, and promptly escalated should the staff member be unable to adequately assist the caller. The Directors utilize daily telephone performance reports, call recordings and real-time service observations to monitor telephone performance.

Section G.4

Describe how utilization data is gathered, analyzed, and reported. Include the process for monitoring and evaluating the utilization of services when a variance has been identified (both under- and over- utilization) in the utilization pattern of a provider and a member. Provide an example of how your analysis of data resulted in successful interventions to alter unfavorable utilization patterns in the system. Individuals who will make medical necessity determinations must be identified if the criteria are based on the dental training, qualifications, and experience of the DBP dental director or other qualified and trained professionals.

MCNA is committed to monitoring the appropriateness of quality and necessity of dental services provided to our members. The UM program facilitates the early detection of potential quality of care issues, provides the tools to improve care where needed, and integrates the information into the Utilization Management process. MCNA's Utilization Management program looks at both overutilization and underutilization of covered services. This review process identifies if members are not seeking preventive care in a timely manner. The data is gathered to support our quality initiatives and outreach efforts to increase screening rates.

MCNA is provider owned and we recognize the challenges of influencing or changing a provider's behavior. We dedicate significant resources to our Provider Relations department for communication and training in order to ensure the best possible outcomes for our members.

Gathering UM Data

MCNA maintains all data elements related to our members and providers. Each member has a unique member eligibility record to ensure care coordination and allow for the development of targeted interventions.

MCNA's **comprehensive, sophisticated technology solution**, DentalTrac™, gathers, generates, and maintains the following data:

- Claims
- Member eligibility
- Case management
- Utilization review
- Member and provider hotline interactions
- Grievances and appeals
- Key performance indicators
- Quality improvement
- Member and provider satisfaction survey
- Provider credentialing
- Provider access and availability survey



Data is maintained in HIPAA compliant **redundant** locations and is always available on a 24x7x365 basis through our DentalTrac™ system. In addition to storing all key production transactions, we store and warehouse indefinitely all data files exchanged with our clients, paper and fax data, digital and scanned x-rays, and any other supporting documentation to our transactions. This information is indexed and stored within DentalTrac™ for **prompt access and retrieval**.

Data Collection, Analysis, and Reporting

MCNA utilizes a three-tiered Data Analysis methodology that helps us identify barriers, trends, and unfavorable utilization patterns. The first tier of analysis is a systems approach using DentalTrac™ which adjudicates all prior authorization requests using the National Correct Coding Initiative edits in addition to applying our customized edits to verify member eligibility, provider status, and benefit coverage. Additionally, DentalTrac™ reviews the CDT codes against the member's prior dental history to determine the benefit limitations of dental services according to the contractual agreement. MCNA's experienced UM staff review the reports to compare the current data versus historical data and trends.

The second tier of analysis is delegated to the UM department which conducts provider and member profiling. The Dental Director and Director of Utilization Management regularly review **Provider Profiling Reports** (PPRs) that are generated for individual dentists and specialists, dentists in the same facility or organization, all dentists in a county, parish, or region, and other stratifications. Reports contain, at a minimum, the following elements:

- Provider behavior patterns related to billing and procedures.
- Dental care expenditures by types of service (i.e., preventive vs. restorative).
- Variances between the services billed and prior authorizations requested.
- Aggregate overutilization and underutilization data analysis to identify member behavior patterns and individual provider patterns relative to standards of dental practice.
- Review authorization requests to identify unnecessary or incorrect procedures that could result in inappropriate financial gain. For example, overutilizing stainless steel crowns and incorrectly coded (CDT) extractions (simple vs. surgical).
- Trends of specific providers repeatedly billing for emergency services.

The third and final tier of the analysis consists of the UM Committee, which provides oversight to identify desirable and undesirable utilization trends and opportunities for improvement, and develops measurable interventions such as member and provider outreach and education activities. UM Committee activities are reported quarterly to the Quality Improvement Committee (QIC).

Monitoring Overutilization and Underutilization

MCNA's Utilization Management department monitors overutilization and underutilization of dental services. Our comprehensive approach to monitoring employs dental indicators that assist us in flagging patterns of care. DentalTrac™ mines the information from our data warehouse to produce performance indicators including:

- Provider practice profiles available from utilization management statistics
- Preventive services (HEDIS measures)
- Provider referral patterns
- Member complaints, grievances, and appeals nature and frequency
- Potential quality of care issues
- Primary Dentist change request data
- Referral and authorization data
- Member and provider demographics

Through DentalTrac™'s Business Intelligence module, MCNA generates a **wide variety of reports** using the indicators above. They contain information regarding the dental services provided to our members, including approval rates and turnaround time performance. Reports are generated and analyzed to evaluate overall plan performance, and specific practitioner and diagnostic category performance. Individual practitioner profiles are analyzed and when potential overutilization and underutilization of dental services is identified, the reports are referred to the Quality Improvement Committee for review. Any identified performance outlier is documented and discussed with the practitioner. Depending upon the severity of the performance issue, the practitioner may also be asked to comply with a corrective action plan and receive additional monitoring. Practitioner variances are documented and placed in the practitioner's file for consideration during the re-credentialing process.

MCNA utilizes the reports to identify predictable patterns of care and provider behavior by analyzing the following components:

- CDT codes
- Provider authorization requests
- Frequency of claim submissions and resubmissions
- Non-compliant required documentation submission

Utilization Management Objectives

- ❖ Routinely assess the effectiveness and efficacy of our clinical criteria and guidelines and service authorization practices
- ❖ Evaluate the use of dental treatment technologies by our providers
- ❖ Detect fraud and abuse in the utilization of dental services and refer suspected cases to the Office of the Inspector General
- ❖ Detect overutilization and underutilization of diagnostic, preventive and restorative services to ensure that essential services such as dental checkups, early childhood screening for caries, sealants and parental counseling are provided
- ❖ Compare the utilization of services by members and providers with norms for comparable individuals within MCNA and in other dental programs whose data is available
- ❖ Profile providers regarding utilization patterns and their compliance with MCNA clinical guidelines and utilization policies

- Non-compliant patient dental chart record keeping
- Member treatment histories

Our state-of-the-art management information system, DentalTrac™, captures and processes prior authorizations and utilization data. The claims module of DentalTrac™ collects this data and reports are generated routinely to determine utilization patterns that fall outside of the norm. Please see Section F.11 for more detail on our comprehensive provider profiling approach. MCNA will submit profile reports to DHH in accordance with their frequency schedule. MCNA understands that DHH reserves the right to request additional reports as deemed necessary.

Addressing Provider Overutilization and Underutilization

If MCNA detects a pattern of provider **underutilization** of medically necessary services, such as EPSDT screenings, we will conduct outreach and educate the provider on the appropriate clinical practice guidelines. **Underutilization occurs when a provider is either not rendering procedures in accordance with the AAPD/EPSDT periodicity schedule or providing a less comprehensive treatment than the accepted standard of care.** MCNA will continue to monitor and engage the provider to encourage the appropriate use of Covered Benefits. Providers that consistently fail to adhere to MCNA clinical practice guidelines may be considered for termination from our network. The most common under utilization of dental services include:

- Provider failing to render a fluoride treatment at the time of a dental prophylaxis (cleaning)
- Provider extracting a healthy tooth in lieu of a dental restoration (filling)
- Provider rendering a prophylaxis (dental cleaning) in lieu of a more thorough full mouth debridement or periodontal procedure based on the needs of the member
- Provider failing to adhere to the EPSDT periodicity schedule

When an unfavorable **overutilization** pattern is identified for a provider, they are contacted for supporting documentation. Once the information is received, it is forwarded to our Quality Improvement department for analysis by a Clinical Reviewer. If a quality of care issue is suspected, the Clinical Reviewer will examine the provider's requests for services and utilize the supporting documentation to determine if the treatment met the qualifying criteria and current standards of care. If the treatment(s) met the qualifying criteria and no fraudulent or quality issues are identified, then no additional provider education is required. If quality issues are identified, the provider will be contacted by the Dental Director who will review the quality issues and recommend remedial action. This could include additional provider education, intensive monitoring and the implementation of a corrective action plan. If fraudulent activity is suspected the information is sent to MCNA's Special Investigations Unit. The most common overutilization of dental services include:

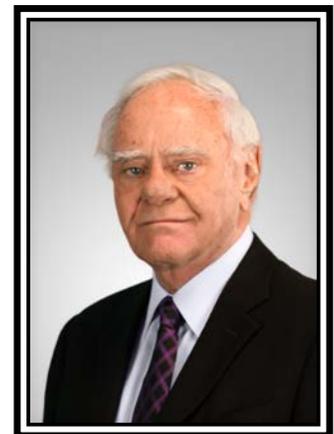
- Performing a stainless steel crown procedure in lieu of multi-surface fillings on primary teeth
- Upcoding extractions
- Unbundling of x-rays
- Performing a more invasive procedure than required, such as a one surface resin restoration in lieu of a sealant

Example of Successful Intervention

The following is an example of a successful intervention to curb excessive utilization of orthodontia in the State of Texas:

In late 2011, as the Texas Health and Human Services Commission (HHSC) prepared for the transition of its Medicaid and CHIP dental programs to managed care, it challenged its three dental contractors to develop clinical guidelines for its orthodontia benefit in an effort to combat rampant fraud and abuse, and reign in the runaway costs plaguing the program. MCNA emerged as the leader among all three dental contractors in developing the clinical guidelines for orthodontia that were ultimately adopted by the HHSC.

Malcolm Meister, DDS, MSD, JD, MCNA's National Orthodontic Dental Director, former Chairman of the Department of Orthodontics at Nova Southeastern College of Dentistry, Diplomate of the American Board of Orthodontics, and former President of the Florida Association of Orthodontics, developed the clinical criteria and guidelines for orthodontia on behalf of MCNA.



Dr. Meister led the effort and redrafted the criteria to be used by HHSC and all dental contractors to ensure that only medically necessary orthodontia services are eligible for coverage. **These guidelines have resulted in significant savings for the Texas Medicaid and CHIP programs and changed the practice patterns of orthodontic providers across the state, saving the Texas program over \$100 million annually.**

MCNA currently serves approximately 1.4 million Medicaid and CHIP children throughout the State of Texas.

Addressing Member Overutilization and Underutilization

When an unfavorable member underutilization pattern is identified, we conduct outreach to educate members and their responsible parties on the available benefits and recommended standards for utilization of those benefits. We explain the importance of good oral hygiene and how poor oral health can have negative outcomes and impact the member's general health and well-being. Our outreach efforts always close with an offer to help the member set up an appointment to receive dental care.

The teen population as a whole typically underutilizes routine preventive care. To increase teen adherence to the EPSDT periodicity schedule, MCNA has developed targeted interventions to educate teens on the importance of good oral health. In our Texas market, MCNA provides telephonic outreach to all teens that have not had their annual dental checkup. During these calls MCNA attempts to schedule appointments for the teen members and assists with arranging transportation services if needed. MCNA's Member Advocate and Outreach Specialists (MAOS) also attend health fairs and

community outreach events targeted to teens. In Texas for calendar year 2013, MCNA successfully outreached to over 5,000 teen members through these events.

In order to incentivize participating providers to increase access and availability of preventive services in Florida, MCNA launched the **Healthy Holiday Smiles Promotion in October 2013**. The program is designed to address the issues identified by the Pew Charitable Trusts with respect to underutilization in Florida's Medicaid dental program, and to increase our EPSDT screening rates and the volume of preventive services rendered. The ultimate goal is to improve the state's HEDIS measure (annual dental visit), increase the utilization of preventive dental services, increase member and provider satisfaction, and recognize providers who are able to render these services.

This special holiday promotion is scheduled to run through March 31, 2014. The Healthy Holiday Smiles Promotion is designed for providers who render preventive treatment to our Medicaid members who have not had a dental checkup in 2013. The providers are compensated at twice the reimbursement rates published in our fee schedule for the following five CDT codes:

- **D1110** – Dental prophylaxis adult
- **D1120** – Dental prophylaxis child
- **D1206** – Topical fluoride varnish
- **D1208** – Topical application of fluoride
- **D1351** – Dental sealant per tooth

The Healthy Holiday Smiles Promotion is driven by a targeted outbound call campaign to members who have not received a dental service in the prior twelve-month period. Additionally, we send postcards to the members that fail to receive a call due to disconnected phone lines, incorrect phone numbers in the state's enrollment data, and other causes. Our Member Services department provides personalized attention and assistance in an effort to bridge care gaps to these members as they coordinate appointments and facilitate dental care. The initiative also encourages providers to increase their own efforts at outreach within their practice through their respective "recall/recare" systems.

The Healthy Holiday Smiles outreach campaign has been very successful and to date we have received dental claims for over 36,000 children who had not been to the dentist in the previous 12 months.

MCNA's 2013 Healthy Holiday Smiles Promotion Flyer

MCNA Presents
2013 Healthy Holiday Smiles Promotion!

Dear MCNA Provider,

At MCNA we are committed to preventive dental care.
As part of our special holiday promotion from **October 1 through March 31, 2014**, we are

DOUBLING your reimbursement rate

for select preventive service codes you provide to MCNA members in the Florida Medicaid Statewide Prepaid Dental Health Program who have not been to the dentist in 2013.

Your reimbursement rates will be **DOUBLED** for the following codes*:

✓ D1110 – Dental prophylaxis adult	✓ D1208 – Topical application of fluoride
✓ D1120 – Dental prophylaxis child	✓ D1351 – Dental sealant per tooth
✓ D1206 – Topical fluoride varnish	

* Please note that the standard benefit limitations for these codes still apply. You can find the most up-to-date information in your Provider Manual.

This special holiday promotion will yield direct benefits for you:

- ✓ Increase member and community awareness of your practice and the services your dental office provides.
- ✓ Improve the oral health of the children in your community.

For more information, call MCNA Provider Relations at 1 (855) 698-6262. We look forward to connecting with you about this outstanding opportunity to join us in our initiative to positively impact the oral health of our members!

MCNA's proprietary management information system, DentalTrac™, makes it very difficult for a member to overutilize services. Our edits are based on plan benefit design and customized to the frequency dictated under the pertinent state contract or AAPD and ADA recommended standards. Pre-authorization requests will not be approved when a member is exceeding the recommended care pattern.

Should an unfavorable member overutilization pattern be identified, MCNA reaches out to the member. For example, a member has multiple problem-focused exams (CDT 0140) with different providers and individual periapical x-rays (CDT 0220 and 0230) at a higher frequency than normal. We educate the member on available benefits to include appropriate utilization expectations. If the trend persists, a Clinical Reviewer will examine the requests for services and compare that with the supporting documentation to determine if the treatment requests meet the qualifying criteria. If the treatment(s) met the qualifying criteria and no fraudulent activity is identified then no further member education is provided. If fraudulent activity is suspected, the information is sent to the Special Investigations Unit. For more detail on MCNA's Special Investigations Unit, please see section N.

Individuals Who Will Make Medical Necessity Determinations

We are proud of our policy that only licensed dentists with appropriate clinical expertise in treating the member's condition are utilized by MCNA for all medical necessity determinations. MCNA will always consider the appropriateness of a specific dental treatment for which prior authorization is sought on its own merit based on the radiographs, narratives, and other supporting documentation submitted with the request. MCNA Clinical Reviewers are required to attest that no adverse determination will be made regarding any dental procedure or service outside of the scope of their individual expertise.

Section H.1

Describe your system for tracking each member's screening, diagnosis, and treatment including, at minimum, the components of the system, the key features of each component, the use of technology, and the data sources for populating the system.

Dr. Philip Hunke, MCNA's Louisiana and Texas Plan President, served as President of the American Academy of Pediatric Dentistry (AAPD), provided project leadership, and contributed content to the accepted and published clinical guidelines for the AAPD that Louisiana mirrors in its EPSDT dental program. **These nationally accepted EPSDT guidelines form the foundation of MCNA's approach to screening and treatment in all states in our service area.**

Our stated mission is the improvement of the oral health outcomes in state sponsored Medicaid and CHIP programs by continuously stressing prevention, diagnosis, and early treatment intervention. MCNA has a robust Louisiana network with over 1,074 access points. Our dentists utilize the **entire spectrum** of diagnostic services available so early problems can be detected and addressed promptly. Our dentists coupled with our innovative member education and outreach approach, are instrumental in preventing premature tooth loss due to dental decay. Dental concerns can be addressed before painful, time consuming, and costly treatment is required. This results in fewer missed school days for our members, healthier lives, and the reduction of the overall costs to the State of Louisiana.

Tracking EPSDT Using MCNA's DentalTrac™ System

MCNA believes that early treatment is better for both our members and the program. We **fully integrate** all member data to create a unique member eligibility record for each individual we serve to ensure a comprehensive, coordinated approach to quality dental treatment.

The Member Eligibility module of DentalTrac™, MCNA's **comprehensive, sophisticated technology solution**, generates and maintains all information related to EPSDT utilization in each member's eligibility record. Provider claims data is the primary data source for tracking each member's screening, diagnosis, and treatment. Our Member Eligibility module contains critical data regarding member eligibility, case management, utilization review, claims, MCNA's Member and Provider Hotline interactions, grievances and appeals, key performance indicators, quality improvement, surveys and additional elements.



Member Eligibility Module

Data is maintained in HIPAA compliant **redundant** locations and is always available on a 24x7x365 basis through our DentalTrac™ system. In addition to storing all key production transactions, we store and warehouse indefinitely all data files exchanged with our clients, paper and fax data, digital and

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- **Provider Involvement:** Providers are key to MCNA's multi-faceted EPSDT strategy. Our providers are educated about the importance of member adherence to the EPSDT periodicity schedule. MCNA's Provider Portal notifies Primary Care Dentists when any member assigned to their panel is out of compliance with the EPSDT schedule so that the provider can attempt to make contact and schedule an appointment.
- **Targeted Outreach:** Certain age groups and special populations are less likely to adhere to the EPSDT periodicity schedule. Teenagers are a particularly difficult group in terms of ensuring all needed screenings and treatments are obtained in a timely manner. The Annual EPSDT Participation Report (Form CMS 416) for Federal Fiscal Year 2012 shows that nationally fewer than 40% of Medicaid eligible teens age 15-18 access preventive dental services. To address the barriers to care for this age group, MCNA created a targeted, two-pronged approach to teen outreach in our Texas market.
 - First, MCNA Member Advocate and Outreach Specialists (MAOS) attend teen oriented health fairs and events across the state. They educate teens on the importance of good oral health and instruct them on proper hygiene habits.
 - Second, MCNA institutes an outbound call campaign targeting teen members who have not had a checkup in the prior six (6) month period. Our approach is to try and schedule the member for a visit through a three party call to the member's primary care dentist.



Since March 2012, MCNA has been able to connect with over 14,000 teens identified as having care gaps.

For a more detailed description of our proprietary management information system, DentalTrac™, and the process of maintaining and submitting EPSDT encounter data, please refer to Section Q (Information Systems) of this response.

MCNA is committed to ensuring our Louisiana members receive services in accordance with the EPSDT periodicity schedule. **Our team's proven record of success makes MCNA the right fit for Louisiana.**

Section H.2

Describe your approach to member education and outreach regarding EPSDT including the use of the tracking system described in H.1 above and any innovative/non-traditional mechanisms. Include:

- How you will conduct member education and outreach regarding EPSDT including any innovative/non-traditional methods that go beyond the standard methods;
- How you will work with members to improve compliance with the periodicity schedule, including how you will motivate parents/members and what steps you will take to identify and reach out to members (or their parents) who have missed screening appointments (highlighting any innovative/non-traditional approaches); and
- How you will design and monitor your education and outreach program to ensure compliance with the RFP.

MCNA is committed to the goals of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and will ensure that children and adolescents receive appropriate dental services.

MCNA captures dental screening information to quickly facilitate preventive and restorative care for our members. We improve oral health outcomes through early identification of decay, inflammation, infection, periodontal disease and malocclusions.

MCNA has developed Louisiana-specific outreach education campaigns designed to address dental health issues that are most likely to have an impact on our membership. EPSDT adherence and promoting preventive dental health services are critical elements of our initiatives. We will submit the campaigns to DHH for approval prior to the go-live date.

E arly	Assessing and identifying problems early
P eriodic	Checking children's oral health at periodic, age-appropriate intervals
S creening	Providing dental and other related screening tests to detect potential problems
D iagnosis	Performing diagnostic tests to follow up when a risk is identified
T reatment	Control, correct or reduce oral health problems found

MCNA’s Approach

We use a continuous quality improvement cycle to meet the screening periodicity requirements for EPSDT. Our Quality Improvement Committee (QIC) oversees this process that includes the following:

- Establish goals to increase the utilization of preventive services and screenings
- Identify measurements
- Establish a baseline
- Identify barriers
- Create and implement an action plan
- Continuously measure improvements against an established baseline on a quarterly basis

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MCNA strives to prevent hospital based care and full mouth restorations by **educating members and their parents or guardians** about the destructive effects of poor oral health and the importance of prevention through timely EPSDT visits. We distribute educational materials such as postcards, brochures, and flyers at the outreach events we sponsor and attend. Additionally, we provide dental care kits (toothbrushes, toothpaste, and floss), backpacks, and water bottles to those in attendance.

Care Gap Alerts form the basis of targeted mail outreach campaigns to members who have not been receiving care in accordance with the EPSDT periodicity schedule. Our outreach materials are published in a variety of languages that represent the cultural and ethnic diversity of Louisiana. Below is a **sample postcard in English and Vietnamese** to remind our Louisiana members to seek dental care and offer assistance in scheduling an appointment.



Sample Dental Visit Reminder Postcard to be Mailed to Louisiana Members

Our Quality Improvement department uses telephonic and direct mail outreach to increase EPSDT screening rates. We contact all members within the first 60 days of enrollment using our DentalTrac™ automated system. MCNA encourages our members, and their parents and guardians, to schedule dental appointments promptly after enrollment to obtain their initial dental evaluation.

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Part Two: Technical Approach

Section H: EPSDT

Our member communication mechanisms are constantly evolving. Social media is now a primary source of information for people of all ages. MCNA's **social media strategy** incorporates text messages, member emails, Facebook posts, YouTube videos, and Twitter tweets to educate our members.

The following are examples of categories of educational content being communicated through all applicable mediums:

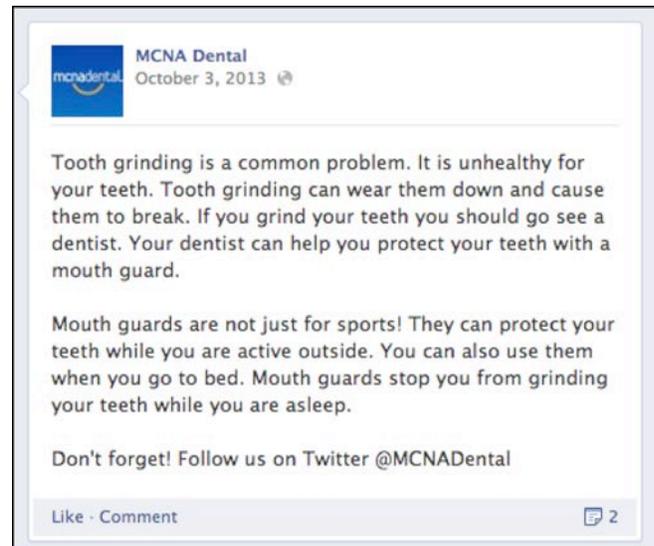
- Importance of preventive services such as sealants and fluoride application
- Adherence to EPSDT requirements
- Healthy eating habits
- Tooth brushing tips such as type of toothbrush to use and duration of brushing
- What to expect at the first dental visit

The results from MCNA's innovative social media initiative will be analyzed to identify any common themes such as demographic details with respect to members who still demonstrate non-compliance with Louisiana's EPSDT periodicity schedule. Using this research MCNA will create a secondary campaign designed to address any identified common barriers to care. **This population-centered, focused approach to EPSDT adherence ensures that no members are left behind when it comes to preventive care.**

Experienced Member Advocate and Outreach Specialists (MAOS) ensure members receive appointment reminders, assistance with scheduling dental appointments, transportation assistance, oral health education, and if needed, one-on-one assistance with submitting grievances and appeals and understanding plan benefits. MAOS also participate in community outreach events where they focus on educating members, their parents, and members of the public about the benefits of adhering to the EPSDT periodicity schedule and improving overall oral health outcomes. To facilitate continuity of care, network providers can inform MAOS of members who continuously break appointments so that MAOS can conduct outreach to the members and ensure they receive dental care in an appropriate and timely manner.

Population-specific, **cutting edge outreach** efforts are MCNA's specialty. In Texas, MCNA's MAOS assist with targeted population outreach efforts like our teen outreach program detailed in H.1.

Children of Migrant Farmworkers (CMFWs) are another special population within the State of Texas, as well as in the State of Louisiana. The CMFWs are identified as needing additional assistance because



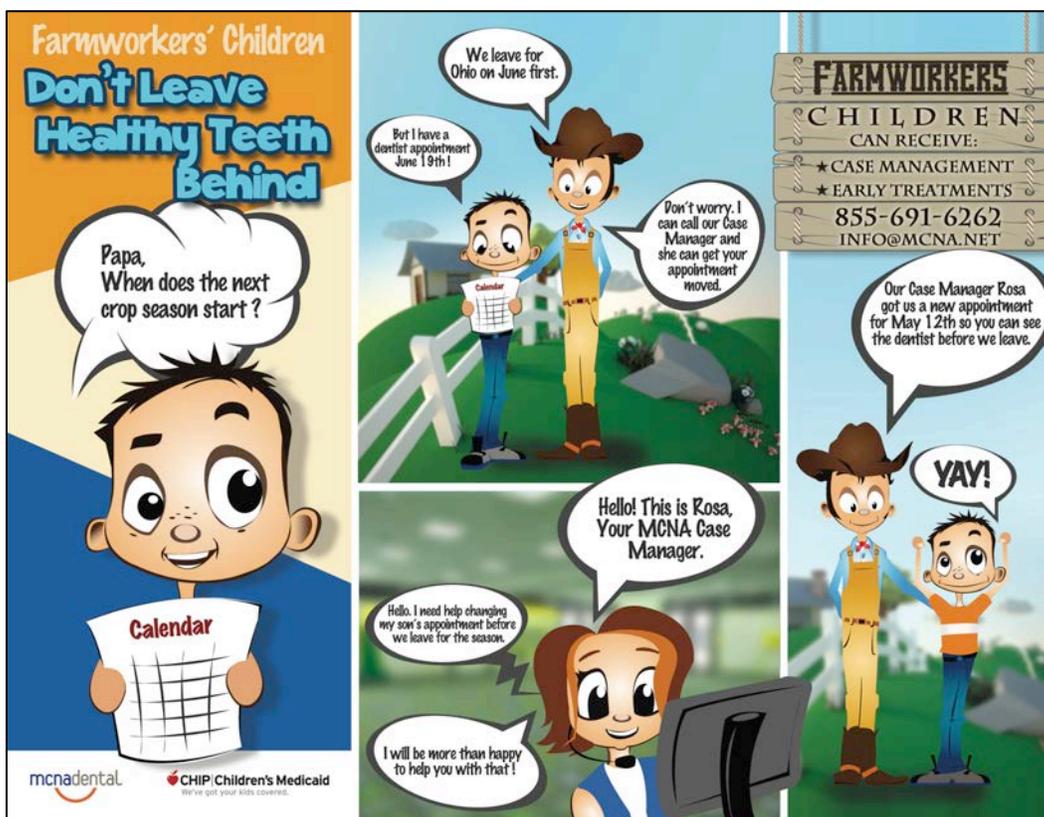
Sample Facebook Posting from MCNA

of unconventional living conditions, migratory work patterns, unhealthy working conditions, poverty, poor nutrition, lack of education, and illiteracy.

The Texas benefit design recognizes the importance of ensuring that this very mobile population remains compliant with the EPSDT periodicity schedule; and to help achieve compliance, the benefit allows for “accelerated services” for CMFWs. If a CMFW member will be migrating when it is time for their six (6) month checkup, the CMFW can receive their visit slightly ahead of the periodicity schedule.

MAOS are integral to our approach to increase EPSDT adherence in the CMFW population. Our **hands-on approach to care** for the CMFWs is an example of our commitment to reducing health care disparities for members of racial or ethnic minorities.

MCNA developed targeted member materials for the CMFW group using a popular format known as a **fotonovela**. The fotonovela is a comic book style communication format favored by the Hispanic community of Texas. **The Texas Health and Human Services Commission commended MCNA’s “out of the box” outreach approach and has adopted the following fotonovela as part of their CMFW training:**



MCNA’s **unique** outreach effort yielded very positive results in our Texas program. In 2013, MCNA identified 8,076 CMFWs and provided accelerated services to over 1,030 of these vulnerable children throughout all regions in Texas. **We look forward to replicating this proven approach for our Louisiana Children of Migrant Farmworkers members.**

Section H.3

Describe your approach to ensuring that providers deliver and document all required components of EPSDT screening.

Our Approach to Ensuring Provider Compliance with Delivery and Documentation of EPSDT Screenings

MCNA requires providers to **fully document** the services they deliver to our members. All EPSDT screening requirements are documented in their dental record keeping system. DentalTrac™ maintains all claims data received from providers including all information that the State of Louisiana will need to complete the annual EPSDT report (Form CMS 416) in accordance with CMS requirements.

Educating Providers

MCNA **educates** our network providers about the importance of EPSDT, as well as all dental record keeping requirements. All providers receive this information during our **Provider Orientation Seminars and Webinars**. Over 5,500 Florida and Texas providers received training in 2013. MCNA will host a series of seminars and webinars for providers across the State of Louisiana. During these sessions, providers will receive training on covered benefits, claims submission, EPSDT, the state's periodicity schedule, dental record keeping, their role in MCNA's quality improvement process, utilization management requirements, and other state and federal requirements. For our draft schedule of provider training sessions, please see Section F.9.

MCNA's Dental Record Reviewers are integral to provider education. They assist providers in understanding their role in the MCNA Quality Assessment and Performance Improvement Program. Providers are educated about the dental record keeping requirements for MCNA including the need to document all EPSDT requirements at each member visit.

Our providers also receive instruction on the following subjects from our Dental Record Reviewers:

- The importance of preventive dental services
- Full compliance with the AAPD/EPSDT guidelines
- The components of an effective recall system
- Strategies for delivering meaningful oral hygiene instructions to the member and parents or guardians
- The requirements for reporting members who continuously break appointments to MCNA's Member Advocate and Outreach Specialists to facilitate continuity of care

Routine dental record reviews ensure **compliance** with our clinical practice guidelines, cultural competency standards, and standards for record keeping and data management. A statistically significant sample of charts is audited annually for selected providers who treat ten or more MCNA

Part Two: Technical Approach

Section H: EPSDT



members annually. Any provider scoring less than 90% is placed on a corrective action plan (CAP). Providers are re-audited in order to assess improvement on the areas identified in the CAP. Providers failing to come into compliance with MCNA's standards are then referred to the Credentialing Committee for additional action. Should fraud or abuse be suspected as a result of a dental record review, the Quality Improvement department will refer the case to MCNA's Special Investigations Unit (SIU) for a comprehensive review and investigation. For more information on MCNA's efforts to combat fraud and abuse, please refer to Section N of this response.

Below is MCNA's Dental Record Review Audit Tool. This review thoroughly captures all required service delivery elements and **ensures that providers deliver and document** all required components of EPSDT screening. Following the Dental Record Audit Review Tool, please see an example of a training certification for a provider who received in-person training by our Quality Improvement staff.

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Section I.1

Document experience in other States to positively impact the healthcare status of Medicaid and or CHIP populations. Examples of areas of interest include, but are not limited to the following:

- Reduction of inappropriate utilization of emergent services
- EPSDT
- Children with special health care needs
- Case management
- Reduction in racial and ethnic health care disparities to improve health status

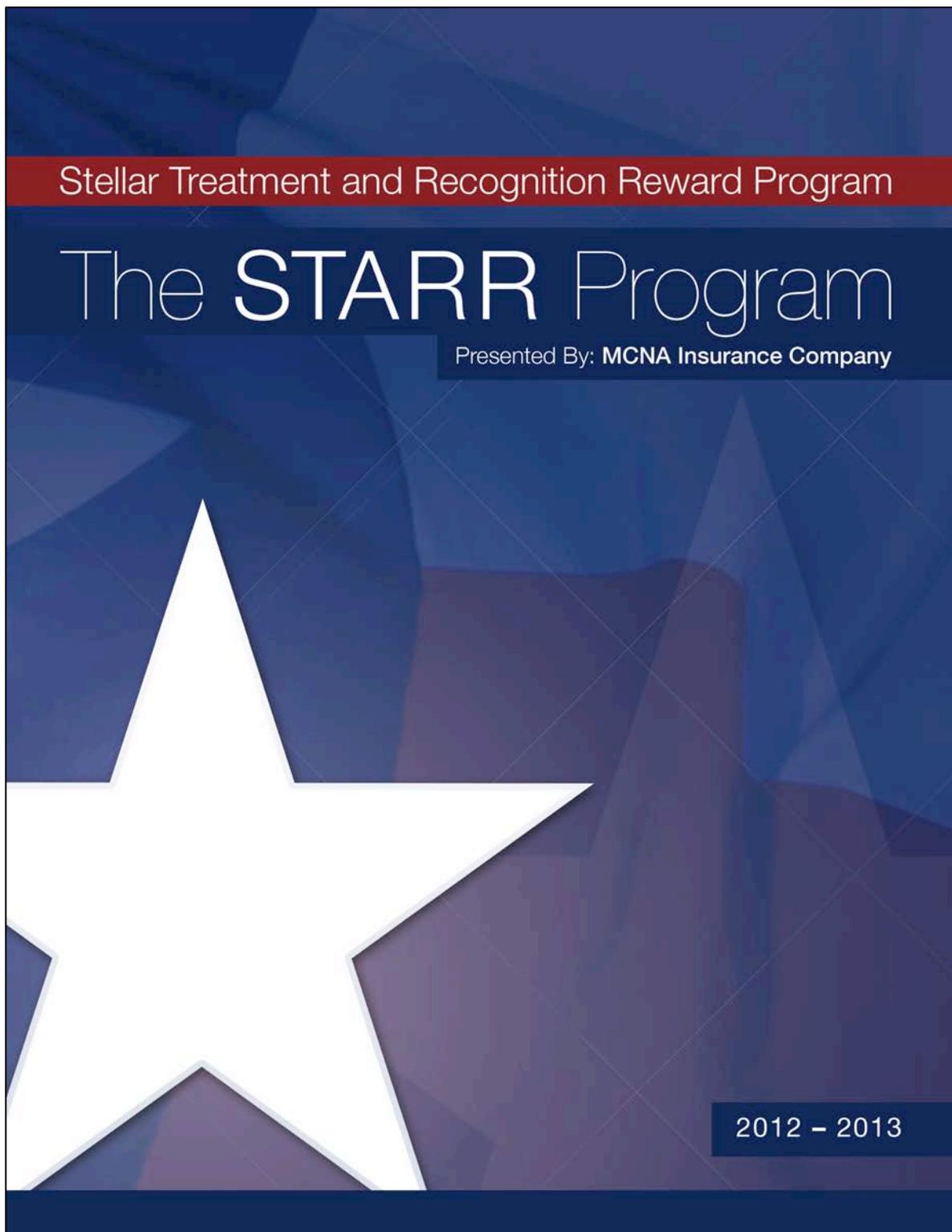
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MCNA's Stellar Treatment and Recognition Reward (STARR) Program [1/5]



MCNA’s Stellar Treatment and Recognition Reward (STARR) Program [2/5]



Dear Colleague,

MCNA Insurance Company is pleased to announce our **Stellar Treatment and Recognition Reward (STARR) Program** for our Texas Main Dental Home Providers. Over the course of the past year, we have enjoyed getting to know you as Providers and working to enhance the oral health care of the children of Texas.

As former President of the American Academy of Pediatric Dentistry (AAPD) and the Texas Academy of Pediatric Dentistry (TAPD), I had the opportunity to lead the development of the AAPD’s clinical guidelines emphasizing the importance of oral health intervention and the dental home model of care. As the Texas President for MCNA Dental, I am committed to maintaining an emphasis on improving the oral health outcomes of our Texas children and reducing their risk for dental disease.

MCNA’s innovative STARR Program is designed to recognize our Providers who render stellar treatment. The program rewards Main Dental Home Providers who perform a high volume of five select preventive services. These services were selected based on AAPD guidelines and the emerging quality of care indicators from the Dental Quality Alliance.

All Main Dental Home Providers are eligible for program participation once they meet the defined qualifying criteria. Stars are awarded in each of the five preventive service categories, and Providers are placed into tiers based on their cumulative number of stars. Scorecards will be posted in their Provider Portal account that identify their star total and recognition tier.

MCNA values your participation in our Provider Network. This program is designed to reward your hard work and dedication. Together we can build a foundation for a lifetime of positive oral health outcomes for the children of Texas!

Sincerely,

Philip H. Hunke, D.D.S., M.S.D.
President



MCNA’s Stellar Treatment and Recognition Reward (STARR) Program [3/5]

Star Allocation Service Categories

Once a Provider meets MCNA’s qualifying criteria, their practice patterns are evaluated and scored based on the number of MCNA members receiving the following five recommended preventive services:



Prophylaxis Treatments

Microbial plaque is the primary etiological factor in caries and periodontal disease. According to the AAPD Guideline on the Role of Dental Prophylaxis in Pediatric Dentistry, professional prophylaxis is necessary to provide long-term inhibition of gingivitis. Although it may be possible to remove most plaque using mechanical oral hygiene aids, many patients do not have the motivation or skill to maintain a plaque-free state for extended periods of time.



Fluoride Application

The AAPD affirms that fluoride is a safe and effective measure for reducing the risk of caries. According to the current AAPD Guideline on Fluoride Therapy, use of fluorides for the prevention and control of caries is documented to be both safe and highly effective. Fluoride has several caries-protective mechanisms of action, including enamel remineralization and altering bacterial metabolism to help prevent caries.



Sealant Application

The AAPD recommends the use of sealants after the eruption of the first and second permanent molars. Sealants are 100 percent effective if they are fully retained on the tooth. According to the Surgeon General’s 2000 report on oral health, sealants have been shown to reduce decay by more than 70 percent. The combination of sealants and fluoride has the potential to nearly eliminate tooth decay in school age children.



Recall Visits

Professional care is necessary to maintain oral health. The AAPD emphasizes the importance of initiating professional oral health intervention in infancy and continuing through adolescence and beyond. The periodicity of professional oral health intervention and services is based on a patient’s individual needs and risk assessment. Minimum guidelines include a comprehensive or periodic oral evaluation once every six months.



First Dental Home Visit (D0145)

Establishment of the First Dental Home sets the stage for an ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. It begins as early as 6 months of age and includes referral to dental specialists when appropriate.

MCNA’s Stellar Treatment and Recognition Reward (STARR) Program [4/5]

Qualifying Criteria

In order to qualify as a STARR Provider:

- You must have been an active **MCNA Main Dental Home Provider** at the end of the plan year (March 1, 2012 – May 31, 2013).
- You must have treated at least **150 MCNA Members** in your practice over the course of the plan year.
- **At least 40% of the members** treated had to receive a comprehensive oral examination (D0120, D0150, or D0145 as applicable) within 210 days of assignment to you.
- You must have been in **good standing** with MCNA and all federal and state agencies throughout the measurement period.
- Your **office must be active** with MCNA on the date of Recognition Reward payment.

150
MCNA Members Treated

40%
Oral Exam Within 210 Days

Quality of Care Concerns

MCNA reviews dental practice patterns that indicate inappropriate or substandard treatment. “Re-treatment” or the use of multiple restorations on the same surface and tooth can indicate a poor quality of initial work. Two stars will be deducted in the event Re-treatment exceeds 5% for all MCNA Members treated. A Provider with a re-treatment rate in excess of 10% for all MCNA Members treated is not eligible for this program.

Recognition Tiers

MCNA has established four recognition tiers and scored each of the five categories from zero to three stars, based on the percentage of members treated by you that receive each service. **The maximum number of stars available is 15.** Your cumulative star total determines your qualifying tier as follows:



MCNA’s Stellar Treatment and Recognition Reward (STARR) Program [5/5]

2012-2013 Year in Review

At the end of the 2012-2013 measurement period, over 90% of MCNA’s Main Dental Home Providers who qualified for the STARR Program were in Tier 1 or Tier 2.



STARR Scorecard

You will have access to a scorecard in your Provider Portal account that details your star allocation, cumulative star total, and corresponding tier achievement for your facility and each provider at your facility. The scorecard will reflect the score for services performed at that facility only.

Recognition Rewards

A Main Dental Home Provider who qualified for Recognition Tiers 1 through 4 shall receive a cash Recognition Reward from MCNA. The total amount of the cash Recognition Reward available for any given year is subject to Texas Health and Human Services Commission (HHSC) approval. Each facility that has a Qualifying Main Dental Home Provider will receive a personalized letter detailing the Recognition Tier achieved by the Provider, and a check for the dollar amount of their Recognition Reward.



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MCNA's 2013 Healthy Holiday Smiles Promotion Flyer

MCNA Presents
2013 Healthy Holiday Smiles Promotion!

Dear MCNA Provider,

At MCNA we are committed to preventive dental care. As part of our special holiday promotion from **October 1 through March 31, 2014**, we are

DOUBLING your reimbursement rate

for select preventive service codes you provide to MCNA members in the Florida Medicaid Statewide Prepaid Dental Health Program who have not been to the dentist in 2013.

Your reimbursement rates will be **DOUBLED** for the following codes*:

- ✓ D1110 – Dental prophylaxis adult
- ✓ D1120 – Dental prophylaxis child
- ✓ D1206 – Topical fluoride varnish
- ✓ D1208 – Topical application of fluoride
- ✓ D1351 – Dental sealant per tooth

* Please note that the standard benefit limitations for these codes still apply. You can find the most up-to-date information in your Provider Manual.

This special holiday promotion will yield direct benefits for you:

- ✓ Increase member and community awareness of your practice and the services your dental office provides.
- ✓ Improve the oral health of the children in your community.

For more information, call MCNA Provider Relations at 1 (855) 698-6262. We look forward to connecting with you about this outstanding opportunity to join us in our initiative to positively impact the oral health of our members!

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Texas Migrant Farmworkers Fotonovela

English Version:

Farmworkers' Children Don't Leave Healthy Teeth Behind

Papa, When does the next crop season start?

Calendar

We leave for Ohio on June first.

But I have a dentist appointment June 19th!

Don't worry. I can call our Case Manager and she can get your appointment moved.

Our Case Manager Rosa got us a new appointment for May 12th so you can see the dentist before we leave.

YAY!

Hello! This is Rosa, Your MCNA Case Manager.

Hello. I need help changing my son's appointment before we leave for the season.

I will be more than happy to help you with that!

FARMWORKERS CHILDREN CAN RECEIVE:

- * CASE MANAGEMENT
- * EARLY TREATMENTS

855-691-6262
INFO@MCNA.NET

mcnadental CHIP Children's Medicaid We've got your kids covered.

Spanish Version:

Niños de trabajadores agrícolas No se olviden de los dientes sanos

Papá, ¿cuándo empieza la próxima temporada de cosecha?

Calendario

¡Salimos a Ohio el primero de junio!

Pero tengo cita con el dentista el 19 de junio.

¡No te preocupes! Voy a llamar a nuestra gestora de casos y ella puede cambiar tu cita.

Nuestra gestora de casos, Rosa, nos cambió la cita para el 12 de mayo y puedas ver al dentista antes de irnos.

YAY!

¡Hola! Mi nombre es Rosa y soy su gestora de casos de MCNA.

Hola, necesito cambiar la cita de mi hijo antes de irnos al final de esta temporada. ¿Nos puede ayudar?

¡Sí! Me dará mucho gusto el poder atenderlo.

TRAJADORES AGRÍCOLAS LOS NIÑOS PUEDEN RECIBIR:

- * GESTIÓN DE CASOS
- * TRATAMIENTO PRECOZ

855-691-6262
INFO@MCNA.NET

mcnadental CHIP Children's Medicaid Protegemos la salud de sus hijos.

Texas Migrant Farmworkers Informational Flyer

A Season To Smile!

Are you a seasonal farmworker?

MCNA Dental has special benefits just for your child! MCNA has a specially trained group of Member Advocates dedicated to our farmworker children. Our Member Advocates are here to help you with all of your child's dental needs. They can also help schedule your child's dental checkup! At MCNA, we are committed to making sure your child gets the dental care and service they deserve.

Need a ride?

Member Advocates can assist you with transportation or gas to and from your dental visit. Through Medicaid's free ride services, they can help arrange for a ride to come and pick up both you and your child. If you need gas to get to the dentist, we can help you with that too!

Leaving for work?

We can even help get your child early dental treatment if you have to travel out of the area. Member Advocates are on hand to help you schedule your child's appointment before you leave for work. MCNA offers the following special services to your child:

- Benefits such as accelerated services, dental cleanings, exams, x-rays, fluoride treatment, sealants, and much more.
- A toll free hotline you can call for help with your dental benefits.
- A large network of providers that allows you to find the right dentist 24/7. Choose from a wide range of General Dentists and Specialists to suit your child's needs.
- Access to our online provider directory at www.mcna.net. You can search for a dentist by name, gender, location, and language.

Don't wait! Call today and let us put our experience to work for your children! 1-855-691-6262

MCNA TX_MFW_0713

Section I.2

Describe how you will identify quality improvement opportunities. Describe the process that will be utilized to select a performance improvement project, and the process to be utilized to improve care or services. Include information on how interventions will be evaluated for effectiveness. Identify proposed members of the Quality Assessment Committee.

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Section I.3

Provide a description of focus studies performed, quality improvement projects, and any improvements you have implemented and their outcomes. Such outcomes should include cost savings realized, process efficiencies, and improvements to member health status. Such descriptions should address such activities since 2002 and how issues and root causes were identified, and what was changed.

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Section I.4

Describe your proposed Quality Assessment and Performance Improvement (QAPI). Such description should address:

- The QAPI proposed to be implemented during the term of the contract.
- How the proposed QAPI s will expand quality improvement services.
- How the proposed QAPI will improve the health care status of the Louisiana Medicaid population.
- Rationale for selecting the particular programs including the identification of particular health care problems and issues identified within the Louisiana Medicaid population that each program will address and the underlying cause(s) of such problems and issues.
- How you will keep DHH informed of QAPI program actions, recommendations and outcomes on an ongoing and timely manner.
- How the proposed QAPIs may include, but is not necessarily, limited to the following:
 - New innovative programs and processes.
 - Contracts and/or partnerships being established to enhance the delivery of health care such as contracts/partnerships with school districts and/or School Based Health Clinics.

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Section I.5

Describe how feedback (complaints, survey results etc.) from members and providers will be used to drive changes and/or improvements to your operations. Provide a member and a provider example of how feedback has been used by you to drive change in other Medicaid managed care contracts.

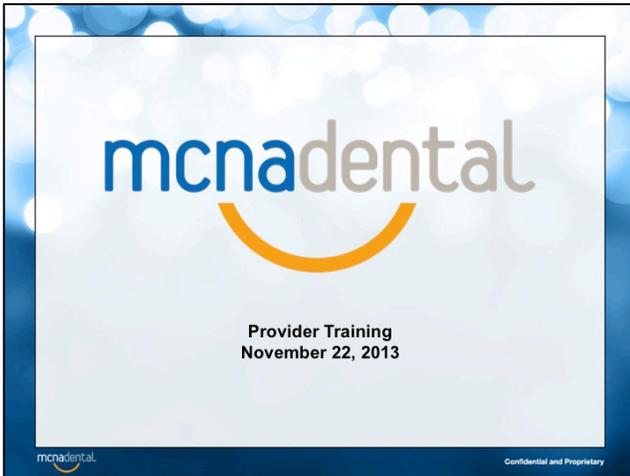
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Excerpts from MCNA’s Diagnostic Quality Provider Training Slideshow




Decision-making criteria

MCNA's Utilization Management Criteria uses components of dental standards from the American Academy of Pediatric Dentistry (www.aapd.org) and the American Dental Association (www.ada.org).

The procedure codes used by MCNA are described in the American Dental Association's Code Manual. Requests for documentation of these codes are determined by community accepted dental standards for authorization such as treatment plans, narratives, radiographs and periodontal charting.



Narratives

What MCNA considers as a good narrative would include specifics of tooth #, surface, and/or location involved. Also an explanation to specific circumstances of when and how long the procedure was performed. It should describe any medications dispensed, how they were given and how much was given. It should state any symptoms the patient was having such as pain, swelling, and/or infection. Also it should include any compromising medical or physical condition of the patient. When applicable include duration of procedure performed.

** Cut and Paste Narratives used on every Member are not recommended*

All About X-Rays

- MCNA's Clinical Reviewers need to examine x-rays of diagnostic quality when considering certain claims submissions and pre-authorization requests from your office
- With a high-quality x-ray, we can process your claim or pre-authorization as quickly as possible and meet our goal of being an effective partner to you in delivering quality dental services to MCNA members under your care



Diagnostic Quality X-Rays

What makes an x-ray of diagnostic quality?

- Simply put, a diagnostic x-ray is a film that is of a quality good enough to be used to aid in making a determination about the claim or pre-authorization request it supports.
- The film must be readable, meaning it can neither be too light or too dark.
- If a specific tooth is in question on the claim or pre-authorization, that tooth must be present in the image on the x-ray, including the whole tooth structure or the area surrounding the tooth (if it is also in question).
- Labeling of right and left side images. It is easy to forget this aspect of the x-rays, but without the correct labels designating right from left, it is possible they will be useless as diagnostic tools. Before submitting x-rays to MCNA, please take a second to make sure images of both sides are labeled correctly.

Remember, diagnostic quality is in the details!

Peer-to-Peer

- At MCNA all clinical determinations are made by Texas licensed dentists
- The Peer-to-Peer process gives providers the opportunity to discuss clinical situations with an MCNA clinical reviewer of the same specialty
- If you would like a Peer-to-Peer discussion please contact the Provider Hotline at 855-776-6262



Sample "Dental Details" Monthly Provider Newsletter

Topics in This Issue: CHIP into TIERS · Enhancement to Provider Portal · Updated Credentialing Application

dental details

for texas dental providers · october 2013

CHIP into TIERS: New ID Numbers and Date of Service

All of MCNA's active Texas CHIP members have by now been informed of their new CHIP ID number and received a sticker featuring that new number to affix to their existing ID card. When you need to submit claims for services rendered to these CHIP members, you will need to look to the date of service to determine which ID number to use.

Your office should submit claims using a CHIP member's new 9-digit numeric ID number for dates of service on and after October 1, 2013. If you have a claim to submit with a date of service before October 1, you should use the member's legacy alphanumeric ID number.

Remember, we are here to help! Please call our Provider Hotline at 1-855-776-6262 if you need assistance in making a determination about which CHIP member ID number to use when submitting a claim.

Enhancement to Provider Portal

MCNA has improved the process for submitting appeals online through our Provider Portal (<http://portal.mcna.net>). As a result of the popularity of the online appeals submission tool among our network providers, we have made some adjustments to it in an effort to more effectively route the submissions we receive.

When you log in to your Provider Portal account and navigate to the online appeals submission tool located under the Support and Downloads tab, you will be asked to provide information about what your appeal is related to. You can do this simply by selecting a choice from the list provided. This additional step allows our system to deliver your submission to the appropriate department as either an appeal or as a claims reconsideration. If it is an appeal, it will move on to the Appeals Department. If it is a claims reconsideration, it will be reviewed by one of MCNA's dental claims examiners for a "second look" at the initial claims processing decision.

After you successfully submit your information, you will be presented with a confirmation screen. This screen will indicate whether your submission has been classified as an appeal or as a claims reconsideration.

At MCNA, we value your feedback and continually look for ways to improve our systems and processes to meet your needs. For more information about this and other convenient tools available to you through our Provider Portal, please call our Provider Hotline at 1-855-776-6262 today. Let us assist you in learning more about all that MCNA can offer you and your practice!

Need to Reach Us?

Contact MCNA's Provider Hotline at **1-855-PRO-MCNA** (1-855-776-6262). We welcome all of your questions and comments!

Reminder: Updated Credentialing Application Available Online!

Is your office using the updated version of MCNA's credentialing application? It is conveniently available for you to download from our website (<http://www.mcnatx.net>). If you have an older version of the application on file for use when you must credential providers who are new to your practice, please take a moment to download a copy of the most recent credentialing application.

MCNA Dental · Dental Details · For Texas Dental Providers · October 2013
Page 1 of 1

MCNA_TX_DD_2013_10

Section I.6

Provide, in Excel format, the proposer's results for:

- HEDIS measures specified below for the last three measurement years (2010, 2011, 2012) for each of your State Medicaid contracts.
 - If you do not have results for a particular measure or year, provide the results that you do have.
 - If you do not have results for your Medicaid product line in a state where you have a Medicaid contract, provide the commercial product line results with an indicator stating the product line.
 - If you do not have Medicaid HEDIS results for at least five states, provide your commercial HEDIS measures for your largest contracts for up to five states (e.g., if you have HEDIS results for the three states where you have a Medicaid contract, you only have Medicare HEDIS for one other state, provide commercial HEDIS results for another state).
 - If you do not have HEDIS results for five states, provide the results that you do have.
 - In addition to the spreadsheet, please provide an explanation of how you selected the states, contracts, product lines, etc. that are included in the spreadsheet and explain any missing information (measure, year, or Medicaid contract). Include the Proposer's parent organization, affiliates, and subsidiaries.
 - Provide results for the following HEDIS measures:
 - Annual Dental Visit
- 416 Report measures specified below for the last three measurement CMS years (2010, 2011, and 2012) for each of your State Medicaid contracts.
 - Line 12a - Total Eligibles Receiving Any Dental Services
 - Line 12b - Total Eligibles Receiving Preventive Dental Services
 - Line 12c - Total Eligibles Receiving Dental Treatment
 - Line 12d — Total Eligibles Receiving a Sealant on a Permanent Molar Tooth, and
 - Line 12e — Total Eligibles Receiving Diagnostic Dental Services
 - For each of your State Medicaid contracts that received a CMS State Focused Dental Review (2008), please outline all findings, recommendations, etc. revealed in the State-specific reports, as well as the steps that were taken to improve recommendations and rectify all findings. Focus

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Section J.1

Describe proposed content for your member educational materials) and attach a examples used with Medicaid or CHIP populations in other states.

MCNA's member materials promote responsible utilization of dental benefits to improve our members' oral health outcomes. Our years of experience with Medicaid and CHIP programs have taught us that raising our members' awareness about the importance of preventive care, and how to access that care requires the development of close ties with each member. **MCNA is committed to increasing EPSDT/AAPD periodicity compliance rates for our children and adolescent members.** For our adult members, we are committed to ensuring their understanding of the Denture Program and the benefits available. MCNA does more than provide information; we encourage our members to be enthusiastic about having healthy teeth and gums.

We understand the importance of **timely and accurate** communication with new enrollees. Within five (5) days of enrollment each member will receive a DHH-approved Welcome Packet. Our Welcome Packet includes a Welcome Letter, Provider Directory, and an informative, easy-to-understand Member Handbook with the following additional information:

- How to Contact MCNA
- Member Rights and Responsibilities
- Eligibility
- Enrollment and Disenrollment
- The Role of the Primary Care Dentist
- How to Change Primary Care Dentists
- Covered Services
- How to Obtain Pre-Authorization for Dental Services
- Accessing Dental Care
- Obtaining a Replacement ID Card (if applicable)
- What To Do in an Emergency Situation (including natural disasters)
- Benefit Exclusions and Limitations
- Notice of Privacy Practices
- Filing a Complaint, Grievance, or Appeal
- Requesting a State Fair Hearing
- Reporting Suspected Fraud and Abuse
- Coordination and Continuity of Care
- How to Access Out of Network Care
- How to Obtain Prevention and Wellness Information
- Member Information and Release Form
- Oral Health Assessment Form
- Other DHH Requirements

Though not required, MCNA will include a printed Provider Directory in each member Welcome Packet in order to ensure that members have complete information to select the PCD of their choice.

MCNA creates and distributes a variety of educational materials that provide information about the importance of good oral health, how to utilize covered benefits, how to access care, and other targeted topics. We partner with faith based and other community organizations to increase oral health awareness and coordinate educational outreach efforts. Our educational materials are written at a 6th grade Flesch-Kincaid reading level, for all prevalent languages (spoken by at least 5% of the population statewide). Currently our materials are available in English, French, Creole, Spanish, Braille, and large print.

Please see the following examples of MCNA member educational materials used with Medicaid and CHIP populations in other states.

Postcards

- **Dental Visit Reminder (Mockup for Louisiana):** To be sent to all Louisiana children and adolescent MCNA members within 60 days of enrollment to promote timely dental visits and increase EPSDT screening rates. (*Attachment J1-1*)
- **Community Resource Fair & Backpack Giveaway:** Invited members in the surrounding community to MCNA's back-to-school health fair where they would receive free health and dental screenings, fluoride application, immunizations, backpacks, and other school supplies. This event was held in collaboration with the City of Lauderdale Lakes, Florida, and the Kiwanis Club of Lauderdale Lakes. (*Attachment J1-2*)

MCNA's Own Oral Health Education Videos for Kids (posted on www.MCNA.net and YouTube)



- **"Because I Said So!":** Motivates children to brush and floss their teeth regularly and educates them on the effects of neglecting to follow a daily oral hygiene regimen at home. (<http://www.youtube.com/watch?v=ewjzwqWNkus>) (*Attachment J1-3*)
- **"Effects of Sugar":** Educates children on how the sugar content found in many of the foods they consume on a daily basis can affect their teeth. Children are informed of other healthy options that are good for their teeth and overall health. (<http://www.youtube.com/watch?v=DXFWwL9V3Uo>) (*Attachment J1-4*)

Educational Flyers Distributed to Members

- **MCNA Dental's Crossword Puzzle:** A fun way to challenge and instruct children on proper tooth brushing techniques, preventive dental care, and tooth decay. (*Attachment J1-5*)
- **Tooth Fairy Tips:** Provides children with helpful hints regarding nutrition, preventive care, and oral habits that could be harmful to their teeth. (*Attachment J1-6*)

- **Your Baby's First Tooth:** Educates parents on the importance of taking their baby for their first dental checkup between six months to twelve months of age. This adheres to the periodicity schedule outlined by the American Academy of Pediatric Dentistry (AAPD). (*Attachment J1-7*)
- **How to Avoid Baby Bottle Tooth Decay:** Raises awareness about one of the leading causes of tooth decay in young children. Parents are given helpful tips to keep their baby's teeth healthy and cavity free. (*Attachment J1-8*)
- **Why Do I Need A Professional Cleaning?:** Educates adults and children about the importance of a professional dental cleaning in addition to their daily oral hygiene regimen. (*Attachment J1-9*)
- **Time for the Tooth Fairy:** Prepares parents for the natural process of children losing teeth. It provides tips for parents to help their children overcome fear of losing their teeth. (*Attachment J1-10*)
- **Healthy Smiles for Mom & Baby:** Raises oral health awareness among pregnant women and educates them on how to prevent tooth decay in infants and young children, including how to avoid baby bottle tooth decay. Expectant mothers are also educated on how their oral health habits impact the health of their unborn child. (*Attachment J1-11*)
- **Cavity Fighters:** Educates parents on the importance of fluoride and sealant placement and how they play a vital role in preventing cavities in children. (*Attachment J1-12*)
- **Keys to a Healthy Smile:** Advises parents on when and how they should begin incorporating a daily oral hygiene regimen with their children. Parents are also educated on how a healthy diet can impact the development of their children's teeth. (*Attachment J1-13*)
- **Oral Hygiene Tips:** Instructs parents how to properly brush and floss their children's teeth. Recommendations are also given to parents on the type of toothbrush to use as well as how often their toothbrush should be replaced. (*Attachment J1-14*)
- **Dental Word Finder:** A creative word search that introduces common dental terminology to children in a fun and educational way. (*Attachment J1-15*)
- **MCNA Dental Case Management:** Introduces members to MCNA's Case Management department. It provides details on how we can help members with special needs. (*Attachment J1-16*)

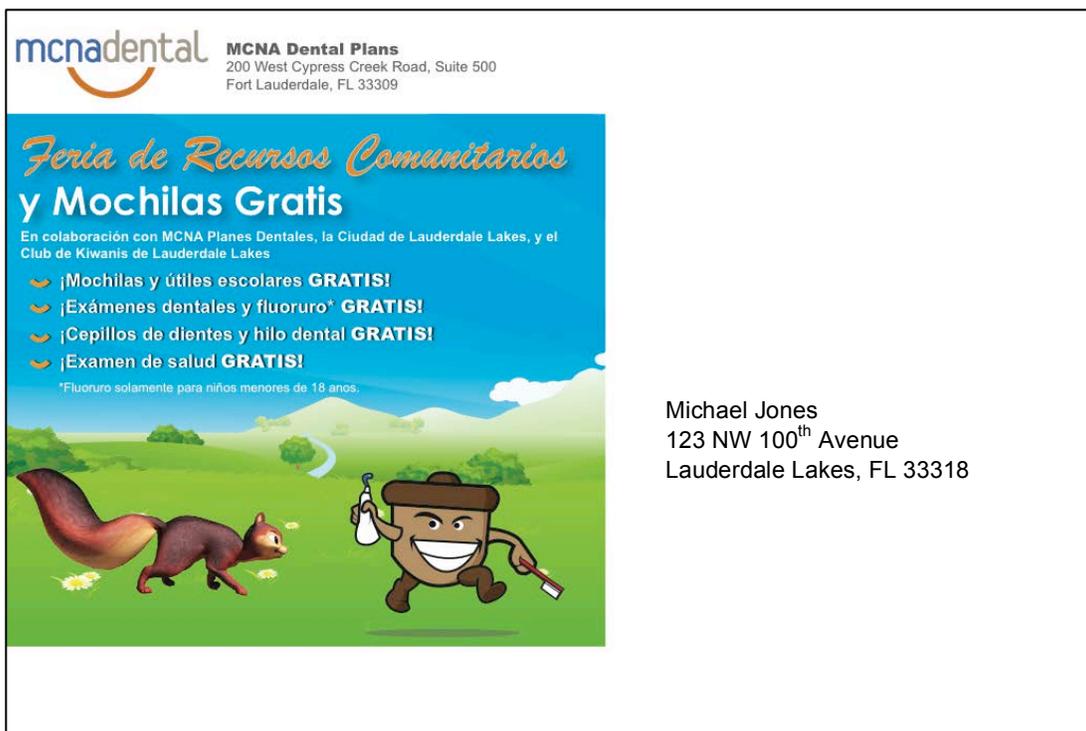
Member Handbook

- **Texas Medicaid Member Handbook:** This handbook is included in all new member welcome packets and provides members with important information about MCNA and their plan benefits. It is also available on our website and by request to an MCNA Member Services Representative. (*Attachment J1-17*)

Attachment J1-1: Postcard: Dental Visit Reminder (Mockup for Louisiana)



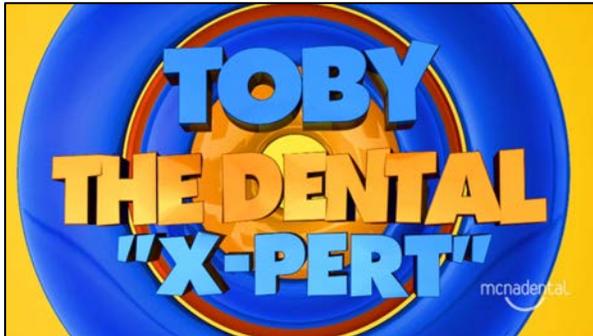
Attachment J1-2: Postcard: Community Resource Fair & Backpack Giveaway



Attachment J1-3: MCNA's Own Oral Health Education Videos for Kids:
"Because I Said So!"



Attachment J1-4: MCNA's Own Oral Health Education Videos for Kids:
"Effects of Sugar"



Attachment J1-5: Educational Flyers: MCNA Dental's Crossword Puzzle

MCNA Dental's CROSSWORD PUZZLE!

ACROSS

1. What you put on your tooth brush.
5. Pictures of your teeth.
8. Nice sweet treat.
9. Used to see hard area in the mouth.
10. Mouthwash helps bad _____!
11. Helps remove food stuck between your teeth.
14. Holes in teeth.
15. Germs from mouth can travel here.
16. Sticks on teeth to protect against cavities.
17. At least two times a day.

DOWN

1. How many minutes to brush.
2. Bacteria that sticks on our teeth.
3. Visit the dentist every ____ months.
4. The room where you get x-rays.
6. We want a bright, healthy one.
7. Used to clean your teeth.
8. Makes teeth strong to fight against cavities.
12. Can be bad for your teeth.
13. How to brush your teeth.

ANSWERS:

Across:
 1. Toothpaste 5. X-rays 8. Fruit 9. Mirror
 10. Breath 11. Flossing 14. Cavities

Down:
 15. Heart 16. Sealants 17. Brush

Circles:
 7. Toothbrush 8. Fluoride 12. Sugar

1. Two 2. Plaque 3. Six 4. Exam 6. Smile

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CHIP Children's Medicaid
We've got your kids covered.

Attachment J1-6: Educational Flyers: Tooth Fairy Tips



Attachment J1-7: Educational Flyers: Your Baby's First Tooth

YOUR BABY'S FIRST TOOTH!

The best time to take your baby to the dentist is when the first tooth erupts. The American Academy of Pediatric Dentists (AAPD) recommends that children have their first dental exam at age 6 to 12 months. Early dental visits help to prevent and detect tooth decay. It is a great opportunity for parents to learn how to care for their child's oral health. For example, parents should clean their baby's gums with a soft moist washcloth daily. A soft toothbrush should be used when baby teeth begin to appear.

Here are some things the dentist checks in the first visit:

- 1 Teeth
- 2 Child's bite
- 3 Gums
- 4 Jaw
- 5 Oral tissue
- 6 Tooth brushing habits

Unhealthy and missing baby teeth can cause problems for permanent teeth. Teeth that are not aligned, missing and overcrowded affect the growth of permanent teeth.

Baby teeth are important because they:

- 1 Help children to chew their food
- 2 Assist with speech development
- 3 Save space for permanent teeth
- 4 Promote healthy smiles
- 5 Help children feel good about the way they look

CHIP Children's Medicaid
We've got your kids covered.

Toll-Free: (855) 691-6262 • TTY: (800) 955-8771 • Web: <http://www.mcna.net>

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Attachment J1-8: Educational Flyers: How to Avoid Baby Bottle Tooth Decay

HOW TO AVOID BABY BOTTLE TOOTH DECAY

A leading cause of tooth decay in children is "baby bottle tooth decay". It is caused by teeth being in contact with sugar for long periods of time. The sugary liquids in the bottle cling to your baby's teeth. This sugar produces acid. The acid attacks the teeth. Long term contact with these acids can cause decay. When decay is left untreated it can lead to early tooth loss. Baby teeth should not be lost too early. Baby teeth are considered "space savers" for permanent teeth. Early tooth loss in children can cause crooked teeth and problems chewing. But there is good news! Baby bottle tooth decay is preventable!

HERE ARE SOME TIPS TO KEEP YOUR BABY'S TEETH HEALTHY:

- 1 Avoid long term contact with sugary drinks. This will help prevent decay.
- 2 Don't put your baby to bed with a bottle filled with juice, milk, or soda; ONLY WATER.
- 3 Water is the safest liquid for your baby's teeth.
- 4 Clean your baby's teeth with a wet washcloth or toothbrush.
- 5 Take your baby to the dentist by their first birthday.

mcnadental
Toll-Free: (855) 691-4262 - TTY: (800) 955-8771 - www.mcnadental.com
CHIP Children's Medicaid
We're all your best chance.

Attachment J1-9: Educational Flyers: Why Do I Need A Professional Cleaning?

WHY DO I NEED A PROFESSIONAL CLEANING?

Plaque is a soft-sticky layer of bacteria that builds up on teeth daily. If this soft plaque is not removed daily it begins to get hard. Plaque takes 24-48 hours to harden. When it gets hard, it is called tartar. Brushing and flossing will remove most plaque but not hard tartar... and that is why you need a professional cleaning.

HERE ARE SOME MORE REASONS WHY YOU NEED A PROFESSIONAL CLEANING:

1. We all miss areas when we brush and floss.
2. A dental professional can clean the teeth with special instruments.
3. A professional cleaning helps prevent gum disease.
4. The dental professional can show you how to brush and floss correctly.
5. Plaque and surface stains are removed by your dental professional and leave the teeth looking and feeling clean and polished.
6. Hard deposits are also removed that cannot be removed by a toothbrush or floss.
7. A professional cleaning should be done at least every 6 months.

**YOU TOO CAN HAVE A SMILE LIKE THIS!
DON'T WAIT, SCHEDULE AN APPOINTMENT **TODAY!****

CHIP Children's Medicaid
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Attachment J1-10: Educational Flyers: Time for the Tooth Fairy!

mcnadental

Time for the Tooth Fairy!

What's happening to my child's teeth!?

Did you know that starting around age 6, your child's baby teeth will start to loosen? Don't worry! This is natural!

The teeth will start to wiggle. They will get so loose that they will fall out. They won't fall out all at the same time. It often happens one by one. Your child's baby teeth need to fall out to make room for their adult teeth. This process is part of growing up.

Does your child's dentist need to pull the teeth out? No! The baby teeth will fall out on their own. Your dentist knows it is best to let the teeth go through this process naturally.

Wiggling your child's teeth is okay, too. It won't hurt their gums or their adult teeth. Your child can touch the loose baby teeth with their tongue or their fingers. That's okay. Let them explore this healthy part of their growth.

Is your child scared by what is happening to their baby teeth?

You can help by talking to your child about it. Here are some tips you can use to make your child feel better:

- Tell your child that they will get new adult teeth to replace their baby teeth.
- If your child has pain, use a cold compress or a pain reliever to help.
- Tell your child that it is normal for their gums to be sore. The gums may even bleed a little when your child chews food.
- Tell your child about the Tooth Fairy! The idea that they will get a coin for each baby tooth that falls out will make them excited!

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Attachment J1-11: Educational Flyers: Healthy Smiles for Mom & Baby [1/2]



Healthy Smiles

for Mom & Baby

Good Oral Health During Pregnancy

Your oral health can affect your overall health during pregnancy. Good oral health habits can have a positive impact on the health of your unborn child. Research shows a link between gum disease and low birth weight babies. Women who are pregnant with gum disease are more likely to have a baby that is born too early.

Pregnancy Gingivitis

Many pregnant women may begin to notice red, puffy or sore gums that bleed when they brush. This is known as pregnancy gingivitis. It often occurs during the second to eighth months of pregnancy. Hormone levels rise and make the gums more sensitive to plaque. To reduce pregnancy gingivitis, keep your teeth and the area between your gums and teeth clean.

A Healthy Diet

Eating a balanced diet is needed to make sure you get the right amount of nutrients to nourish both you and your baby. Your baby's teeth begin to develop between the third and sixth month of pregnancy so you want to make sure you receive enough calcium, protein, and vitamins A, C, and D. Healthy food choices such as cheese, fresh fruits, and vegetables are rich in vitamins and great for your teeth. Some say calcium is lost from the mother's teeth during pregnancy and given to the baby. This is a myth! Your baby gets calcium from your diet, not from your teeth.

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Attachment J1-11: Educational Flyers: Healthy Smiles for Mom & Baby [2/2]

Baby Bottle Tooth Decay

Tooth decay found in infants and young children is called baby bottle tooth decay. It occurs when sugary liquids like milk, formula, and fruit juice lay on the teeth for long periods of time. Bacteria in the mouth use the sugar to make acids that attack the teeth. Putting your child to sleep with a bottle or sippy cup that has sugary liquids can cause baby bottle tooth decay. Dipping your child's pacifier in sugar or honey can be just as harmful and can cause decay.



Baby bottle tooth decay occurs on the upper front teeth but can also affect other teeth. It can cause your baby to have pain. If not treated, it can even cause infection.

The good news is baby bottle tooth decay can be prevented! Here are some tips that you can do to avoid baby bottle tooth decay.

- Never allow your baby to fall asleep with a bottle containing anything but water.
- Wipe the baby's gums with a small piece of gauze or a washcloth after feedings.
- Start brushing your child's teeth as soon as the first tooth comes in. You may begin using toothpaste when your child is able to spit it out.
- Make sure your child is getting enough fluoride to help fight cavities. If your local water supply does not have any fluoride, consult with your dentist.
- Take your baby to the dentist by their 1st birthday!



Oral Hygiene Tips

Here are a few tips to help prevent cavities and gum disease during pregnancy:

- Brush your teeth twice a day with fluoride toothpaste.
- Use floss daily to clean in between your teeth.
- Eat a balanced diet.
- Visit your dentist regularly for check-ups.

Visit our website at www.mcna.net for more oral hygiene tips.

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Attachment J1-12: Educational Flyers: Cavity Fighters



WHAT IS FLUORIDE?

- ★ Fluoride is a mineral found in food and water.
- ★ Fluoride is one of the best ways to fight cavities.
- ★ It makes the teeth strong.
- ★ Sugar and germs in the mouth make acid that can make teeth weak. Fluoride will help make them strong again.
- ★ Most children get fluoride in their drinking water or toothpaste.
- ★ If your child drinks water that does not have fluoride, he or she may need a fluoride rinse. Ask your doctor or dentist to see if this is needed.
- ★ When using toothpaste with fluoride, use only a small bit. From 2-5yrs, use a pea-sized amount. Use a “smear” of toothpaste for a child less than two years of age.

WHAT ARE DENTAL SEALANTS?

- ★ A dental sealant is a plastic material that covers and seals the chewing part of your child’s molars (back teeth) and stops cavities from forming.
- ★ Ninety percent (90%) of children’s cavities start on their back teeth.
- ★ Most dentists place sealants on molars after they come out. Ask your dentist if your child might help from a dental sealant.



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Attachment J1-13: Educational Flyers: Keys to a Healthy Smile!



KEYS TO A HEALTHY SMILE!

HOW I CAN HELP MY CHILD HAVE A HEALTHY SMILE

- ★ Start brushing your child’s teeth as soon as the first tooth comes in! Before the teeth come in, use a clean, damp cloth to wipe the plaque from their gums.
- ★ Try to clean your child’s teeth two (2) times a day.
- ★ Once the child has a few teeth, start with a small soft toothbrush. If the child is under two, ask your doctor if you should use toothpaste with fluoride.
- ★ Use a “smear” of toothpaste to brush the teeth of a child less than two. From 2-5 yrs, use a pea-sized amount to help your child to brush.

A HEALTHY DIET IS ALSO KEY TO A HEALTHY SMILE

- ★ Having a healthy diet helps for your child to have strong, cavity-fighting teeth.
- ★ Sugars and starches that are in many foods like candy, cookies, soda, and potato chips, mix with plaque on teeth and make acids. These acids make the teeth weak and cause cavities.
- ★ Try to watch the number of times your child snacks. If your child must snack, try healthy foods like raw vegetables, yogurt, and fresh fruits.



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Attachment J1-14: Educational Flyers: Oral Hygiene Tips



ORAL HYGIENE TIPS

FUN FACTS ON BRUSHING

- ★ Always use a SOFT toothbrush and softly brush the inside, outside and the chewing part of each tooth. Make sure the bristles are brushing along the gums.
- ★ Brush your child’s teeth in little circles on the gums and on the teeth.
- ★ Brush for at least two (2) minutes and don’t forget to brush the tongue! Germs can stay on the tongue and cause bad breath!
- ★ Watch your child to make sure they are using the right amount of toothpaste and are not swallowing it because this can make white spots on their adult teeth.
- ★ Use a new toothbrush every three (3) months or when the bristles are worn out, whichever may come first.

WHEN SHOULD MY CHILD START FLOSSING?

- ★ Flossing can start as soon as two (2) teeth touch each other.
- ★ Until they are able to floss alone, you can help them learn to floss. Let your child know that flossing helps to remove plaque in places the toothbrush cannot reach.

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Attachment J1-15: Educational Flyers: Dental Word Finder

DENTAL WORD FINDER

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FIND THESE WORDS:

1. TOOTH
2. SMILE
3. CAVITY
4. DENTIST
5. SEALANT
6. X-RAY
7. FLOSS
8. MOLAR

C	S	M	I	L	E	A	B
A	C	D	E	M	F	G	D
V	H	F	L	O	S	S	E
I	W	K	M	L	N	O	N
T	N	A	L	A	E	S	T
Y	P	Q	R	R	S	T	I
U	X	R	A	Y	V	W	S
X	Y	Z	H	T	O	O	T

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Attachment J1-16: Educational Flyers: MCNA Dental Case Management

MCNA Dental

Do you need help getting dental care for your child?

MCNA Dental's Case Management Department can help!

- Members with special needs.
- Members who need a lot of dental treatment.
- Members who need treatment that is covered by their medical insurance.
- Members who are pregnant.

The Case Management Department can help you:

- Find a dentist who speaks your language
- Find a dentist who can treat you at a time that is good for you.
- Set up a visit to your dentist.
- Find a dentist who can treat your special needs.
- Get the paperwork that your dentist needs to treat you.



Do you have a question or do you need help? Call MCNA Dental's Case Management Department at **1-800-494-6262**. You can call us Monday to Friday, 8 a.m. to 5 p.m. Central Time. Please call 1-800-735-2989 if you have a hearing or speech disability.



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Attachment J1-17: Member Handbook: Texas Medicaid [1/38]

mcnadental

Member Handbook
Texas Medicaid Dental Services

Children's Medicaid

If you have questions, please call Member Services at 1-855-691-6262 (Toll Free).
Si tiene preguntas, comuníquese con Servicio a Miembros al 1-855-691-6262 (Número gratuito).

Our Commitment to You

At MCNA, we are committed to improving your overall health. We make sure you get great dental care and service you can trust.

It is important to us that our members know the steps to maintain good dental habits.

We are here to help you. If you have any questions, please call our Member Services Hotline (Toll Free) at: **1-855-691-6262**.

Attachment J1-17: Member Handbook: Texas Medicaid [2/38]

Member Handbook for Texas Medicaid Dental Services

Welcome to MCNA

Welcome to MCNA Dental. We are a proud Provider for the Texas Medicaid Dental Services Program. Your child has been enrolled with MCNA. We are happy to be the dental plan for your child. We have a network of General Dentists and Specialists to treat your child. Our dentists will serve as your child's Main Dental Home Dentist (known as "Main Dentist").

This Handbook has the information you need for your child to have these dental services. Please read it to understand your child's dental plan. The Member Handbook is available in audio, larger print, Braille, and other languages. Call Member Services toll-free at 1-855-691-6262 or email us at info@mcna.net if you would like another Member Handbook. If you are deaf or hearing impaired, call Sprint Relay Service toll-free at 1-800-735-2989 for help.

Please call MCNA's Member Services toll-free number for help with choosing your child's Main Dental Home Dentist for regular dental check-ups. After you choose your child's Main Dental Home Dentist, call their office to schedule your child's first dental visit within 60 days of joining MCNA Dental. This will help make good dental habits.

If for any reason you would like to change your child's Main Dental Home Dentist, please contact our Member Services Department toll-free at 1-855-691-6262 or by email at info@mcna.net.

Good dental health is important to us. We hope your child uses the dental benefits provided by MCNA. We look forward to serving your child!

Page 1

Member Handbook for Texas Medicaid Dental Services

MCNA's Member Services

Our Member Services Hotline is available during normal business hours Monday to Friday, 8:00 a.m. to 7:00 p.m. Central Time (excluding state-approved holidays). MCNA has staff that speaks English, Spanish and Creole. We can also help you in other languages. You can contact our Member Services Hotline toll-free at 1-855-691-6262 to speak with a Member Services representative. For the deaf or hearing impaired, please call Sprint Relay Service toll-free at 1-800-735-2989. If you call after our regular business hours, you can leave a message on our secure voice mailbox. We will return your call the next business day.

When you speak with our Member Services, they will be able to answer any questions you may have and give you information on:

- Covered services and limitations
- Emergencies
- Choosing a dentist
- Changing to another dentist
- Scheduling appointments
- Getting an interpreter
- Transportation services

They can also give you information that will teach you about:

- The correct way to brush and floss your teeth.
- Why it is important to go to the dentist.
- How often you should go to the dentist.
- Healthy eating.
- Health fairs and education classes.

MCNA has Medicaid Member Advocates that will help you file complaints and appeals. They will also help you during the complaints and appeals process. The Member Advocates can tell you how to get covered and non-covered services. You can speak with a Member Advocate by calling our Member Services Hotline.

If you call after regular business hours or during a weekend, you will get an answering service or a recording with operating hours and what to do in case of an emergency. If you don't have an emergency, call your Main Dentist during regular business hours.

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Attachment J1-17: Member Handbook: Texas Medicaid [3/38]

Member Handbook for Texas Medicaid Dental Services	
Important Resources	
MCNA Member Services	
Hours of Operations:	Monday - Friday 8:00 a.m. - 7:00 p.m. Central Time <i>Excluding state-approved holidays.</i>
Toll-Free Phone Number:	1-855-691-6262
Hearing Impaired (TTY):	1-800-735-2989
MCNA Dental Helpline:	1-855-688-6262
MCNA Fraud Hotline:	1-855-392-6262
Website:	www.MCNA.net
Mailing Address:	4400 NW Loop 410, Suite 250 San Antonio, Texas 78229
Texas Health and Human Services Commission (HHSC)	
Toll-Free Phone Number:	1-800-252-8263
Hearing Impaired (TTY):	1-800-735-2989
Medicaid Managed Care Helpline:	1-866-566-8989 1-866-222-4306 (TTY)
Website:	www.hhsc.state.tx.us
Office of Inspector General (OIG)	
Toll-Free Fraud Hotline:	1-800-436-6184
Other Useful Numbers	
Medicaid Transportation Program:	1-877-633-8747
How to find services in your area: (Transportation, financial help, etc.)	2-1-1
For emergency services:	9-1-1
Texas Relay Service: (Call if you have lost your hearing, or if it's hard for you to hear)	7-1-1

Member Handbook for Texas Medicaid Dental Services	
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Attachment J1-17: Member Handbook: Texas Medicaid [5/38]

Member Handbook for Texas Medicaid Dental Services

Member ID Cards

How to Use Your Card

To use your card:

- Have the Member's ID handy when calling Member Services.
- Bring the Member's ID with you when you go to the dentist.
- Show the Member's ID when they see the dentist. The dentist needs the Member's ID to check eligibility and benefits.

How to Replace Your Card if Lost

If you lose your Member ID card, call Member Services toll-free at **1-855-691-6262** or call **1-800-735-2989** for the hearing impaired.

Who to Call in an Emergency

During normal business hours, call your child's Main Dentist to find out how to get emergency services. If your child needs emergency dental services after the Main Dentist's office has closed, do one of the following:

- If your child gets medical services through a Medicaid health plan, call that medical health plan.
- If your child does not have a Medicaid health plan, call **1-800-252-8263** or call **911**.

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Member Handbook for Texas Medicaid Dental Services

Dental Providers

What do I need to bring when I take my child to the dentist?

You must take their MCNA Member ID card. You will need to show the ID card each time you go to the dentist. If you have other dental coverage, also bring that information to show your dentist.

What is a Main Dentist?

A Main Dentist can be a general dentist or a dentist who only treats children. This is the dentist who gives your child services that prevent teeth problems. This dentist also can fix most teeth problems. Your child's Main Dentist also can send your child to a specialist for teeth problems that are harder to fix, if that kind of treatment is needed.

How can I find a Main Dentist?

A list of Main Dental Home Dentists (Main Dentists) in your area can be found in your MCNA Medicaid Provider Directory. You can choose any Main Dentist listed in the directory. This directory will also give you information about each Main dentist such as:

- Office location and office hours.
- The languages the office staff and dentist speak.
- If the dentist is accepting new patients.
- The ages the dentist treats.

If you need help finding a dentist, you may call our Member Services Hotline toll-free at **1-855-691-6262**. You can also go to your website at <http://www.mcnatx.net/find-dentist/> to find a dentist using our online Texas Medicaid Provider Directory. You can search for a dentist by:

- Dentist or office name
- Type of dentist (Specialty)
- Male or female dentist
- The language that the dentist or office speaks
- Dentists that are accepting new patients
- Office city
- Office zip code
- and more

You can get a printed copy of the Texas Medicaid Provider Directory by calling our Member Services Hotline toll-free at **1-855-691-6262**.

At what age can my child start seeing a Main Dentist?

Your child can start seeing a Main Dentist as early as 6 months of age.

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Attachment J1-17: Member Handbook: Texas Medicaid [6/38]

Member Handbook for Texas Medicaid Dental Services

Dental Providers

Can a clinic be my child's Main Dentist?
(Rural Health Clinic/Federally Qualified Health Center)

Yes. Only Rural Health Clinics/Federally Qualified Health Centers (RHC/FQHC) can be your child's Main Dentist. You cannot pick other clinics to be a Main Dentist for your child.

How can I change my child's Main Dentist?

You can change Main Dentists by calling us toll-free at 1-855-691-6262. Or you can write to:

MCNA Dental
4400 NW Loop 410, Suite 250
San Antonio, TX 78229

How many times can I change my child's Main Dentist?

You can change your child's Main Dentist as many times as you like. Look in your MCNA Medicaid Provider Directory to help you find a dentist or call our Member Services toll-free at 1-855-691-6262.

If I change my child's Main Dentist, when can we start getting services from that Provider?

You start getting services from your new Main Dentist the day following the change. Once the change has been made, call the dentist to schedule an appointment.

Is there any reason I might be denied if I ask to change my child's Main Dentist?

We might turn down your request for one of the reasons listed below:

- The Main Dentist you want to change to is not accepting new patients.
- The Main Dentist you want to change to does not provide the types of dental services your child needs.

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Member Handbook for Texas Medicaid Dental Services

Dental Providers

Can a Main Dentist ask to move my child to another Main Dentist?

Your child can be moved from one Main Dentist to another for one of the reasons listed below:

- If you or your child don't follow the dentist's advice.
- If you or your child are repeatedly loud or disruptive while in the dentist's waiting room or treatment area.
- If your relationship with your child's Main Dentist is not working for either you or the dentist.

What if I choose to take my child to another dentist who is not my child's Main Dentist?

Your Main Dentist will provide you with preventative care and will refer you to specialists as needed. You will need a referral from your Main Dentist to see another dentist.

What are out-of-network and in-network dentists?

In-network dentists have agreed to join MCNA's network of dentists to treat our members. Out-of-network dentists have not joined our network.

What if I choose to take my child to a dentist that is out of network?

You will have to pay for any out-of-network services not authorized by MCNA, except for emergency care.

What if I choose to take my child to a dentist that does not accept Medicaid?

You will have to pay for any dental services that are done by dentists that do not accept Medicaid.

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Attachment J1-17: Member Handbook: Texas Medicaid [7/38]

Member Handbook for Texas Medicaid Dental Services

Dental Providers

How do I get dental care for my child after the Main Dentist's office is closed?

If your child needs dental care after the office is closed and it is not an emergency, you can call your child's Main Dentist's office and leave a message with the answering service. The dentist's staff will call you back when the office reopens.

If your child needs emergency dental work after the office has closed, do one of the following:

- If your child gets medical services through a Medicaid medical health plan, call that medical health plan.
- If your child does not have a Medicaid medical health plan, call 1-800-252-8263 or call 911.

You can also call our 24 hour Dental Hotline toll-free at 1-855-688-6262 to speak with a dental hygienist to answer your questions about emergency care.

What if MCNA terminates (disenrolls) my child's Main Dentist?

We will send you a letter if your dentist is no longer part of our network and assign you to a new Main Dentist. If your child is getting care from the dentist for a dental condition, in some cases, we will allow your child to keep seeing the dentist for 90 days or until the care is done.

If you want to change the Main Dentist that we assigned to your child or you would like for your child to continue seeing their dentist, please call our Member Services toll-free at 1-855-691-6262.

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Member Handbook for Texas Medicaid Dental Services

Changing Dental Plans

What if I want to change my child's dental plan? How many times can I change my child's dental plan?

You can change your child's dental plan by contacting the Medicaid Enrollment Broker's toll-free telephone number at 1-800-964-2777. This is a free call.

There is no limit to the number of times you can change your child's dental plan, but you cannot change plans more than once a month.

If I change my child's dental plan, when will we be able to start using the new dental plan?

If you call to change your child's dental plan on or before the 15th of the month, the change will take place on the first day of the following month. If you call after the 15th of the month, the change will take place the first day of the second month after that. For example:

- If you call on or before April 15, your change will take place on May 1.
- If you call after April 15, your change will take place on June 1.

Can MCNA ask that my child get dropped from their dental plan?

A dental plan can ask that a child be removed from their plan for the following reasons:

- The child or the child's caregiver misuses the child's membership card or loans it to another person,
- The child or the child's caregiver is disruptive, unruly, or uncooperative at the dentist's office, or
- The child or the child's caregiver refuses to follow the dental plan's rules and restrictions.

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Attachment J1-17: Member Handbook: Texas Medicaid [8/38]

Member Handbook for Texas Medicaid Dental Services

Benefits

What are my child's dental benefits with Medicaid?

Below are your child's benefits. These services must be:

- Medically necessary.
- Carried out or handled by an MCNA dentist.

Office Visits

- Topical fluoride application
 - Limit 1 every 6 months
 - Limit age 6 months to 12 years
- Sealant per tooth
 - Limited to permanent 1st and 2nd molars and maxillary premolars only
 - Limit 1 every 3 years
- Cleaning/Prophylaxis
 - Limit 1 every 6 months
- Space maintainers

Oral Exams

- Comprehensive Oral Exam
 - Limit 1 every 3 years
- Regular Oral Exams
 - Limit 1 every 6 months
- Emergency Exams

X-Rays

- Intraoral periapical x-rays
 - Limit 1 service per day
- Intraoral periapical each additional film
- Complete set of x-rays (including bitewings)
 - Limit 1 every 3 years
- Panoramic x-rays
 - Limit 1 every 3 years
- Bitewings single film, two films, and 4 films
 - Limit 1 service per day

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Member Handbook for Texas Medicaid Dental Services

Benefits

Restorative Services (Fillings and Crowns)

- Amalgam restorations, primary or permanent (silver fillings)
- Composite/Resin restorations, anterior, posterior primary, and posterior permanent (white fillings)
- Prefabricated stainless steel crowns
- Gold Foil Restorations (Permanent Teeth Only) - Ages 13-20
- Inlay/Onlay Restorations (Permanent Teeth Only) - Ages 13-20
- Crown - Single Restorations - Ages 13-20

Oral Surgery (Extractions)

- Extractions, including surgical extractions
- Biopsies
- Surgical treatment of diseases, injuries, deformities and defects
- Incision and drainage of abscesses
- Surgical Preparation of Ridge for Dentures
- Oral and maxillofacial surgery services (treatment for conditions, defects, injuries, and cosmetic needs of the mouth, teeth, jaws and face)

Endodontic Services (Root Canals)

- Pulpotomy
- Root canal therapy on primary and permanent teeth
- Endodontic Retreatment
- Recalcification Procedure
- Apicoectomy

Periodontal Services (Treatment of the Gums)

- Gingival flap procedure
- Scaling and root planning
- Gingivectomy

Removable Prosthodontics (Dentures)

- Complete Dentures - Ages 3-20
- Immediate Dentures - Ages 13-20
- Partial Dentures - Upper and Lower Resin - Ages 6-20
- Partial Dentures - Upper and Lower cast metal - Ages 9-20
- Adjustment to Dentures - Ages 3-20
- Repairs, relines and adjustment of dentures

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Attachment J1-17: Member Handbook: Texas Medicaid [9/38]

Member Handbook for Texas Medicaid Dental Services

Benefits

Implant Services

- Surgical Implants
- Implant Supported Prosthetics

Prosthodontics Fixed Services

- Fixed Partial Dental Pontics - Ages 16-20
- Fixed Partial Dental Retaines - Inlays/Onlays
- Fixed Partial Dental Retaines - Crowns

Orthodontic Services (Braces)

- MCNA follows Medicaid's rules for braces. Braces for cosmetic reasons are not covered. Braces are only covered when the condition of the child's teeth or jaw affects the child's growth.

Analgesia and Behavior Management

- Limited to Members with specific physical, mental or patient management issues.

Sedation

- Intravenous administration of drugs
- Non-intravenous administration of drugs, limit 2 times every 12 months
- Injectable Medications
- The injection of medicine to treat illness or disease

Hospitalization

- Hospitalization is covered if the Member can't be safely treated in the dental office

Palliative Treatment

- Covered services necessary to relieve pain and discomfort on an emergency basis

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Member Handbook for Texas Medicaid Dental Services

Benefits

How do I get these services for my child?

Your Main Dentist can give or arrange for you to get the dental care that your child needs.

After choosing a Main Dentist:

- Call your Main Dentist to schedule an appointment.
- Tell the Dentist you are covered by Texas Medicaid.
- Make sure the Dentist is an MCNA Dental contracted dentist for the Texas Medicaid Dental Program.
- Visit your dentist regularly for checkups.
- Follow your dentist's instructions for brushing and flossing.

What services are not covered?

The following services are not covered under the plan:

- Services that are not medically necessary to the member's dental health
- Dental care for cosmetic reasons
- Experimental procedures
- Services which are eligible for reimbursement by insurance or covered under any other insurance or medical health plan
- Dental expenses related to any dental services:
 - Started after the member's coverage ended
 - Received before the member became eligible for these services
- Service that are not specifically listed as a covered benefit
- Malignancies
- Prescriptions or drugs

How much do I have to pay for my child's dental care?

You do not have to pay for Medicaid medically necessary covered services. You will have to pay for the following services:

- Non-covered or optional services you choose to have done.
- Services provided by a non-network dentist.
- Services your child receives before their dental coverage starts.

How do I get drugs the dentist has ordered for my child (prescriptions)?

Prescriptions are not covered under this program. You may want to contact your Medicaid medical health plan to see if they can help you by covering your prescriptions.

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Attachment J1-17: Member Handbook: Texas Medicaid [10/38]

Member Handbook for Texas Medicaid Dental Services

Benefits

Who do I call if I have problems getting drugs the dentist ordered for my child (prescriptions)?
 You may want to contact your Medicaid medical health plan to see if they can help you with getting your prescriptions.

What extra benefits do I have as an MCNA member?
 Value-added services are extra services MCNA offers. As a member of MCNA in addition to the standard Medicaid services, your child can also receive:

Bright Beginnings
 You must be eligible for special needs case management services from MCNA Dental or pregnant. You will receive a free dental kit that includes: toothbrush, toothpaste, floss, and oral health education materials.

Toll-free 24 Hour Dental Hotline
 MCNA offers a 24 hour toll-free hotline that can be reached at **1-855-688-6262**. Dental Hygienists will be available to answer your questions or concerns about oral health issues, treatments and emergency care.
 After normal business hours, our Dental Hygienist will respond to your voice or email messages within one hour.

Walmart Gift Card
 When you are enrolled with MCNA, each household of MCNA Dental Members will receive a \$10.00 Walmart Gift Card that can only be used to buy dental products such as toothpaste, toothbrushes, and mouthwash.
 This Gift Card is limited to one Gift Card per MCNA Dental Member household regardless of the number of Medicaid Members living in the house.
 The Walmart Gift Card cannot be used with other gift or discount cards, assigned, or transferred.

How do I get the extra benefits?
 Call our Member Services toll-free at **1-855-691-6262** for questions on how to get these services.

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Member Handbook for Texas Medicaid Dental Services

Dental Care and Other Services

What is routine dental care?
 Routine dental services include:

- Diagnostic and preventive visits.
- Therapeutic services such as fillings, crowns, root canals and/or extractions.

What is preventive care?
 Preventive care helps your child maintain good oral health. It prevents or reduces future problems with your child's teeth. Preventive care includes:

- Regular dental exams
- Routine cleanings
- Fluoridation or fluoride therapy
- Dental sealants
- X-rays
- Good home care
- Patient education

What are Dental Sealants?
 Sealants are plastic materials that are put on your child's back teeth (called "molars"). The tops of these teeth have little grooves. Food can get stuck in these grooves and a toothbrush can't always get it out. Sealants fill in these grooves and help keep out the food and germs that cause cavities. Either a dentist or hygienist may perform a dental sealant procedure.
 Ask your child's Main Dentist about dental sealants and if your child will benefit from them.

What is Fluoridation?
 Fluoride protects and keeps your child's teeth strong. It also reduces cavities and tooth sensitivity.

What does Medically Necessary mean?
 That's the standard for deciding whether Medicaid will cover a dental service for your child. For dental services or products provided, the test is whether a prudent dentist would provide the service or product to a patient to diagnose, prevent, or treat dental pain, infection, disease, dysfunction, or disfiguration in accordance with generally accepted procedures of the professional dental community.

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Attachment J1-17: Member Handbook: Texas Medicaid [11/38]

Member Handbook for Texas Medicaid Dental Services

Dental Care and Other Services

How often should my child see a dentist for routine check-ups? How soon can I expect my child to be seen?

Your child should see the dentist for a routine check-up every 6 months.

Members should be scheduled for appointments:

- Within 24 hours for emergency services.
- Within 14 days for therapeutic and diagnostic services.
- Within 30 days for routine services for preventive care.

What if my child needs routine dental care or emergency dental services when he or she is out of town or out of Texas?

If your child needs routine dental care when traveling, call us toll-free at 1-855-691-6262 and we will help you find a dentist.

If your child needs emergency dental services while traveling, go to a nearby hospital, then call your Medicaid medical health plan. If your child does not have a Medicaid medical health plan, call 1-800-252-8263 or call 911.

What if my child needs dental services when he or she is out of the country?

Dental services performed out of the country are not covered by Medicaid.

What do I have to do if I move?

As soon as you have your new address, call the Texas Health and Human Services Commission at 1-800-252-8263 to update your address.

Before you get Medicaid services in your new area, you must call MCNA, unless you need emergency services. You will continue to get care through MCNA until HHSC changes your address.

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Member Handbook for Texas Medicaid Dental Services

Dental Care and Other Services

What if I get a bill from my child's dentist?

Who do I call?

Your Dentist cannot bill you for covered and approved dental services. You do not have to pay bills that MCNA should pay for. Call Member Services for help at 1-855-691-6262.

What information will they need?

Please have your child's Member ID card and the bill you received from your dentist when you call. You will need to tell Member Services who sent you the bill, the date of service, the amount and the dentist's address and phone number.

What is a Second Opinion?

You can get a second opinion if you are unhappy with your child's dentist, or disagree with their opinion about the care for your child. You can get a second opinion from another MCNA dentist or non-network dentist for any reason including:

- You are not sure if the treatment is reasonable and necessary.
- Your child's dentist cannot diagnose the problem.
- You have questions about the work your dentist wants to do.
- You think that the suggested treatment may harm your child.
- The treatment your child is currently getting is not helping.

Call our Member Services toll-free at 1-855-691-6262 if you need help getting a second opinion for your child.

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Attachment J1-17: Member Handbook: Texas Medicaid [12/38]

Member Handbook for Texas Medicaid Dental Services

Emergency Dental Services

Does Medicaid cover for emergency dental services?

Medicaid covers limited emergency dental services for the following:

- Dislocated jaw
- Traumatic damage to teeth and supporting structures
- Removal of cysts
- Treatment of oral abscess of tooth or gum origin
- Treatment and devices for correction of craniofacial anomalies
- Drugs for any of the above conditions

Medicaid also covers dental services your child gets in a hospital. This includes services the doctor provides and other services your child might need, like anesthesia.

If your child is in a Medicaid medical health plan, the health plan will pay for these services. If your child is not in a Medicaid medical health plan, HHSC will pay for these services.

How do I get emergency dental care for my child and who do I call?

Call your child's Main Dentist to find out how your child can get emergency dental services. If the office is closed, do one of the following:

- If your child gets medical services through a Medicaid medical health plan, call that medical health plan.
- If your child does not have a Medicaid medical health plan, call 1-800-252-8263 or call 911.

How soon can I expect my child to be seen?

Your child should get emergency dental services no later than 24 hours after you call.

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Member Handbook for Texas Medicaid Dental Services

Texas Health Steps

What is Texas Health Steps?

Texas Health Steps is a special health care program for children covered by Medicaid. It is for children and teens age 0 to 20 years of age who have Medicaid. It is designed to keep children healthy.

What services are offered by Texas Health Steps?

- Regular medical and dental checkups
- Case management services
- Vaccines (immunizations) to prevent illness
- Eye checkups and glasses
- Hearing test and hearing aids
- Medicine
- Other health care services, if needed

How and when do I get Texas Health Steps dental checkups for my child?

To keep your child's teeth healthy, call your child's dentist to schedule a Texas Health Steps dental visit. Your child should start getting dental check-ups every 6 months starting at 6 months of age.

Does my child's dentist have to be part of the MCNA network?

Yes, your child's dentist must be an MCNA network dentist.

What if I need to cancel my child's dental visit?

Call your dentist office if you need to cancel a Texas Health Steps dental visit as soon as possible. Make sure you reschedule as soon as you can.

What if I am out of town and my child is due for a Texas Health Steps dental checkup?

If you are out of town when your child is due for a Texas Health Steps checkup, you can use any Texas Health Steps Dentist in Texas. If you need help or have questions, call our Member Services at 1-855-691-6262.

What if I am a Migrant Farmworker?

Tell your Main Dentist and the office staff will work with you to set up your child's checkup before you leave the area.

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Attachment J1-17: Member Handbook: Texas Medicaid [13/38]

Member Handbook for Texas Medicaid Dental Services

First Dental Homes

What is a First Dental Home?
 MCNA Medicaid Members can get dental checkups by an approved First Dental Home Dentist. They give care to children from 6-35 months of age. Your child will get dental services that will improve your child's teeth. Your child can see the dentist every 3 months if needed.

What is included in a First Dental Home visit?
 During your child's first dental home visit, the dentist will:

- Decide if your child will get tooth decay. The dentist will ask you questions and look at your child's teeth.
- Clean your child's teeth.
- Show you how to take care of your child's teeth.
- Put topical fluoride on your child's teeth.
- Give you educational handouts to take home for your child's age. They will tell you how to take care of your child's teeth while at home.
- Make your child's next visit before you leave the dentist office.

How Do I Find a First Dental Home Dentist?
 Look in your Medicaid Provider Directory and pick a First Dental Home Dentist for your child. Just look for under the Main Dentist's name.

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Member Handbook for Texas Medicaid Dental Services

Dental Specialists

What if my child needs to see a special dentist (specialist)?
 Your child's Main Dentist will give you a referral so your child can go to a specialist.

MCNA has dental specialists in all areas of Texas. If your child's Main Dentist thinks special care is needed, your child will be sent to an MCNA Specialist in your area.

How do I get specialty services approved?
 If the specialist thinks your child needs special care, the specialist will send MCNA a request (prior authorization) before you get the service. We will look at the request to make sure the services are medically necessary. We have rules to follow when we make decisions about dental services. This is called the Prior Authorization process. This process takes 3 days for regular requests and 1 day for emergency requests.

We will let your child's dentist know if we approve the request. The dentist will contact you to make an appointment. We will tell you and your child's dentist if we deny or limit the services the dentist asks for.

If you would like to check the status of the dentist's request, call our Member Services toll-free at **1-855-691-6262**.

How soon can I expect my child to be seen by a specialist?

- If the specialist is providing urgent care, your child will be seen no later than 24 hours from the time you ask for the referral from your Main Dentist.
- If the specialist is providing therapy or your child needs to see the specialist to get a diagnosis, your child will be seen no later than 14 days from the time you ask for the referral.
- If the specialist is providing services to prevent teeth problems, your child will be seen no later than 30 days from the time you ask for the referral.

What dental services do not need a referral?
 Any services done by your Main Dentist do not need a referral.

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Attachment J1-17: Member Handbook: Texas Medicaid [14/38]

Member Handbook for Texas Medicaid Dental Services

Dental Specialists

What if my child is getting treatment for a dental condition by a specialist when he or she is enrolled?

Your child may be getting treatment by a specialist for a dental condition that was approved by HHSC or your child's previous dental plan. To make sure your child's care does not stop, we will allow your child to keep seeing their specialist for medically necessary covered services:

- for 90 days after they become an MCNA member, or
- until your child sees their new MCNA dentist.

If your child has been diagnosed with a terminal illness, like cancer, we will allow your child to keep seeing their dentist for 9 months.

Call our Member Services toll-free at **1-855-691-6262** for help.

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Member Handbook for Texas Medicaid Dental Services

Interpreters

Can someone interpret for me when I talk with my child's dentist?

Yes. You may talk with your dentist in the language you prefer. Call Member Services toll-free at **1-855-691-6262** to arrange translation services for you.

Who do I call for an interpreter?

If you need a translator when you go to the dentist, call Member Services toll-free at **1-855-691-6262**.

How far ahead of time do I need to call?

In most cases, we need at least 48 hours notice. However, you should call us as soon as you have made an appointment with your dentist.

How can I get a face-to-face interpreter in the dentist's office?

We can provide an interpreter while you are at your dentist's office that will help you talk with your dentist face-to-face in the language you prefer. Call us toll-free at **1-855-691-6262** if you would like to have a translator with you in the dentist's office during your appointment. Tell us:

- The language that you speak, and
- The dentist's information

We will schedule an interpreter for your appointment and call you back to confirm that an interpreter has been scheduled. There are no charges for these services.

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Attachment J1-17: Member Handbook: Texas Medicaid [15/38]

Member Handbook for Texas Medicaid Dental Services

Transportation

If I do not have a ride, how can I get my child to the dentist's office?

Children with Medicaid and their caretakers can get free rides or gas money to help get to and from the doctor, dentist, hospital or drug store. This includes rides by bus, taxi, ride-sharing van, and airfare for trips out of town.

Who do I call for a ride to my child's dentist office?

Call **1-877-633-8747** (toll-free) to learn more or set up a ride.

How far ahead of time do I need to call?

Call the Medical Transportation Program (MTP) toll-free at **1-877-633-8747** at least 2 work days or more before you need a ride. If you will need to travel a long way or out of town to see your dentist, call at least 5 work days before you need a ride. If you need a ride the same day you call, they will do everything they can to help.

Can someone I know give me a ride to my child's dentist and get money for mileage?

Yes, but before they can get paid, they will have to fill out a form and show that they have:

- Current driver's license
- Inspection sticker
- License tags
- Liability insurance

The form is called an "Individual Driver Registration Form". Call the Medical Transportation Program (MTP) at **1-877-633-8747** to get a form or ask any questions.

Who do I call if I have a complaint about the service or staff?

If you have a complaint or comment about the service you got from the transportation staff, you can write or call MTP Monday to Friday from 8 a.m. to 5 p.m. at **1-877-633-8747**.

What are the hours of operation and limits for transportation services?

For more information on transportation services, call MTP Monday to Friday from 8 a.m. to 5 p.m. at **1-877-633-8747**.

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Member Handbook for Texas Medicaid Dental Services

Transportation

Medical Transportation Program

Call Center (Scheduling): 1-877-633-8747
Central Office Phone Number: 1-512-706-4900
Document Fax: 1-210-646-3257

Full Risk Broker: LogistiCare, Inc.

Counties Served: Collin, Dallas, Denton, Ellis, Hood, Hunt, Johnson, Kaufman, Navarro, Parker, Rockwall, Tarrant, Wise

Ride Setup, Reservations: 1-855-687-3255 (8 a.m. to 5 p.m.)
 1-877-564-9832

Ride Assist, Complaints: 1-877-564-9834 (24/7)
TTY: 1-866-288-3133 (24/7)

Full Risk Broker: Medical Transportation Management, Inc. (MTM)

Counties Served: Austin, Brazoria, Chambers, Fort Bend, Galveston, Hardin, Harris, Jasper, Jefferson, Liberty, Matagorda, Montgomery, Newton, Orange, Polk, San Jacinto, Tyler, Walker, Waller, Wharton

Reservations, Ride No Show: 1-855-687-4786 (7 a.m. to 6 p.m.)
Hospital Discharges: 1-888-513-0706 (24/7)
Complaints: 1-866-436-0437 (8 a.m. to 5 p.m.)

National TTY Relay Service:

All Users: 7-1-1
TTY Users: 1-800-855-2880
Voice Users: 1-800-855-2881

Spanish TTY Relay Service:

TTY Spanish: 1-800-855-2884
Voice Spanish: 1-800-855-2885

Speech-to-Speech (STS) Language Link Service:

English STS: 1-800-229-5746
Spanish STS: 1-866-260-9470

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Attachment J1-17: Member Handbook: Texas Medicaid [16/38]

Member Handbook for Texas Medicaid Dental Services

Member Rights and Responsibilities

Member Rights

- You have the right to get accurate, easy-to-understand information to help you make good choices about you or your child's dentists and other Providers.
- You have the right to know how your child's dentists are paid. You have a right to know about what those payments are and how they work.
- You have the right to know how MCNA decides about whether a service is covered and/ or medically necessary. You have the right to know about the people in MCNA's office who decide those things.
- You have the right to know the names of the dentists and other Providers enrolled with MCNA and their addresses.
- You have the right to pick from a list of dentists that is large enough so that your child can get the right kind of care when your child needs it.
- You have the right to take part in all the choices about your child's dental care.
- You have the right to speak for your child in all treatment choices.
- You have the right to get a second opinion from another dentist enrolled with MCNA about what kind of treatment your child needs.
- You have the right to be treated fairly by MCNA, dentists and other Providers.
- You have the right to talk to your child's dentists and other Providers in private, and to have your child's dental records kept private. You have the right to look over and copy your child's dental records and to ask for changes to those records.
- You have a right to know that dentists, hospitals, and others who care for your child can advise you about your child's health status, medical care, and treatment. Your child's dental plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
- You have a right to know that you are not responsible for paying for covered services for your child. Dentists, hospitals, and others cannot require you to pay any other amounts for covered services.

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Member Handbook for Texas Medicaid Dental Services

Member Rights and Responsibilities

Member Responsibilities

You and MCNA both have an interest in seeing your child's dental health improve. You can help by assuming these responsibilities.

- You and your child must try to follow healthy habits, such as encouraging your child to exercise, to stay away from tobacco, and to eat a healthy diet.
- You must become involved in the dentist's decisions about you and your child's treatments.
- You must work together with MCNA's dentists and other Providers to pick treatments for your child that you have all agreed upon.
- If you have a disagreement with MCNA you must try first to resolve it using MCNA's complaint process.
- You must learn about what MCNA does and does not cover. You must read your Member Handbook to understand how the rules work.
- If you make an appointment for your child, you must try to get to the dentist's office on time. If you cannot keep the appointment, be sure to call and cancel it.
- You must report misuse by dental and health care Providers, other Members, MCNA, or other dental or medical health plans.

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services (HHS) toll-free at **1-800-368-1019**. You also can view information concerning the HHS Office of Civil Rights online at www.hhs.gov/ocr.

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Attachment J1-17: Member Handbook: Texas Medicaid [17/38]

Member Handbook for Texas Medicaid Dental Services

Complaint Process

What should I do if I have a complaint? Who do I call? Can someone from MCNA help me file a complaint?

If you need help with a problem, we want to help. If you have a complaint, please call us toll-free at **1-855-691-6262** to tell us about your problem. An MCNA Member Advocate can help you file a complaint. Most of the time, we can help you right away or within a few days at the most. You can also file a complaint online at www.mcna.net.

Can someone else file a complaint for me?

You, your dentist, your legal counsel or someone you name to act for your child may file a complaint with MCNA. We will send you a one-page form that you must sign and return to us. This form will tell us that you give permission to the person you name to represent you and your child during the complaint process. You can also get information and complaint forms on our website at www.mcna.net.

What do I need to do to file a complaint? How long will the process take?

Call or write our Member Services toll-free at **1-855-691-6262** to file a complaint. We will look at your complaint and send you a letter with an answer within 30 days from the day we get your complaint. If you want to make your complaint in writing, please send it to:

MCNA Dental
 Attention: Medicaid Complaint
 4400 NW Loop 410, Suite 250
 San Antonio, TX 78229

If I don't like what happens with my complaint, who else can I call?

If you are not happy with our answer to your complaint, you can call the Texas Health and Human Services Commission (HHSC) at **1-800-252-8263** (toll-free).

How can I file a complaint with the HHSC after I have gone through the MCNA complaint process?

If you still have a complaint after you've gone through MCNA's complaint process, call the Texas Health and Human Services Commission (HHSC) at **1-800-252-8263** (toll-free). If you want to make your complaint in writing, please send it to the following address:

Texas Health and Human Services Commission
 Health Plan Operations - H-320
 P.O. Box 85200, Austin, TX 78708-5200
 Attention: Resolution Services

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Member Handbook for Texas Medicaid Dental Services

Appeal Process

What can I do if MCNA denies or limits a service for my child that the dentist has asked for?

If you are not happy with MCNA's decision to deny or limit services requested by your dentist, you can call Member Services toll-free at **1-855-691-6262** and ask for an appeal. You or your child's dentist can send us more information to show why you do not agree with our decision.

How will I find out if services for my child are denied?

MCNA will send you and your child's dentist a letter (notice of action) letting you know if a covered service requested by your dentist is denied or limited and the reason why we denied it. The letter will also tell you how to file an appeal and your right to ask for a State Fair Hearing with HHSC.

What are the timeframes for the appeal process?

After we receive your appeal in writing, we will send you a letter within 5 business days letting you know we got your request. We will look at your appeal and send you a letter with our answer within 30 days from the day we get your appeal.

MCNA has the option to extend up to 14 calendar days if you ask for an extension or we show that there is a need for more information and the delay is in your best interest. If MCNA needs to extend, you will receive written notice of the reason for delay.

Before and during the appeal, you or your representative have the right to look at your case file. You can also look at your dental records and any other documents related to the appeal. Call an MCNA Medicaid Member Advocate toll-free at **1-855-691-6262** if you would like to look at your file.

When can I ask for an appeal?

If you are not happy with our decision to deny or limit requested services, call Member Services at **1-855-691-6262** within 30 days from when you get our denial letter.

You have the option to request an appeal for denial of payment for services in whole or in part. In order to make sure you continue to receive current authorized services, you must file the appeal on or before the later of 10 days following MCNA's mailing of the notice of the action or the intended effective date of the proposed action.

You may have to pay for the continued services if the final decision is that MCNA does not have to cover them.

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Attachment J1-17: Member Handbook: Texas Medicaid [18/38]

Member Handbook for Texas Medicaid Dental Services

Appeal Process

Can I just ask for an appeal or does it have to be in writing?
Every time someone asks for an appeal, that request must be written and signed by the person getting the Medicaid coverage or his or her representative, unless the person asks for an Expedited Appeal, which can be spoken or written.

Can someone from MCNA help me file an appeal?
Yes, an MCNA Member Advocate can help you file an appeal. Please call Member Services toll-free at 1-855-691-6262 for help. Tell us that you want to file an appeal. You can also get information and appeal forms on our website at www.mcna.net.

Can someone else file an appeal for my child?
You, your dentist, your legal counsel or someone you name to act for you or your child may file an appeal with MCNA. We will send you a one-page form that you must sign and return to us stating that you give permission to the person you name to represent you and your child during the appeal process.

What else can I do if I'm still not happy?
You can request a State Fair Hearing anytime during or after MCNA's appeals process. Please see the State Fair Hearing section of this handbook for more information.

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Member Handbook for Texas Medicaid Dental Services

Expedited Appeals

What is an Expedited Appeal?
Ask for an Expedited Appeal when you don't have time to wait for a standard appeal - when your child's life or health is in danger. When you ask for an expedited appeal, MCNA has to make a decision quickly based on the condition of your child's health.

How do I ask for an expedited appeal?
The expedited appeal can be made either spoken or in writing. Call Member Services toll-free at 1-855-691-6262 for help. You or your child's dentist can send us more information to show why you do not agree with our decision.

How long does an expedited appeal take?
If you have an expedited appeal, we will call you and your dentist with our decision within 3 business days from when we get your appeal. We will also send you a letter telling you our decision. The letter will also tell you that you can ask for an expedited State Fair Hearing with HHSC.

What happens if MCNA says it won't do an expedited appeal?
If MCNA decides not to expedite your appeal, the appeal will be processed through the normal appeal process, which will be resolved within 30 days.

Who can help me file an expedited appeal?
Please call MCNA Member Services toll-free at 1-855-691-6262. A Member Advocate will help you file an expedited appeal. Tell us that you want to file an expedited appeal. You can also get information and appeal forms on our website www.mcna.net.

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Attachment J1-17: Member Handbook: Texas Medicaid [19/38]

Member Handbook for Texas Medicaid Dental Services

State Fair Hearing

Can I ask for a State Fair Hearing?

If you, as a caretaker of the Member of MCNA, disagree with MCNA's decision, you have the right to ask for a fair hearing. You may name someone to represent you by writing a letter to MCNA telling us the name of the person you want to represent you. A doctor or other medical Provider may be your representative. If you want to challenge a decision made by MCNA, you or your representative must ask for the fair hearing within 90 days of the date on MCNA's letter with the decision. If you do not ask for the fair hearing within 90 days, you may lose your right to a fair hearing. To ask for a fair hearing, you or your representative should either send a letter to:

MCNA Dental
 Attention: Medicaid Appeals
 4400 NW Loop 410, Suite 250
 San Antonio, TX 78229

Or call toll-free **1-855-691-6262**.

If you ask for a fair hearing within 10 days from the time you get the hearing notice from MCNA, your child has the right to keep getting any service MCNA denied or reduced at least until the final hearing decision is made. If you do not request a fair hearing within 10 days from the time you get the hearing notice, the service MCNA denied will be stopped.

If you ask for a fair hearing, you will get a packet of information letting you know the date, time and location of the hearing. Most fair hearings are held by telephone. At that time, you or your representative can tell why you need the service MCNA denied.

HHSC will give you a final decision within 90 days from the date you asked for the hearing.

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Member Handbook for Texas Medicaid Dental Services

Reporting Fraud and Abuse

Do you want to report Waste, Abuse, or Fraud?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health-care Provider, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse, or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for Medicaid services that weren't given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use a Medicaid Dental ID.
- Using someone else's Medicaid Dental ID.
- Not telling the truth about the amount of money or resources he or she has to get benefits.

To report waste, abuse, or fraud, choose one of the following:

- Call the OIG Hotline at **1-800-436-6184** or
- Visit <https://oig.hhsc.state.tx.us/>. Under the box labeled "I WANT TO," click "Report Fraud, Waste, or Abuse" to complete the online form.
- You can report directly to MCNA:
MCNA Dental - Attention: Special Investigations Unit
 4400 NW Loop 410, Suite 250, San Antonio, TX 78229
 MCNA's toll-free Fraud Hotline: **1-855-392-6262**

How do I report a dentist I think is misusing or cheating the system?

To report waste, abuse or fraud, gather as much information as possible.

When reporting about a Provider (a doctor, dentist, counselor, etc.) include:

- Name, address, and phone number of Provider.
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the Provider and facility, if you have it.
- Type of Provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation.
- Dates of events.
- Summary of what happened.

When reporting about someone who gets benefits, include:

- The person's name.
- The person's date of birth, Social Security number, or case number if you have it.
- The city where the person lives.
- Specific details about the waste, abuse or fraud.

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Attachment J1-17: Member Handbook: Texas Medicaid [20/38]

Manual del miembro para los servicios dentales de Medicaid en Texas

Bienvenido a MCNA

Bienvenido a MCNA Dental. Nos enorgullece ser proveedores del Programa de servicios dentales de Medicaid en Texas. Su hijo ha sido inscrito en MCNA. Nos complace ser los proveedores del plan dental de su hijo. Contamos con una red de dentistas generales y especializados para tratar a su hijo. Cualquiera de nuestros dentistas puede servir de dentista principal de su hijo.

Este manual contiene la información que necesita para que su hijo reciba estos servicios dentales. Léalo para comprender el plan dental de su hijo. El Manual del miembro está disponible en grabación de audio, imprenta grande y otros idiomas. Comuníquese con Servicio a Miembros al número gratuito **1-855-691-6262** o envíenos un correo electrónico a **info@mcna.net** si desea otra copia del Manual del miembro. Si es sordo o tiene impedimentos auditivos, comuníquese con Servicio de Intermediación de Sprint al número gratuito **1-800-735-2989** para obtener ayuda.

Comuníquese con el número gratuito de Servicio a Miembros para obtener ayuda en la elección del dentista principal de su hijo para controles dentales periódicos. Después de elegir el dentista principal de su hijo, comuníquese con el consultorio para fijar su primera consulta dentro de 60 días de haberse registrado con MCNA Dental. Esto contribuirá a la creación de buenos hábitos dentales.

Si por cualquier motivo desea cambiar el dentista principal de su hijo, comuníquese con nuestro Departamento de Servicio a Miembros al número gratuito **1-855-691-6262** o por correo electrónico a **info@mcna.net**.

La buena salud dental es importante para nosotros. Esperamos que su hijo aproveche los beneficios dentales que ofrece MCNA. ¡Esperamos poder atenderlo!

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Manual del miembro para los servicios dentales de Medicaid en Texas

Servicio a Miembros de MCNA

La línea directa de Servicio a Miembros está disponible en el horario normal de atención de lunes a viernes, de 8:00 a. m. a 7:00 p. m., hora central (excepto en feriados nacionales). MCNA cuenta con personal que habla inglés, español y lengua criolla o "creole". También podemos ayudarlo con otros idiomas. Puede comunicarse con la línea directa de Servicio a Miembros al número gratuito **1-855-691-6262** para hablar con un representante de Servicio a Miembros. Si es sordo o tiene dificultades de audición, llame al Servicio de Intermediación de Sprint al número gratuito **1-800-735-2989**. Si llama después de nuestro horario de atención regular, puede dejar un mensaje en nuestro buzón de correo de voz seguro. Le devolveremos la llamada el próximo día hábil.

Cuando hable con nuestro Servicio a Miembros, el personal podrá responderle cualquier pregunta que pueda tener y brindarle información sobre:

- Servicios cubiertos y limitaciones
- Emergencias
- Cómo elegir un dentista
- Cómo cambiarse a otro dentista
- Cómo solicitar citas
- Cómo obtener un intérprete
- Servicios de transporte

También puede brindarle información a fin de que aprenda sobre:

- La forma correcta de cepillarse los dientes y usar hilo dental.
- Por qué es importante consultar al dentista.
- Con qué frecuencia debe consultar al dentista.
- Alimentación saludable.
- Ferias de salud y clases de educación.

MCNA tiene Representantes de miembros de Medicaid que lo ayudarán a presentar quejas y apelaciones. Además, lo ayudarán durante el proceso de quejas y apelaciones. Los Representantes de miembros pueden informarle cómo obtener servicios cubiertos y no cubiertos. Puede hablar con un Representante de miembros si llama a la línea directa de Servicio a Miembros.

Si usted llame después de horas hábiles o durante el fin de semana será conectado con un servicio de contestación automática o un mensaje grabado que le dará el horario de negocio y lo que debe hacer si tiene una emergencia. Si no tiene una emergencia, llame al Dentista Principal durante horas hábiles.

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Recursos importantes	
Servicio a Miembros de MCNA	
Horario de atención:	De lunes a viernes De 8:00 a. m. a 7:00 p. m., hora central. <i>Excepto en feriados nacionales.</i>
Número telefónico gratuito:	1-855-691-6262
Personas con Dificultades de Audición (TTY):	1-800-735-2989
Línea de ayuda dental de MCNA:	1-855-688-6262
Línea directa de fraude de MCNA:	1-855-392-6262
Sitio web:	www.MCNA.net
Domicilio postal:	4400 NW Loop 410, Suite 250 San Antonio, Texas 78229
Comisión de Servicios de Salud y Humanos de Texas (HHSC)	
Número telefónico gratuito:	1-800-252-8263
Personas con Dificultades de Audición (TTY):	1-800-735-2989
Línea directa de atención administrada de Medicaid:	1-866-566-8989 1-866-222-4306 (TTY)
Sitio web:	www.hhsc.state.tx.us
Oficina del Inspector General (OIG)	
Número gratuito de Línea directa de fraude:	1-800-436-6184
Otros números útiles	
Programa de transporte de Medicaid:	1-877-633-8747
Cómo encontrar servicios en su área: (Transporte, ayuda financiera, etc.)	2-1-1
Para servicios de emergencia:	9-1-1
Servicio de Intermediación de Texas: (Llame si ha perdido la audición o si tiene dificultades para escuchar)	7-1-1
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Manual del miembro para los servicios dentales de Medicaid en Texas

Elegibilidad e inscripción

La Comisión de Servicios de Salud y Humanos (Health and Human Services Commission, HHSC) de Texas le brindará información sobre:

- Elegibilidad
- Inscripción
- Anulación de la inscripción
- Otros programas estatales
- Ley Federal de Portabilidad y Responsabilidad de Seguros de Salud de 1996 (HIPAA)

¿Puede anularse la inscripción de mi hijo al Programa Medicaid?

La anulación de la inscripción al programa Medicaid puede ocurrir si su hijo pierde la elegibilidad para Medicaid. Su hijo puede perder la elegibilidad para Medicaid por uno de los siguientes motivos:

- Si usted no volvió a inscribirse al finalizar el periodo de cobertura de 12 meses.
- Si su hijo fallece.
- Si su hijo se muda de forma permanente del Estado.
- Si cambió el estado del seguro de salud, como la inscripción de su hijo a un plan de salud patrocinado por el empleador.
- Si el padre del niño o el representante autorizado solicita (por escrito) la anulación voluntaria de la inscripción de un niño.

Si tiene preguntas acerca de los beneficios de Medicaid de su hijo, llame a atención administrada de Medicaid de la Comisión de Servicios de Salud y Humanos (Health and Human Services Commission, HHSC) línea de ayuda. Puede llamar al número gratuito **1-866-566-8989**. Si tiene dificultades de audición, llame al **1-866-222-4306**.

La línea de ayuda de atención administrada de Medicaid de la HHSC también lo ayudará a:

- Encontrar el camino en el laberinto del sistema de atención administrada.
- Comprender los derechos de su hijo.
- Defender los derechos de su hijo.
- Resolver problemas, incluido el acceso a la atención.

¿Qué sucede si ya no es elegible para Medicaid?

Se anulará su inscripción a MCNA si ya no es elegible para Medicaid. Si pierde la elegibilidad para Medicaid, pero vuelve a ser elegible dentro de los seis (6) meses o menos, se lo reinscribirá en el mismo plan dental que estaba inscrito antes de perder su elegibilidad para Medicaid. Se lo reinscribirá con el mismo dentista principal que tenía antes. Si ya no es elegible para Medicaid según los ingresos, es posible que su hijo sea elegible para el Programa de Seguro de Salud para Niños (Children's Health Insurance Program, CHIP). Para obtener más información, llame a CHIP al número gratuito **1-800-647-6558**.

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Manual del miembro para los servicios dentales de Medicaid en Texas

Tarjetas de identificación de miembro

Dentro del sobre encontrará la tarjeta de identificación de su hijo. Sáquela y lívela siempre con usted. Recuerde llevar la tarjeta de identificación a todas las citas dentales de su hijo. Comuníquese con MCNA al número gratuito **1-855-691-6262** para solicitar una nueva tarjeta de identificación, en caso de que la extravíe o que alguna información sea errónea.

FRENTE

For Member Services Call Toll-Free: 1-855-691-6262

Para información a los miembros e instrucciones en Español, por favor llame al 1-855-691-6262

Véase la sección de sobre MCNA del

¿QUÉ ES UN MIEMBRO?	¿CÓMO SE HA CLASIFICADO?
El miembro es una persona que se inscribe en el programa de Medicaid de Texas para recibir servicios dentales. El miembro debe cumplir con los requisitos de elegibilidad para Medicaid de Texas.	El miembro puede clasificarse como un miembro de Medicaid de Texas de varias maneras. El miembro puede clasificarse como un miembro de Medicaid de Texas si es un niño de un hogar con ingresos bajos, un adulto con ingresos bajos, un adulto con discapacidad o un adulto con una enfermedad crónica.
¿CÓMO SE HA CLASIFICADO?	¿CÓMO SE HA CLASIFICADO?
El miembro puede clasificarse como un miembro de Medicaid de Texas si es un niño de un hogar con ingresos bajos, un adulto con ingresos bajos, un adulto con discapacidad o un adulto con una enfermedad crónica.	El miembro puede clasificarse como un miembro de Medicaid de Texas si es un niño de un hogar con ingresos bajos, un adulto con ingresos bajos, un adulto con discapacidad o un adulto con una enfermedad crónica.

DORSO

Esta tarjeta tiene información importante acerca de sus beneficios dentales:

- Solo el miembro puede utilizar su tarjeta de identificación de miembro para recibir servicios dentales.
- Nadie más puede utilizar la tarjeta de identificación de miembro para recibir servicios. Si lo hace, esa persona deberá pagar los servicios que reciba.
- Es posible que MCNA no pueda mantenerlo inscrito en el plan si otra persona utiliza su tarjeta de identificación de miembro.

Cómo leer su tarjeta de identificación

A continuación se describe cómo leer su tarjeta de identificación de miembro:

- Member Name:** el nombre del miembro
- Member ID:** el número de identificación de miembro de los servicios dentales de Medicaid en Texas
- Effective Date:** la fecha en la que comenzó la cobertura del miembro en los servicios dentales de Medicaid en Texas
- Plan:** muestra que el miembro está inscrito en los servicios dentales de Medicaid en Texas
- Main Dentist:** el nombre del dentista principal del miembro
- Main Dentist Phone:** el número de teléfono para comunicarse con el dentista principal del miembro
- Main Dentist Office:** el nombre del consultorio en el que trabaja el dentista principal del miembro
- Main Dentist Address:** la dirección del consultorio en el que trabaja el dentista principal del miembro

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Manual del miembro para los servicios dentales de Medicaid en Texas

Tarjetas de identificación de miembro

Cómo utilizar su tarjeta de identificación

Para utilizar su tarjeta:

- Tenga a mano la tarjeta de identificación de miembro cuando llame a Servicio a Miembros.
- Lleve la tarjeta de identificación de miembro cuando vaya al dentista.
- Muestre la tarjeta de identificación de miembro cuando consulte a la dentista. El dentista necesita la tarjeta de identificación de miembro para ver los elegibilidad y beneficios.

Cómo reemplazar su tarjeta si la pierde

Si pierde su tarjeta de identificación de miembro, comuníquese con Servicio a Miembros al número gratuito 1-855-691-6262 o llame al 1-800-735-2989 si tiene dificultades de la audición.

A quién llamar en caso de una emergencia

En el horario normal de atención, llame al dentista principal de su hijo para averiguar cómo recibir servicios de emergencia. Si su hijo necesita servicios dentales de emergencia después del horario de atención del consultorio del dentista principal, siga uno de los pasos que se describen a continuación:

- Si su hijo recibe servicios médicos a través del plan de salud de Medicaid, comuníquese con el plan médico de salud.
- Si su hijo no tiene un plan de salud de Medicaid, llame al 1-800-252-8263 o al 911.

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Manual del miembro para los servicios dentales de Medicaid en Texas

Proveedores dentales

¿Qué debo llevar cuando lleve a mi hijo al dentista?

Debe llevar la tarjeta de identificación de miembro de MCNA de su hijo. Deberá mostrar la tarjeta de identificación cada vez que vaya al dentista. Si tiene otra cobertura dental, también lleve esa información para mostrársela a su dentista.

¿Qué es un dentista principal?

Un dentista principal puede ser un dentista general o uno especializado en la atención de niños únicamente. Este es el dentista que presta servicios que previenen problemas dentales a su hijo. Además, este dentista puede solucionar la mayoría de problemas dentales. Es posible que el dentista principal de su hijo lo remita a un especialista en caso de problemas dentales más difíciles de solucionar, si ese tipo de tratamiento es necesario.

¿Cómo puedo encontrar un dentista principal?

Puede encontrar una lista de dentistas principales en su área en su Directorio de proveedores de Medicaid de MCNA. Puede elegir cualquier dentista principal que aparece en el directorio. Este directorio también le brindará información sobre cada dentista principal, como:

- La ubicación del consultorio y el horario de atención
- Los idiomas que hablan el personal del consultorio y el dentista
- Si el dentista acepta pacientes nuevos
- Las edades que trata el dentista

Si necesita ayuda para encontrar un dentista, puede llamar a la línea directa de Servicio a Miembros al número gratuito 1-855-691-6262. También puede visitar nuestro sitio web en <http://www.mcnatx.net/encontrar-dentista/> para encontrar un dentista si usa nuestro Directorio de proveedores de Medicaid en Texas en Internet. Puede buscar un dentista por:

- Nombre del dentista o del consultorio
- Tipo de dentista (especialidad)
- Dentistas de sexo femenino o masculino
- El idioma que habla el dentista o el personal del consultorio
- Dentistas que aceptan pacientes nuevos
- Ciudad del consultorio
- Código postal del consultorio
- ¡y mucho más!

Puede obtener una copia impresa del Directorio de Proveedores Medicaid en Texas si se comunica con nuestro Servicio a Miembros al número gratuito 1-855-691-6262.

¿A qué edad puede mi hijo comenzar a consultar a un dentista principal?

Los niños disponen de atención dental con un dentista principal desde los 6 meses de edad.

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Manual del miembro para los servicios dentales de Medicaid en Texas

Proveedores dentales

¿Puede una clínica ser el dentista principal de mi hijo?
(Centro de salud rural/Centro de salud aprobado por el gobierno federal)

Si. Solo los Centros de salud rural (Rural Health Clinics, RHC)/Centros de salud aprobados por el gobierno federal (Federally Qualified Health Centers, FQHC) pueden ser el dentista principal de su hijo. Usted no puede elegir que otras clínicas sean el dentista principal de su hijo.

¿Cómo puedo cambiar el dentista principal de mi hijo?

Puede cambiar el dentista principal de su hijo si llama a nuestro número gratuito 1-855-691-6262. O puede escribir a:

MCNA Dental
4400 NW Loop 410, Suite 250
San Antonio, TX 78229

¿Cuántas veces puedo cambiar el dentista principal de mi hijo?

Puede cambiar el dentista principal de su hijo las veces que quiera. Consulte su Directorio de proveedores de Medicaid de MCNA para encontrar a un dentista o llame a nuestro Servicio a Miembros al número gratuito 1-855-691-6262.

Si cambio el dentista principal de mi hijo, ¿cuándo puedo comenzar a recibir servicios de ese proveedor?

Comienza a recibir los servicios del nuevo dentista principal el día posterior al cambio. Una vez que se realizó el cambio, llame al dentista para fijar una cita.

¿Existe algún motivo por el cual se pueda denegar mi solicitud de cambiar el dentista principal de mi hijo?

Es posible que rechacemos su pedido por uno de los motivos que aparecen a continuación:

- El dentista principal al cual desea cambiarse no acepta pacientes nuevos.
- El dentista principal al cual desea cambiarse no presta los tipos de servicios que necesita su hijo.

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Manual del miembro para los servicios dentales de Medicaid en Texas

Proveedores dentales

¿Puede un dentista principal solicitar remitir a mi hijo a otro dentista principal?

Su hijo puede ser remitido de un dentista principal a otro por uno de los motivos que aparecen a continuación:

- Si usted o su hijo no siguen las indicaciones del dentista.
- Si usted o su hijo hacen ruido o se comportan de manera perjudicial reiteradamente mientras está en la sala de espera o el área de tratamiento del dentista.
- Si su relación con el dentista principal de su hijo no funciona para usted o para el dentista.

¿Qué sucede si decido llevar a mi hijo a otro dentista que no sea su dentista principal?

Su dentista principal le proporcionará atención preventiva y lo remitirá a un especialista de ser necesario. Necesitará una remisión de su dentista principal para consultar a otro dentista.

¿Qué son los dentistas fuera de la red y dentro de la red?

Los dentistas dentro de la red han acordado unirse a la red de dentistas de MCNA para tratar a nuestros miembros. Los dentistas fuera de la red no se han unido a nuestra red.

¿Qué sucede si decido llevar a mi hijo a un dentista fuera de la red?

Deberá pagar cualquier servicio fuera de la red no autorizado por MCNA, salvo en caso de atención de emergencia.

¿Qué sucede si decido llevar a mi hijo a un dentista que no acepte Medicaid?

Deberá pagar cualquier servicio dental prestado por dentistas que no acepten Medicaid.

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Attachment J1-17: Member Handbook: Texas Medicaid [25/38]

Manual del miembro para los servicios dentales de Medicaid en Texas

Proveedores dentales

¿Cómo obtengo atención dental para mi hijo después del horario de atención del consultorio de mi dentista principal?

Si su hijo necesita atención dental después del horario de atención del consultorio y no es una emergencia, puede llamar al consultorio del dentista principal de su hijo y dejar un mensaje en el servicio de contestador de llamadas. El personal del dentista le devolverá la llamada cuando abra el consultorio.

Si su hijo necesita trabajos dentales de emergencia después del horario de atención del consultorio, siga uno de los pasos que se describen a continuación:

- Si su hijo recibe servicios médicos a través del plan médico de salud de Medicaid, comuníquese con el plan médico de salud.
- Si su hijo no tiene un plan médico de salud de Medicaid, llame al 1-800-252-6263 o al 911.

También puede llamar a nuestra línea directa dental las 24 horas al número gratuito 1-855-688-6262 para hablar con un higienista dental que responderá sus preguntas sobre atención de emergencia.

¿Qué sucede si MCNA finaliza el contrato (anula la inscripción) del dentista principal de mi hijo?

Le enviaremos una carta si su dentista ya no forma parte de nuestra red y le asignaremos un nuevo dentista principal. Si su hijo recibe atención del dentista por una condición dental, en algunos casos, permitiremos que su hijo siga consultando al dentista por 90 días o hasta que se haya terminado la atención.

Si desea cambiar el dentista principal que le asignamos a su hijo o desea que su hijo siga consultando a su dentista, comuníquese con nuestro Servicio a Miembros al número gratuito 1-855-691-6262.

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Manual del miembro para los servicios dentales de Medicaid en Texas

Cómo cambiar su plan dental

¿Qué sucede si deseo cambiar el plan dental de mi hijo? ¿Cuántas veces puedo cambiar el plan dental de mi hijo?

Puede cambiar el plan dental de su hijo si se comunica con el número telefónico gratuito del agente de inscripción de Medicaid al 1-800-964-2777. Esta llamada es gratuita.

No hay límite al número de veces que puede cambiar el plan dental de su hijo, pero no puede cambiar de plan más de una vez al mes.

Si cambio el plan dental de mi hijo, ¿cuándo podré comenzar a utilizar el nuevo plan dental?

Si llama para cambiar el plan dental de su hijo el día 15 del mes o antes, el cambio se llevará a cabo el primer día del siguiente mes. Si llama después del día 15 del mes, el cambio se llevará a cabo el primer día del segundo mes posterior a la solicitud. Por ejemplo:

- Si llama el 15 de abril o antes, su cambio se llevará a cabo el 1 de mayo.
- Si llama después del 15 de abril, su cambio se realizará el 1 de junio.

¿Puede MCNA solicitar que den de baja a mi hijo de su plan dental?

Un plan dental puede solicitar que se destituya a un niño de su plan por los siguientes motivos:

- El niño o el cuidador del niño utilizan indebidamente la tarjeta de miembro del niño o se la prestan a otra persona,
- El niño o el cuidador del niño se comportan de manera perjudicial, indisciplinada o poco cooperativa, o
- El niño o el cuidador del niño se niegan a seguir las reglamentaciones y restricciones del plan dental.

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Attachment J1-17: Member Handbook: Texas Medicaid [26/38]

Manual del miembro para los servicios dentales de Medicaid en Texas

Beneficios

¿Cuáles son los beneficios dentales de mi hijo con Medicaid?

A continuación se enumeran los beneficios de su hijo. Los servicios deben ser:

- Médicamente necesarios.
- Realizados o tratados por parte de un dentista de MCNA.

Visitas al consultorio

- Aplicación de flúor
 - Límite de 1 cada 6 meses
 - Límite de 6 meses de edad a 12 años de edad
- Sellantes por diente
 - Limitado únicamente a los primeros y segundos molares y premolares maxilares
 - Límite de 1 cada 3 años
- Limpieza/Profilaxis
 - Límite de 1 cada 6 meses
- Mantenedores de espacio

Exámenes orales

- Examen oral completo
 - Límite de 1 cada 3 años
- Exámenes orales regulares
 - Límite de 1 cada 6 meses
- Exámenes de emergencia

Radiografías

- Radiografías periapicales intraorales
 - Límite de 1 servicio por día
- Cada película adicional de la radiografía periapical intraoral
- Radiografías completas (incluidas las radiografías de mordida)
 - Límite de 1 cada 3 años
- Radiografías panorámicas
 - Límite de 1 cada 3 años
- Película sencilla, dos películas y 4 películas de radiografía de mordida
 - Límite de 1 servicio por día

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Manual del miembro para los servicios dentales de Medicaid en Texas

Beneficios

Servicios de restauración (empastes y coronas)

- Restauraciones con amalgama, dientes primarios o permanentes (empastes plateados)
- Restauraciones de resina/resina compuesta, dientes anteriores, dientes primarios posteriores y dientes posteriores permanentes (empastes blancos)
- Coronas prefabricadas de acero inoxidable
- Restauraciones con oro laminado (Únicamente en dientes permanentes) – De 13 a 20 años de edad
- Restauraciones incrustaciones/recubrimientos (Únicamente en dientes permanentes) – De 13 a 20 años de edad
- Corona – Restauraciones individuales – De 13 a 20 años de edad

Cirugía oral (extracciones)

- Extracciones, incluidas las extracciones quirúrgicas
- Biopsias
- Tratamiento quirúrgico de enfermedades, lesiones, deformidades y defectos
- Incisión y drenaje de abscesos
- Preparación quirúrgica de cresta para dentaduras
- Servicios de cirugía oral y maxilofacial (tratamiento por condiciones, defectos, lesiones y necesidades cosméticas de la boca, la dentadura, las mandíbulas y la cara)

Servicios de endodoncia

- Pulpotomía
- Tratamiento de conducto en los dientes primarios y permanentes
- Revisión de endodoncia
- Procedimiento de recalcificación
- Apicoectomía

Servicios periodontales (tratamiento de las encías)

- Procedimiento de colgajo gingival
- Raspado dental y aplanamiento de raíz
- Gingivectomía

Prostodoncia removible (dentaduras postizas)

- Dentadura postiza completa - De 3 a 20 años de edad
- Dentadura postiza inmediata - De 13 a 20 años de edad
- Dentadura postiza parcial – Superior e inferior de resina - De 6 a 20 años de edad
- Dentadura postiza parcial – Superior e inferior de metal fundido - De 9 a 20 años de edad
- Ajuste a dentadura postiza - De 3 a 20 años de edad
- Reparaciones, realineamientos y ajustes de dentaduras postizas

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Manual del miembro para los servicios dentales de Medicaid en Texas

Beneficios

Servicios de implantes

- Implantes quirúrgicos
- Prótesis de implantes con soporte

Servicios de prostodoncia fija

- Póntico para dentaduras parciales fijas- De 16 a 20 años de edad
- Retenedores de dentaduras fijas parciales- Incrustaciones y recubrimientos
- Retenedores de dentaduras fijas parciales- Coronas

Servicios de ortodoncia (frenillos dentales)

- MCNA cumple con las reglamentaciones de Medicaid para los frenillos dentales. Los frenillos dentales con fines cosméticos no tienen cobertura. Los frenillos dentales solo tienen cobertura cuando el problema de la dentadura o la mandíbula del niño afectan su crecimiento.

Analgesia y manejo del comportamiento

- Limitado a miembros con problemas físicos, mentales o de manejo del paciente.

Sedación

- Administración intravenosa de medicamentos
- Administración no intravenosa de medicamentos, límite de 2 veces cada 12 meses
- Medicamentos inyectables
- La inyección de medicamentos para tratar una enfermedad

Hospitalización

- La hospitalización está cubierta si el miembro no puede ser tratado de manera segura en el consultorio dental

Tratamiento paliativo

- Servicios necesarios cubiertos para aliviar el dolor y el malestar en casos de emergencia

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Manual del miembro para los servicios dentales de Medicaid en Texas

Beneficios

¿Cómo obtengo estos servicios para mi hijo?

Su dentista principal puede prestar la atención dental que su hijo necesita o coordinar para que la reciba.

Después de elegir un dentista principal:

- Llame a su dentista principal para fijar una cita.
- Informe a su dentista que tiene cobertura de Medicaid de Texas.
- Asegúrese de que el dentista sea un dentista contratado de MCNA Dental para el Programa dental de Medicaid en Texas.
- Visite a su dentista con frecuencia para realizarse controles.
- Siga las indicaciones del dentista para cepillarse los dientes y usar hilo dental.

¿Qué servicios no tienen cobertura?

Los siguientes servicios no tienen cobertura según el plan:

- Servicios que no son médicamente necesarios para la salud dental del miembro
- Atención dental por motivos cosméticos
- Procedimientos experimentales
- Servicios elegibles para recibir reembolso del seguro o cubiertos según cualquier otro seguro o plan médico de salud
- Gastos dentales relacionados con cualquier servicio dental:
 - Comenzado después de la terminación de la cobertura del miembro
 - Recibidos antes de que el miembro fuera elegible para recibir estos servicios
- Servicios que no están enumerados específicamente como beneficios cubiertos
- Malignidades
- Recetas o medicamentos

¿Cuánto debo pagar por la atención dental de mi hijo?

No tiene que pagar los servicios cubiertos médicamente necesarios de Medicaid. Usted deberá pagar los siguientes servicios:

- Servicios no cubiertos u opcionales que usted elige realizarse.
- Servicios prestados por un dentista fuera de la red.
- Servicios que su hijo recibe antes de que comience la cobertura dental.

¿Cómo obtengo los medicamentos indicados por el dentista para mi hijo (recetas)?

Las recetas no están cubiertas según este programa. Es posible que desee comunicarse con su plan médico de salud de Medicaid para averiguar si este puede ayudarlo a cubrir sus recetas.

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Attachment J1-17: Member Handbook: Texas Medicaid [28/38]

Manual del miembro para los servicios dentales de Medicaid en Texas

Beneficios

¿A quién debo llamar si tengo problemas para obtener medicamentos que el dentista indicó para mi hijo (recetas)?

Es posible que desee comunicarse con su plan médico de salud de Medicaid para averiguar si este puede ayudarlo a obtener sus recetas.

¿Qué beneficios extra tengo como miembro de MCNA?

Los servicios de valor agregado son servicios extra que ofrece MCNA. Como miembro de MCNA además de los servicios de Medicaid estándar, su hijo también puede recibir:

Un comienzo brillante

Debe ser elegible para recibir servicios de manejo de casos de necesidades especiales de MCNA Dental o estar embarazada. Recibirán un paquete de cuidado dental gratuito que incluye cepillo de dientes, dentífrico, hilo dental, y material impreso con información sobre la salud bucal.

Línea directa dental gratuita las 24 horas

MCNA ofrece una línea directa gratuita las 24 horas con la que puede comunicarse al 1-855-688-6262. Tendrá a su disposición higienistas dentales que atenderán sus preguntas o necesidades en cuanto a problemas de salud bucal, tratamientos y atención de emergencia.

Después del horario normal de atención, nuestros higienistas dentales responderán sus mensajes de voz o correo electrónico dentro de una hora.

Tarjeta de obsequio de Walmart

Cuando está inscrito en MCNA, cada familia miembro de MCNA Dental recibe una tarjeta de obsequio de Walmart por \$10.00 que puede utilizarse únicamente para comprar productos dentales, como dentífrico, cepillos de dientes, e enjuagues bucales.

Esta tarjeta de obsequio se limita a una por familia miembro de MCNA Dental, independientemente de la cantidad de miembros de Medicaid que vivan en la vivienda.

La tarjeta de obsequio de Walmart no se puede asignar, transferir ni utilizar junto con otros regalos o tarjetas de descuentos.

¿Cómo obtengo los beneficios extra?

Comuníquese con nuestro Servicio a Miembros al número gratuito 1-855-691-6262 si tiene preguntas sobre cómo obtener estos servicios.

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Manual del miembro para los servicios dentales de Medicaid en Texas

Atención dental y otros servicios

¿Qué es la atención dental de rutina?

Los servicios dentales de rutina incluyen:

- Visitas de diagnóstico y preventivas.
- Servicios terapéuticos como empastes, coronas, tratamientos de conducto y/o extracciones.

¿Qué es la atención preventiva?

La atención preventiva ayuda a su hijo a mantener una buena salud bucal. Evita o reduce problemas futuros en los dientes de su hijo. La atención preventiva incluye:

- Exámenes dentales periódicos
- Limpiezas de rutina
- Fluorización o tratamiento con fluoruro
- Sellantes dentales
- Radiografías
- Buena atención en el hogar
- Educación del paciente

¿Qué son los sellantes dentales?

Los sellantes son materiales de plástico que se colocan en los dientes de atrás (llamados "molares"). La parte superior de estos dientes tiene pequeñas hendiduras. La comida puede quedar atrapada en estas hendiduras y el cepillado de dientes no siempre puede sacarla. Los sellantes rellenan las hendiduras y ayudan a impedir la entrada de comida y gérmenes que causan caries. Un dentista o un higienista pueden realizar un procedimiento de sellante dental.

Pregunte al dentista principal de su hijo sobre los sellantes dentales y si su hijo se beneficiaría si se los realizara.

¿Qué es la fluorización?

El flúor protege y mantiene fuertes los dientes de su hijo. Además reduce las caries y la sensibilidad dental.

¿Qué significa médicamente necesario?

Es el estándar para decidir si Medicaid cubrirá un servicio dental para su hijo. Para los servicios o productos dentales proporcionados, la prueba es si un dentista prudente proporcionaría el servicio o producto a un paciente para diagnosticar, prevenir o tratar dolor, infecciones, enfermedades, disfunciones o desfiguraciones dentales de acuerdo con los procedimientos generalmente aceptados de la comunidad dental profesional.

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Attachment J1-17: Member Handbook: Texas Medicaid [29/38]

Manual del miembro para los servicios dentales de Medicaid en Texas

Atención dental y otros servicios

¿Con qué frecuencia debería mi hijo consultar al dentista para realizarse controles de rutina? ¿Cuándo podrá mi hijo recibir atención?

Su hijo debe consultar al dentista para realizarse un control de rutina cada 6 meses.

Los miembros deben fijar las citas:

- Dentro de las 24 horas para servicios de emergencia.
- Dentro de los 14 días para servicios terapéuticos y de diagnóstico.
- Dentro de los 30 días para servicios de rutina para atención preventiva.

¿Qué sucede si mi hijo necesita atención dental de rutina o servicios dentales de emergencia cuando está fuera de la ciudad o de Texas?

Si su hijo necesita atención dental de rutina mientras viaja, llame a nuestro número gratuito 1-855-691-6262 y le ayudaremos a encontrar un dentista.

Si su hijo necesita servicios dentales de emergencia mientras viaja, acuda a un hospital cercano, luego llame a su plan médico de salud de Medicaid. Si su hijo no tiene un plan médico de salud de Medicaid, llame al 1-800-252-8263 o al 911.

¿Qué sucede si mi hijo necesita servicios dentales cuando está fuera del país?

Medicaid no cubre los servicios dentales realizados fuera del país.

¿Qué debo hacer si me mudo?

Apenas sepa su nueva dirección, llame a la Comisión de Servicios de Salud y Humanos de Texas al 1-800-252-8263 para actualizar su dirección.

Antes de recibir los servicios de Medicaid en su área nueva, debe llamar a MCNA, a menos que necesite servicios de emergencia. Seguirá recibiendo atención a través de MCNA hasta que HHSC cambie su dirección.

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Manual del miembro para los servicios dentales de Medicaid en Texas

Atención dental y otros servicios

¿Qué sucede si recibo una factura del dentista de mi hijo?

¿A quién debo llamar?

El dentista no puede facturarle servicios dentales cubiertos y aprobados. No tiene que pagar las facturas que MCNA debería pagar. Llame a Servicio a Miembros al 1-855-691-6262 para obtener ayuda.

¿Qué información necesitarán?

Tenga a mano la tarjeta de identificación de miembro de su hijo y la factura que recibió de su dentista cuando llame. Deberá informar a Servicio a Miembros quién le envió la factura, la fecha del servicio, la cantidad y la dirección y número de teléfono del dentista.

¿Qué es una segunda opinión?

Usted puede obtener una segunda opinión si está disconforme con el dentista de su hijo o no está de acuerdo con la opinión del dentista sobre la atención de su hijo. Puede obtener una segunda opinión de otro dentista de MCNA o de un dentista fuera de la red por cualquier motivo, incluidos:

- No está seguro si el tratamiento es razonable y necesario.
- El dentista de su hijo no puede diagnosticar el problema.
- Tiene preguntas sobre el trabajo que el dentista desea realizar.
- Piensa que el tratamiento sugerido puede dañar a su hijo.
- El tratamiento que recibe actualmente su hijo no está ayudando.

Comuníquese con nuestro Servicio a Miembros al número gratuito 1-855-691-6262 si necesita ayuda sobre cómo obtener una segunda opinión para su hijo.

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Attachment J1-17: Member Handbook: Texas Medicaid [30/38]

Manual del miembro para los servicios dentales de Medicaid en Texas

Servicios de emergencia dental

¿Cubre Medicaid servicios dentales de emergencia?

Medicaid cubre de forma limitada los siguientes servicios dentales de emergencia:

- Dislocación de la mandíbula
- Daño traumático a dientes y estructuras de apoyo
- Extracción de quistes
- Tratamiento de abscesos bucales de origen en los dientes o las encías
- Tratamiento y dispositivos para la corrección de anomalías craneofaciales
- Medicamentos para cualquiera de las condiciones antes mencionadas

Medicaid también cubre los servicios dentales que su hijo recibe en un hospital. Esto incluye los servicios que el médico presta y otros servicios que su hijo pueda necesitar, como anestesia.

Si su hijo tiene un plan médico de salud de Medicaid, el plan de salud pagará estos servicios. Si su hijo no tiene un plan médico de salud de Medicaid, HHSC pagará estos servicios.

¿Cómo obtengo atención dental de emergencia para mi hijo y a quién debo llamar?

Llame al dentista principal de su hijo para averiguar cómo su hijo puede obtener servicios dentales de emergencia. Si el consultorio está cerrado, usted puede hacer lo siguiente:

- Si su hijo recibe servicios médicos a través del plan médico de salud de Medicaid, comuníquese con el plan médico de salud.
- Si su hijo no tiene un plan médico de salud de Medicaid, llame al 1-800-252-8263 o al 911.

¿Cuándo podrá mi hijo recibir atención?

Su hijo debe recibir servicios dentales de emergencia a más tardar 24 horas después de su llamada.

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Manual del miembro para los servicios dentales de Medicaid en Texas

Pasos Sanos de Texas

¿Qué es Pasos Sanos de Texas?

Pasos Sanos de Texas es un programa de atención de la salud especial para niños cubiertos por Medicaid. Es para niños y adolescentes de 0 a 20 años de edad que tienen Medicaid. Está diseñado para mantener a los niños saludables.

¿Qué servicios ofrece Pasos Sanos de Texas?

- Controles médicos y dentales regulares
- Servicios de manejo de casos
- Vacunas para prevenir enfermedades
- Controles oculares y anteojos
- Examen de audición y audífonos
- Medicamentos
- Otros servicios de atención de la salud, de ser necesarios

¿Cómo y cuándo obtengo controles dentales de Pasos Sanos de Texas para mi hijo?

Para mantener los dientes de su hijo sanos, llame al dentista de su hijo para fijar visitas dentales de Pasos Sanos de Texas. Su hijo debe comenzar a obtener controles dentales cada 6 meses a partir de los 6 meses de edad.

¿Debe el dentista de mi hijo pertenecer a la red de MCNA?

Sí, el dentista de su hijo debe ser un dentista de la red de MCNA.

¿Qué sucede si debo cancelar la cita dental de mi hijo?

Llame al consultorio del dentista si necesita cancelar una visita dental de Pasos Sanos de Texas lo antes posible. Asegúrese de reprogramar la cita lo antes posible.

¿Qué sucede si estoy fuera de la ciudad y mi hijo debe realizarse un control dental de Pasos Sanos de Texas?

Si está fuera de la ciudad cuando su hijo debe realizarse un control de Pasos Sanos de Texas, puede utilizar cualquier dentista de Pasos Sanos de Texas en Texas. Si necesita ayuda o tiene preguntas, llame a nuestro Servicio a Miembros al 1-855-691-6262.

¿Qué sucede si soy un agrícola migrante?

Informe a su dentista principal y el personal del consultorio trabajará con usted para fijar el control de su hijo antes de que se marche del área.

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Manual del miembro para los servicios dentales de Medicaid en Texas

Primer Hogar Dental

¿Qué es Primer Hogar Dental?

Los miembros de Medicaid MCNA pueden recibir controles dentales de un dentista aprobado de Primer Hogar Dental. Pueden proporcionar atención a niños de 6 a 35 meses de edad. Su hijo recibirá servicios dentales que le mejorarán los dientes. Su hijo puede consultar al dentista cada 3 meses, de ser necesario.

¿Qué incluye una visita de Primer Hogar Dental?

Durante la primera visita de primer hogar dental de su hijo, el dentista:

- Decidirá si su hijo padecerá caries. El dentista le hará preguntas y revisará los dientes de su hijo.
- Limpiará los dientes de su hijo.
- Le mostrará cómo cuidar los dientes de su hijo.
- Colocará flúor en los dientes de su hijo.
- Le brindará folletos educativos para la edad de su hijo para que se lleve a su hogar. Le enseñarán cómo debe cuidar los dientes de su hijo mientras está en su hogar.
- Fijará la próxima visita de su hijo antes de que se retiren del consultorio.

¿Cómo encuentro un dentista de Primer Hogar Dental?

Busque en su Directorio de Proveedores de Medicaid y elija un Dentista de Primer Hogar Dental para su hijo. Busque debajo del nombre del dentista principal.

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Manual del miembro para los servicios dentales de Medicaid en Texas

Especialistas dentales

¿Qué sucede si mi hijo necesita consultar a un dentista especial (especialista)?

El dentista principal de su hijo le otorgará una remisión para que su hijo pueda ir a un especialista.

MCNA cuenta con especialistas dentales en todas las áreas de Texas. Si el dentista principal de su hijo decide que es necesario un tratamiento especial, lo remitirá a un especialista de MCNA en su área.

¿Cómo obtengo la aprobación de servicios especiales?

Si el especialista considera que su hijo necesita atención especial, el especialista enviará un pedido (autorización previa) a MCNA antes de que reciba el servicio. Revisaremos el pedido para asegurarnos de que los servicios sean médicamente necesarios. Tenemos reglamentaciones que se deben seguir en el momento de tomar decisiones sobre servicios dentales. Esto se denomina proceso de Autorización previa. El proceso demora 3 días para pedidos comunes y 1 día para pedidos de emergencia.

Informaremos a su dentista si aprobamos el pedido. El dentista se comunicará con usted para fijar una cita. Le informaremos a usted y al dentista de su hijo si denegamos o limitamos los servicios que el dentista solicita.

Si desea verificar el estado del pedido del dentista, comuníquese con Servicio a Miembros al número gratuito **1-855-691-6262**.

¿Cuándo podrá mi hijo recibir atención de un especialista?

- Si el especialista proporciona atención urgente, su hijo recibirá atención a más tardar 24 horas después de su pedido de remisión a su dentista principal.
- Si el especialista proporciona terapia o su hijo necesita ver al especialista para obtener un diagnóstico, su hijo recibirá atención a más tardar 14 días después de su pedido de remisión.
- Si el especialista proporciona servicios para evitar problemas dentales, su hijo recibirá atención a más tardar 30 días después de su pedido de remisión.

¿Qué servicios dentales no requieren remisión?

Cualquier servicio realizado por su dentista principal no requiere remisión.

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Attachment J1-17: Member Handbook: Texas Medicaid [32/38]

Manual del miembro para los servicios dentales de Medicaid en Texas

Especialistas dentales

¿Qué sucede si mi hijo recibe tratamiento por una condición dental por parte de un especialista cuando está inscrito?

Es posible que su hijo reciba tratamiento de un especialista por una condición dental aprobada por HHSC o el plan dental anterior de su hijo. Para garantizar que no se interrumpa la atención de su hijo, permitiremos que su hijo siga consultando a su especialista por servicios cubiertos médicamente necesarios:

- Durante los 90 días posteriores de que se convierta en miembro de MCNA, o
- Hasta que su hijo consulte a su nuevo dentista de MCNA.

Si le diagnosticaron una enfermedad terminal a su hijo, como cáncer, permitiremos que siga consultando a su dentista durante 9 meses.

Llame a nuestro Servicio a Miembros al número gratuito 1-855-691-6262 para obtener ayuda.

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Manual del miembro para los servicios dentales de Medicaid en Texas

Intérpretes

¿Puedo utilizar los servicios de un intérprete cuando hable con el dentista de mi hijo?

Si. Puede hablar con su dentista en el idioma que prefiera. Comuníquese con la línea directa de Servicio a Miembros al número gratuito 1-855-691-6262 para coordinar servicios de traducción para usted.

¿A quién debo llamar para solicitar un intérprete?

Si necesita un intérprete cuando consulta al dentista, llame a Servicio a Miembros al número gratuito 1-855-691-6262.

¿Con cuánta anticipación debo llamar?

En la mayoría de los casos, necesitamos al menos 48 horas de anticipación. Sin embargo, debería llamarnos apenas fije la cita con su dentista.

¿Cómo puedo obtener un intérprete en persona en el consultorio del dentista?

Podemos proporcionarle un intérprete mientras está en el consultorio del dentista que lo ayudará a hablar con el dentista en persona en el idioma que usted prefiera. Llame a nuestro número gratuito 1-855-691-6262 si desea tener un traductor con usted en el consultorio del dentista durante su cita. Díganos:

- El idioma que habla, y
- La información del dentista

Solicitaremos los servicios de un intérprete para su cita y lo llamaremos para confirmarle que se ha coordinado la presencia de un intérprete. Estos servicios son gratuitos.

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Attachment J1-17: Member Handbook: Texas Medicaid [33/38]

Manual del miembro para los servicios dentales de Medicaid en Texas

Transporte

Si no puedo trasladarme, ¿cómo puedo llevar a mi hijo al consultorio del dentista?

Los niños que tienen Medicaid y sus cuidadores pueden obtener traslados gratuitos o dinero para gasolina que los ayude a ir y volver del consultorio del médico, el dentista, el hospital o la farmacia. Esto incluye traslados en autobús, taxi, camioneta de uso compartido y pasaje aéreo para viajes fuera de la ciudad.

¿A quién llamo para un paseo a la oficina del dentista de mi hijo?

Llame al **1-877-633-8747** (número gratuito) para obtener más información o coordinar su traslado.

¿Con cuánta anticipación debo llamar?

Llame al Programa de transporte médico (MTP) al número gratuito **1-877-633-8747** al menos 2 días hábiles o más antes de que necesite el traslado. Si necesita desplazarse mucho o fuera de la ciudad para consultar a su dentista, llame al menos 5 días hábiles antes de que necesite el traslado. Si necesita traslado el mismo día que llama, haremos todo lo posible para ayudarlo.

¿Puede llevarme al dentista de mi hijo alguien que conozco y recibir el dinero por el costo del viaje?

Si, pero para poder recibir el pago, deberá completar un formulario y demostrar que tiene:

- Licencia de conductor actual
- Sello de inspección
- Placa
- Seguro de responsabilidad

El formulario se denomina "Formulario de registro de conductor individual". Comuníquese con el Programa de transporte médico (MTP) al **1-877-633-8747** para obtener un formulario o hacer cualquier pregunta.

¿A quién debo llamar si tengo una queja acerca del servicio o el personal?

Si tiene una queja o comentario acerca del servicio que recibió del personal de transporte, puede escribir o llamar al MTP al **1-877-633-8747** de lunes a viernes, de 8:00 a. m. a 5:00 p. m.

¿Cuál es el horario de atención y los límites del servicio de transporte?

Para obtener más información acerca del servicio de transporte, llame al MTP al **1-877-633-8747** de lunes a viernes, de 8:00 a. m. a 5:00 p. m.

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Transporte

Programa de Transporte Médico

Centro de llamadas (programación): 1-877-633-8747
Número teléfono de la Oficina Central: 1-512-706-4900
Fax de Documentos: 1-210-646-3257

Corredor a Todo Riesgo: LogistiCare, Inc.

Los Condados Servidos: Collin, Dallas, Denton, Ellis, Hood, Hunt, Johnson, Kaufman, Navarro, Parker, Rockwall, Tarrant, Wise

Programación de Viaje, Reservaciones: 1-855-687-3255 (De 8 a.m. a 5 p.m.)
 1-877-564-9832

Ayuda de viaje, Quejas: 1-877-564-9834 (24/7)
TTY: 1-866-288-3133 (24/7)

Corredor a Todo Riesgo: Medical Transportation Management, Inc. (MTM)

Los Condados Servidos: Austin, Brazoria, Chambers, Fort Bend, Galveston, Hardin, Harris, Jasper, Jefferson, Liberty, Matagorda, Montgomery, Newton, Orange, Polk, San Jacinto, Tyler, Walker, Waller, Wharton

Reservaciones, Viaje que no se Presenta: 1-855-687-4786 (De 7 a.m. a 6 p.m.)
Las Altas Hospitalarias: 1-888-513-0706 (24/7)
Quejas: 1-866-436-0437 (De 8 a.m. a 5 p.m.)

Servicio de relevo nacional (TTY):

Todos los usuarios: 7-1-1
Usuarios de teléfono teletexto (TTY): 1-800-855-2880
Usuarios de voz: 1-800-855-2881

Servicio de relevo en español (TTY):

TTY en español: 1-800-855-2884
Voz en español: 1-800-855-2885

Servicio de Enlace de Idioma de Voz a Voz (VaV):

Servicio de VaV en Español: 1-866-260-9470
Servicio de VaV en Inglés: 1-800-229-5746

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Manual del miembro para los servicios dentales de Medicaid en Texas

Derechos y responsabilidades de los miembros

Derechos del miembro

- Usted tiene derecho a recibir información correcta y fácil de comprender para ayudarlo a tomar buenas decisiones sobre su dentista, o el de su hijo, y otros proveedores de su hijo.
- Usted tiene derecho a conocer el modo en que los dentistas de su hijo reciben el pago. Usted tiene derecho a saber en qué consisten esos pagos y cómo funcionan.
- Usted tiene derecho a conocer cómo determina MCNA si un servicio está cubierto o si es médicamente necesario. Usted tiene derecho a conocer a las personas que toman estas decisiones en la oficina de MCNA.
- Usted tiene derecho a conocer los nombres de los dentistas y de otros proveedores inscritos en MCNA y sus direcciones.
- Usted tiene derecho a elegir de entre una lista de dentistas que sea lo suficientemente amplia para que su hijo reciba el tipo de atención correcta en el momento que la necesite.
- Usted tiene derecho a participar en todas las decisiones relacionadas con la atención dental de su hijo.
- Usted tiene derecho a expresarse en representación de su hijo en todas las decisiones sobre el tratamiento.
- Usted tiene derecho a obtener una segunda opinión de otro dentista inscrito en MCNA acerca del tipo de tratamiento que su hijo necesita.
- Usted tiene derecho a recibir un trato justo de parte de MCNA, los dentistas y otros proveedores.
- Usted tiene derecho a hablar en privado con los dentistas y otros proveedores de su hijo, y de solicitar la privacidad de los expedientes médicos de su hijo. Usted tiene derecho a leer y a hacer una copia de los registros dentales de su hijo, y a solicitar que se realicen cambios en estos registros.
- Usted tiene derecho a saber que los dentistas, los hospitales y otros proveedores que brindan atención a su hijo pueden asesorarlo respecto del estado de salud, la atención médica y el tratamiento de su hijo. El plan dental de su hijo no puede evitar que ellos le brinden esta información, incluso cuando la atención o el tratamiento no sean un servicio cubierto.
- Usted tiene derecho a saber que usted no es responsable de pagar los servicios cubiertos de su hijo. Los dentistas, los hospitales y otros no pueden exigirle que pague cualquier otra suma por servicios cubiertos.

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Manual del miembro para los servicios dentales de Medicaid en Texas

Derechos y responsabilidades de los miembros

Responsabilidades del miembro

Tanto usted como MCNA están interesados en observar mejoras en la salud de su hijo. Usted puede ayudar si asume las siguientes responsabilidades.

- Usted y su hijo deben tratar de adoptar hábitos saludables, como estimular a su hijo a que realice actividad física, evite el tabaco y tenga una dieta saludable.
- Usted debe participar en las decisiones del dentista acerca de los tratamientos de usted y de su hijo.
- Usted debe trabajar en conjunto con los dentistas y otros proveedores de MCNA para elegir tratamientos para su hijo que hayan sido acordados por todos.
- Si usted está en desacuerdo con MCNA, primero debe intentar resolverlo utilizando el proceso de quejas de MCNA.
- Usted debe obtener información sobre los servicios que están cubiertos y que no están cubiertos por MCNA. Debe leer su Manual del Miembro para comprender cómo funcionan las reglamentaciones.
- Si solicita una cita para su hijo, debe intentar llegar puntualmente al consultorio del dentista. Si no puede asistir a la cita, asegúrese de llamar para cancelarla.
- Debe denunciar el mal uso por parte de proveedores de atención dental y de la salud, otros miembros, MCNA u otros planes dentales o médicos de salud.

Si considera que lo han tratado injustamente o ha sufrido una discriminación, comuníquese con el Departamento de Salud y Servicios Humanos (HHS) de los Estados Unidos al número gratuito **1-800-368-1019**. También puede obtener información en línea relacionada con la Oficina de Derechos Civiles del HHS en www.hhs.gov/ocr.

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Attachment J1-17: Member Handbook: Texas Medicaid [35/38]

Manual del miembro para los servicios dentales de Medicaid en Texas

Proceso de queja

¿Qué debo hacer si tengo una queja? ¿A quién debo llamar? ¿Puedo recibir ayuda de MCNA para presentar una queja?

Si necesita ayuda con un problema, deseamos ayudarlo. Si tiene alguna queja, comuníquese con nuestro número gratuito **1-855-691-6262** para informarnos acerca de su problema. Un representante de MCNA puede ayudarlo a presentar una queja. La mayoría de las veces, podemos prestarle ayuda en seguida o como máximo en unos días. También puede presentar una queja en línea en www.mcna.net.

¿Puede otra persona presentar una queja en mi nombre?

Usted, su dentista, su asesor legal o la persona que nombre para que represente a su hijo pueden presentar una queja ante MCNA. Le enviaremos un formulario de una página que usted debe firmar y enviarnos. Este formulario nos informará que autoriza a la persona que nombra para que lo represente a usted y a su hijo durante el proceso de queja. También puede obtener información y los formularios de queja en nuestro sitio web en www.mcna.net.

¿Qué debo hacer para presentar una queja? ¿Cuánto tiempo llevará el proceso?

Para presentar una queja escriba a Servicio a Miembros o llame a su número gratuito **1-855-691-6262**. Revisaremos su queja y le enviaremos una carta con una respuesta dentro de los 30 días posteriores a la recepción de la queja. Si desea realizar su queja por escrito, envíela a:

MCNA Dental
 Attention: Medicaid Complaint
 4400 NW Loop 410, Suite 250
 San Antonio, TX 78229

Si no estoy de acuerdo con el resultado mi queja, ¿a quién más puedo llamar?

Si no está de acuerdo con la respuesta a su queja, puede llamar a la Comisión de Servicios de Salud y Humanos (HHSC) de Texas al **1-800-252-8263** (número gratuito).

¿Cómo puedo presentar una queja ante el HHSC después de pasar por el proceso de queja de MCNA?

Si todavía tiene una queja después de haber pasado por el proceso de quejas de MCNA, comuníquese con la Comisión de Servicios de Salud y Humanos (HHSC) de Texas al **1-800-252-8263** (número gratuito). Si desea realizar su queja por escrito, envíela a la siguiente dirección:

Texas Health and Human Services Commission
 Health Plan Operations - H-320
 P.O. Box 85200, Austin, TX 78708-5200
 Attention: Resolution Services

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Manual del miembro para los servicios dentales de Medicaid en Texas

Proceso de apelación

¿Qué puedo hacer si MCNA niega o limita un servicio que el dentista solicita para mi hijo?

Si está en desacuerdo con la decisión de MCNA de denegar o limitar servicios solicitados por su dentista, puede llamar a Servicio a Miembros al número gratuito **1-855-691-6262** y solicitar una apelación. Usted o el dentista de su hijo pueden enviarnos más información para demostrar por qué no están de acuerdo con nuestra decisión.

¿Cómo sabré si los servicios para mi hijo fueron rechazados?

MCNA le enviará una carta (notificación de acción) a usted y al dentista de su hijo para informarle si un servicio solicitado por su dentista es denegado o limitado y el motivo por el cual fue denegado. La carta también le indicará cómo presentar una apelación y su derecho a solicitar una audiencia estatal justa ante HHSC.

¿Cuáles son los plazos para el proceso de apelación?

Después de recibir su apelación por escrito, le enviaremos una carta dentro de los 5 días hábiles para informarle que recibimos su pedido. Revisaremos su apelación y le enviaremos una carta con nuestra respuesta dentro de los 30 días posteriores a la recepción de la apelación.

MCNA tiene la opción de extender este período hasta 14 días calendarios, si usted solicita una extensión o si nosotros demostramos que es necesario obtener más información y que la demora será beneficiosa para usted. Si MCNA necesita extender este período, usted recibirá una notificación por escrito del motivo de la demora.

Antes y durante la apelación, usted o su representante tienen el derecho a revisar el expediente de su caso. También puede revisar los registros dentales y cualquier otro documento relacionado con la apelación. Comuníquese con Representante de miembros de Medicaid de MCNA al número gratuito **1-855-691-6262** si desea revisar su expediente.

¿Cuándo puedo solicitar una apelación?

Si no está de acuerdo con nuestra decisión de denegar o limitar los servicios pedidos, llame a Servicio a Miembros al número gratuito **1-855-691-6262** dentro de los 30 días posteriores a la recepción de nuestra carta de denegación.

Tiene la opción de solicitar una apelación por la denegación total o parcial del pago de servicios. Para garantizar la continuidad de los servicios actualmente autorizados, usted debe presentar la apelación antes de que se cumplan los 10 días a partir del envío por correo de la notificación de la medida tomada por MCNA o la fecha de vigencia efectiva pretendida de la medida propuesta.

Es posible que deba pagar por los servicios continuados si la decisión final es que MCNA no tiene que cubrirlos.

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Attachment J1-17: Member Handbook: Texas Medicaid [36/38]

Manual del miembro para los servicios dentales de Medicaid en Texas

Proceso de apelación

¿Puedo simplemente solicitar una apelación en forma oral o debe ser por escrito?

Cada vez que alguien solicita una apelación, el pedido debe ser por escrito y estar firmado por la persona que recibe la cobertura de Medicaid o su representante, a menos que la persona solicite una Apelación expeditiva, que puede realizarse por escrito o de forma oral.

¿Puedo recibir ayuda de MCNA para presentar una apelación?

Si, un Representante de miembros de MCNA puede ayudarlo a presentar una apelación. Llame a Servicio a Miembros al número gratuito 1-855-691-6262 para obtener ayuda. Infórmenos que quiere presentar una apelación. También puede obtener información y los formularios de apelación en nuestro sitio web en www.mcna.net.

¿Puede otra persona presentar una apelación en nombre de mi hijo?

Usted, su dentista, su asesor legal o la persona que nombre para que lo represente a usted o a su hijo pueden presentar una apelación ante MCNA. Le enviaremos un formulario de una página que usted debe firmar y enviarnos. Este formulario indica que usted autoriza a la persona que nombra para que lo represente a usted y a su hijo durante el proceso de apelación.

¿Qué más puedo hacer si sigo disconforme?

Puede solicitar una audiencia estatal justa en cualquier momento durante o después del proceso de apelación de MCNA. Consulte la sección Audiencia estatal justa de este manual para obtener más información.

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Manual del miembro para los servicios dentales de Medicaid en Texas

Apelaciones expeditivas

¿Qué es una apelación expeditiva?

Solicite una apelación expeditiva si no tiene tiempo para el trámite normal, en el caso de que la vida o la salud de su hijo corrieran peligro. Cuando solicita una apelación expeditiva, MCNA tiene que tomar una decisión de forma rápida según la condición de salud de su hijo.

¿Cómo solicito una apelación expeditiva?

La apelación expeditiva puede realizarse de forma oral o por escrito. Llame a Servicio a Miembros al número gratuito 1-855-691-6262 para obtener ayuda. Usted o el dentista de su hijo pueden enviarnos más información para demostrar por qué no están de acuerdo con nuestra decisión.

¿Cuánto tiempo lleva una apelación expeditiva?

Si tiene una apelación expeditiva, los llamaremos a usted y al dentista para informarles nuestra decisión dentro de los 3 días hábiles a partir de la recepción de su apelación. También le enviaremos una carta para informarle nuestra decisión. La carta también le informará que puede solicitar una Audiencia estatal justa expeditiva ante HHSC.

¿Qué sucede si MCNA indica que no hará una apelación expeditiva?

Si MCNA decide no expeditar su apelación, la apelación será procesada con el proceso de apelación normal, que se resolverá dentro de los 30 días.

¿Quién puede ayudarme a presentar una apelación expeditiva?

Comuníquese con Servicio a Miembros de MCNA al número gratuito 1-855-691-6262. Un Representante de miembros de MCNA lo ayudará a presentar una apelación expeditiva. Infórmenos que quiere presentar una apelación expeditiva. También puede obtener información y los formularios de apelación en nuestro sitio web en www.mcna.net.

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Attachment J1-17: Member Handbook: Texas Medicaid [37/38]

Manual del miembro para los servicios dentales de Medicaid en Texas

Audiencia estatal justa

¿Puedo solicitar una audiencia estatal justa?

Si usted, como cuidador del miembro de MCNA, está en desacuerdo con la decisión de MCNA, tiene derecho a solicitar una audiencia estatal justa. Puede nombrar a alguien que lo represente si escribe una carta a MCNA para informarnos el nombre de la persona que desea que lo represente. Un médico u otro proveedor médico puede ser su representante. Si desea cuestionar una decisión tomada por MCNA, usted o su representante deben solicitar una audiencia estatal justa dentro de los 90 días de la fecha de la carta de MCNA con la decisión. Si no solicita una audiencia justa dentro de los 90 días, puede perder su derecho a una audiencia justa. Para solicitar una audiencia justa, usted o su representante deben enviar una carta a:

MCNA Dental
 Attention: Medicaid Appeals
 4400 NW Loop 410, Suite 250
 San Antonio, TX 78229

O llamar al número gratuito **1-855-691-6262**.

Si solicita una audiencia justa dentro de los 10 días de la fecha en que recibió la notificación de la audiencia de MCNA, su hijo tiene derecho a seguir recibiendo cualquier servicio de MCNA denegado o reducido al menos hasta que se tome la decisión final de la audiencia. Si no solicita una audiencia justa dentro de los 10 días desde el momento en que recibe la notificación de la audiencia, el servicio que MCNA denegó se interrumpirá.

Si solicita una audiencia justa, recibirá un paquete de información con la fecha, hora y lugar de la misma. La mayoría de las audiencias justas se celebran por teléfono. En ese momento, usted o su representante pueden indicar por qué es necesario el servicio denegado por MCNA.

HHSC le otorgará una decisión final dentro de los 90 días desde el momento en que usted solicitó la audiencia.

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Manual del miembro para los servicios dentales de Medicaid en Texas

Cómo informar fraude y abuso

¿Quiere denunciar el malgasto, abuso o fraude?

Infórmenos si considera que un médico, un dentista, un farmacéutico en una farmacia, otro proveedor de atención de la salud o una persona que recibe beneficios actúan de forma incorrecta. Actuar de forma incorrecta incluye el malgasto, el abuso o el fraude, que es ilegal. Por ejemplo, infórmenos si considera que alguien:

- Recibe pago por servicios de Medicaid que no se prestaron o no eran necesarios.
- No dice la verdad sobre una afección médica para recibir tratamiento médico.
- Permite que otra persona utilice una identificación del Programa dental de Medicaid.
- Utiliza la identificación del Programa dental de Medicaid de otra persona.
- Miente acerca de la cantidad de dinero o recursos que tiene a fin de recibir beneficios.

Para denunciar malgasto, abuso o fraude, elija una de las siguientes opciones:

- Comuníquese con la línea directa de la OIG al **1-800-436-6184**, o
- Visite <https://oig.hhsc.state.tx.us/>. Debajo de la caja nombrado "I WANT TO," seleccione "Report Fraud, Waste, or Abuse" para completar el formulario en línea.
- Puede denunciar ante MCNA directamente:
MCNA Dental - Attention: Special Investigations Unit
 4400 NW Loop 410, Suite 250, San Antonio, TX 78229
 Número gratuito de la Línea directa de Fraude de MCNA: **1-855-392-6262**

¿Cómo denuncio a un dentista si creo que hace uso indebido o engañoso del sistema?

Para denunciar malgasto, abuso o fraude, recopile toda la información que sea posible.

Quando denuncie a un proveedor (un médico, dentista, asesor, etc.) incluya:

- Nombre, dirección y número de teléfono del proveedor.
- Nombre y dirección del centro (hospital, hogar de ancianos, agencia de atención domiciliar de la salud, etc.).
- Número de Medicaid del proveedor y el centro, si los tiene.
- Tipo de proveedor (médico, dentista, terapeuta, farmacéutico, etc.).
- Nombres y números de teléfono de otros testigos que puedan ayudar en la investigación.
- Fechas de los acontecimientos.
- Resumen de lo que sucedió.

Quando denuncie a una persona que recibe beneficios, incluya:

- El nombre de la persona.
- La fecha de nacimiento, el Número de Seguro Social o el número de caso de la persona si los tiene.
- La ciudad en la que vive la persona.
- Información específica sobre el malgasto, abuso o fraude.

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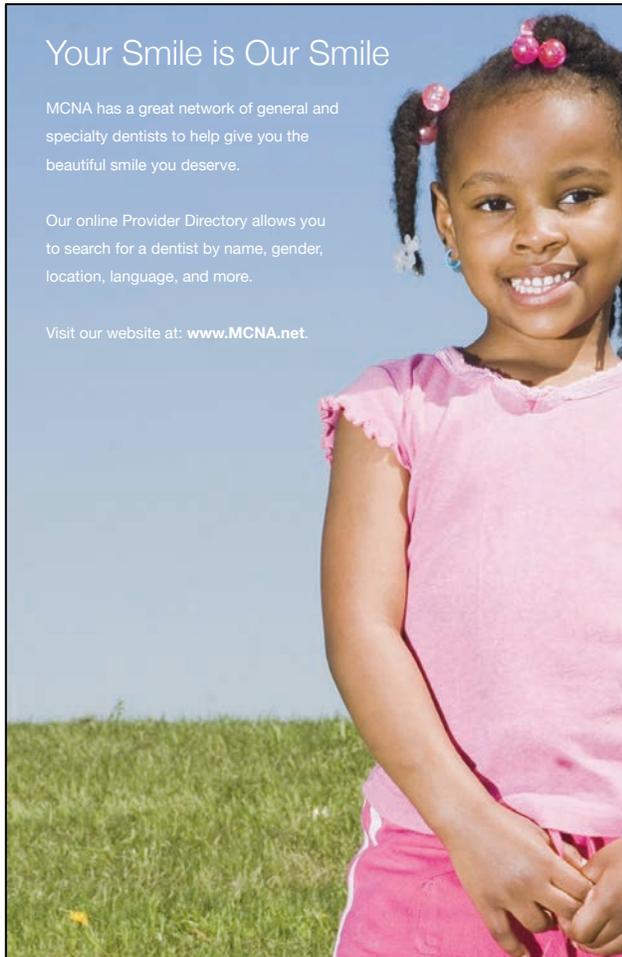
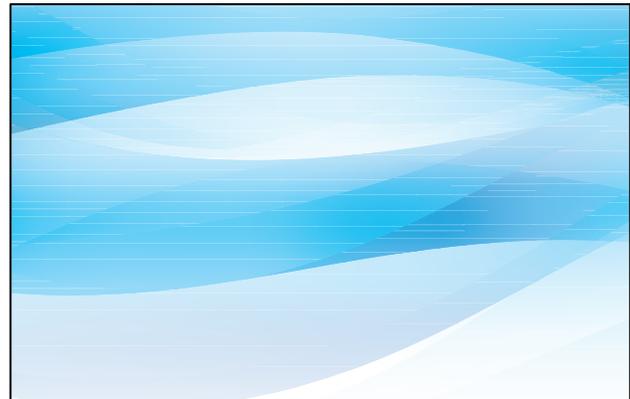
Attachment J1-17: Member Handbook: Texas Medicaid [38/38]

Your Smile is Our Smile

MCNA has a great network of general and specialty dentists to help give you the beautiful smile you deserve.

Our online Provider Directory allows you to search for a dentist by name, gender, location, language, and more.

Visit our website at: www.MCNA.net.

mcnadental

MCNA Dental
 4400 NW Loop 410, Suite 250
 San Antonio, Texas 78229
www.MCNA.net

If you have questions, please call Member Services at **1-855-691-6262** (Toll Free).
 Para información a los miembros e instrucciones en Español,
 por favor llame al: **1-855-691-6262**.



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 Inventory Code: 1J Texas 01/2014

Section J.2

Describe how you will ensure that all written materials meet the language requirements and which reference material you anticipate you will use to meet the sixth (6th) grade reading level requirement.

MCNA was founded on the core philosophy and our committed belief that all individuals, regardless of economic background, should have access to quality dental care. Our vast experience with the Texas, Florida, and Kentucky Medicaid, CHIP, Medicare, and Long Term Care populations gives us a comprehensive understanding of the need for consistent (and persistent) communication with members. Members must have current and accurate information about their dental benefits and the providers available to treat them. To do this, we understand the importance of communicating in a manner that is culturally competent and easy to understand.

We utilize **culturally sensitive** and appropriate educational materials based on the **member's primary language**. Our member materials are available in English, French, Spanish, and Creole, as well as any other languages spoken by approximately 5% or more of the total population in MCNA's service areas. **Our website is available in English, French, Spanish, and Creole.**

MCNA uses the "**Person First**" approach in creating our member materials. Our members are people, not conditions, disabilities, or handicaps and our language always takes this into account. All written materials for Louisiana members are composed using the Person First Policy issued by DHH.

MCNA's goal is to ensure all member materials are consistent in style, language, and format and are written using plain language that is focused on the essential information members need to understand. All member written materials are composed at or below a 6th grade reading level. MCNA's Compliance department is responsible for reviewing and ensuring all member materials adhere to the **Flesch-Kincaid grade level calculation formula**.

When creating member materials, our staff utilizes the following techniques to promote member comprehension:

- Use a positive tone and active voice
- Use bulleted lists to help pinpoint specific topics
- Use short sentences for ease of reading
- Provide specific, need-to-know information
- Avoid using acronyms, jargon, or figures of speech
- Use simple graphics or icons to communicate ideas

Part Two: Technical Approach

Section J: Member Materials

MCNA's Quality Improvement and Member Services departments conduct needs assessments to accurately plan for and implement member materials and services that respond to the cultural and linguistic characteristics of the service area. Based on the findings of the analysis, MCNA translates member materials needed to communicate to each member their benefits, rights and responsibilities, and how to access and utilize dental services. Large print, Braille, and audio recordings are also available to members that are visually impaired. MCNA uses Teneo Linguistics Company (TLC), a Texas certified minority owned business enterprise, for translation services.



MCNA's Communications Committee, whose membership is comprised of leadership from Call Center Operations, Grievances and Appeals, Utilization Management, Provider Services, Quality Improvement, and Compliance, is responsible for providing interdepartmental oversight of the quality, accuracy and appropriateness of all information created for and published in all member and provider communications materials.

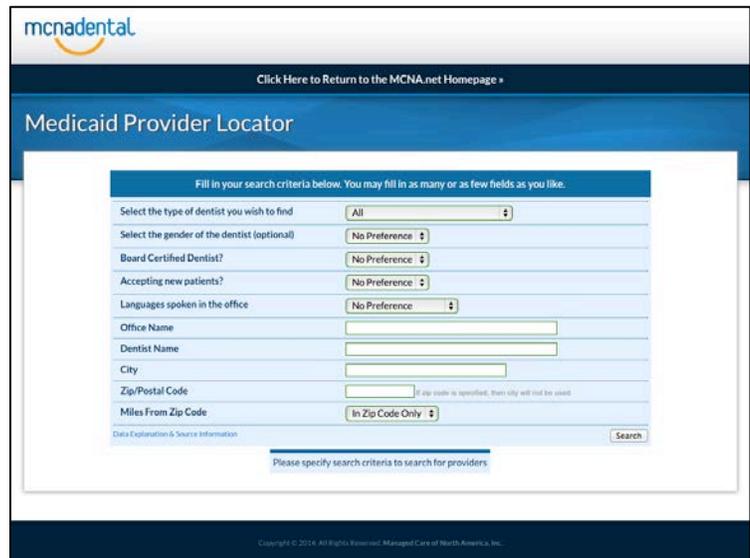
MCNA's Communications Committee reviews and approves all member materials prior to submission to the Compliance department. Upon receipt, the Compliance department reviews the accuracy and readability of the content to ensure compliance with state and federal requirements. Once approved by Compliance, the materials will be submitted to the DHH for further review and approval using the DHH Marketing and Member Education Materials Approval Form prior to use and distribution. Evidence illustrating compliance with the 6th grade Flesch-Kincaid readability level will be included with all materials submitted to DHH.

MCNA's Compliance department and Communications Specialists will maintain a log of all approved DHH member materials. The materials will include the date of issue, date of revision, and, if needed, language showing that the prior versions are obsolete.

Section J.3

Describe your strategy for ensuring the information in your provider directory is accurate and up to date, including the types and frequency of monitoring activities and how often the directory is updated.

Our members can easily locate a participating dental provider by reviewing the Provider Directory included in their Welcome Packet, by visiting MCNA's website, or by calling our toll-free Member Hotline for assistance. The Provider Directory in our Welcome Packet is organized so that a member can find a provider by their name or specialty. Our online Provider Directory interfaces directly with MCNA's proprietary management information system, DentalTrac™, allowing any changes made in our provider network to be available **online** and in **real time**. As a result, members always have access to the latest, most accurate information regarding the nearest dental provider, such as:



- Specialty
- Office Name
- Dentist Name
- Languages Spoken
- Ability to Treat Members with Special Health Care Needs
- Ability to Accept New Patients
- Miles from the City or ZIP Code Requested

Members may contact the toll-free Member Hotline for assistance in selecting a dental provider, or to request a printed Provider Directory. All EPSDT Program members are free to choose a participating general dentist or pediatric dentist in our network without MCNA imposed age restrictions. Denture Program members will be able to choose from a dedicated network of providers who render the services covered under that benefit plan. Our Member Services Representatives (MSRs) are trained to ask the member questions about their preferences for a provider and recommend a compatible provider.

To **ensure the accuracy** and validity of the demographic information in the Medicaid and CHIP provider directories, the MCNA Provider Relations department reviews our provider directory on a quarterly basis. Provider Relations Representatives:

Part Two: Technical Approach

Section J: Member Materials

- Evaluate the web based provider directory for understandability and usefulness to members and prospective members
- Audit a sample of provider entries equaling no less than 25% of the total listing to ensure accuracy
- Contact the provider's office to verify that the information listed is correct

If any discrepancies are identified, the Provider Relations Representative promptly forwards the information to MCNA's **NCQA Certified** Credentialing department. The Credentialing department then updates the provider's information in the Credentialing module of our DentalTrac™ management information system.



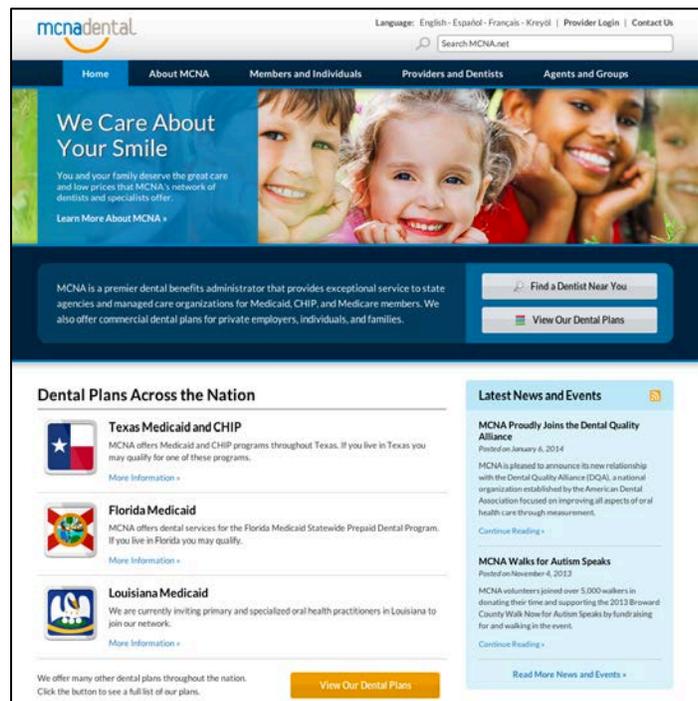
Section J.4

Describe how you will fulfill Internet presence and Web site requirements, including:

- Your procedures for up-dating information on the Web site;
- Your procedures for monitoring e-mail inquiries and providing accurate and timely responses; and
- The procedures, tools and reports you will use to track all interactions and transactions conducted via the Web site activity including the timeliness of response and resolution of said interaction/transaction.

The MCNA corporate website (www.mcna.net) is tailored to meet the needs of the populations we serve. Our website is currently available in English, Spanish, French, and Creole. **This enables MCNA to immediately serve Louisiana’s diverse population in a culturally competent manner through our website well in advance of the go-live date of May 1, 2014.**

The site’s lightweight back-end technology is scalable and adaptable. Anything from additional languages to new pages or entirely new color schemes can be implemented with ease by an internal team of web development specialists. Developed to take advantage of modern web technologies and hosted on efficient and redundant servers, the site offers quick page loads and easy navigation. Detailed usage statistics are collected to support continuous refinement of the user experience as well as enhance reporting opportunities.



The MCNA website is designed to **comply with accessibility standards** to achieve the highest degree of usability. In addition to being cross-browser compatible and compliant with the World Wide Web Consortium’s validation standards, the site meets the guidelines set by Section 508 of the U.S. Rehabilitation Act that address accessibility for people who are visually impaired, deaf, or hard of hearing. The site is designed with clear and resizable fonts, direct navigation, and vibrant colors. No special browsers or plug-ins are necessary to access essential site functionality.

Visitors to the website can search an up-to-date, real-time Provider Directory, filtered by name, specialty, geographic location, and special needs preferences and other criteria.

MCNA providers can access our secure Provider Portal. This integrated, online Provider Portal offers an ideal solution for providers to easily perform necessary day-to-day functions including:

- Verify member eligibility
- Submit claims and view claim status
- View missing information from any claims submitted
- Submit and review the status of appeals
- Request and view prior authorizations and referrals
- Print Remittance Advices (RAs)
- Review a member's dental treatment history
- Create an appointment book
- Manage fee schedules
- View Member Roster
- View and update demographic information
- View individual scorecards and provider profile reports
- Access Provider Manual and newsletter updates

Procedures for Updating Information on MCNA Websites

We believe communication with our members and providers is integral to the provision of quality dental care. In order to ensure our websites maintain relevant information for our members and providers in a timely and accurate manner, our in-house team of expert web development specialists and communications specialists update our websites whenever member or provider materials are revised.

Changes to our websites adhere to a robust set of controls that meet all of our quality assurance processes to ensure content and changes comply with all contractual obligations. When changes are made to our websites, they are performed in a three-tiered approach.

1. The "**Development Tier**" is used exclusively by our Creative Services department when developing new website content or new functionality.
2. Once content within the "Development Tier" is deemed stable and ready for review, it is published to the "**Staging Tier**." The new website content or functionality is thoroughly reviewed by our internal team of quality analysts, the Compliance department, other business stakeholders, as well as the DHH and other delegated third parties as required.
3. Once all parties approve content in the "Staging Tier," it is published to the "**Live Tier**" where it is accessible to the public.

DHH may request the modification or addition of content to our DBPM website at any time. MCNA values the opportunity to work with the DHH and will treat the requests with the highest priority while adhering to our process standards.

REDACTED

REDACTED

Section K.1

Provide a narrative with details regarding your member services line including:

- Training of customer service staff (both initial and ongoing);
- Process for routing calls to appropriate persons, including escalation; The type of information that is available to customer service staff and how this is provided (e.g., hard copy at the person's desk or on-line search capacity);
- Process for handling calls from members with Limited English Proficiency and persons who are hearing impaired;
- Monitoring process for ensuring the quality and accuracy of information provided to members;
- Monitoring process for ensuring adherence to performance standards;
- How your customer service line will interact with other customer service lines maintained by state, parish, or city organizations (eg. Partners for Healthy Babies, WIC, housing assistance, and homeless shelters); and
- After hours procedures.

MCNA's Member Services Representatives (MSRs) are our **"key link"** to the nearly **3,000,000 members** we serve. Our MSRs are at the forefront of our commitment to ensuring that all of our members receive accurate and timely information needed to access dental care, and are responsible for answering all inbound calls from MCNA's members. Each MSR is **extensively trained** to provide accurate and timely resolutions of all inquiries and issues using quality driven customer service skills. Additionally, MSRs make outbound welcome calls to new MCNA members, provide proactive education to members on the importance of proper dental care, and assist them with selecting a Primary Care Dentist.

Our Call Centers handled over 1.1 million calls in 2013. A total of 91.4% of the calls were answered within 30 seconds with an abandonment rate of only 1.07% and an average speed of answer to speak to a live representative of 7.9 seconds.

MCNA's Member Services department is committed to be a **first-call solution-driven** department. We maintain open lines of communication with all of our members to ensure they are kept informed in an accurate and timely manner of any issues or questions concerning their eligibility, covered services, rights and responsibilities, access to care and provider availability.

MCNA has integrated call centers in Texas and Florida. Our work plan for the DBPM contemplates the establishment of a **New Orleans based call center** to supplement our current hotline infrastructure. Our Workforce Management team uses **Computer Telephony Integration (CTI)** for real-time performance monitoring and **the state-of-the-art NICE IEX Workforce Management Solutions** to forecast call volume and staffing needs. All Member Services Representatives are cross-trained to handle multiple plans to minimize wait times for our members and to provide redundancy in the event of a disaster. (For more information about our Disaster Recovery and Business Continuity Plan, please refer to Section L of this response.)



Customer Service Excellence

MCNA is **committed** to delivering superior customer service that meets the needs of our members in a consistent, personalized manner unsurpassed in professionalism, politeness and promptness.

MCNA's Commitments to Service	
S elfless	We will demonstrate dedication to our members through our conduct, conversation and results.
E thical	We will act with cultural competency, integrity and a sense of responsibility to our members.
R espectful	We will treat each member like they are a member of our own family and ensure that every interaction is conducted in a pleasant and professional manner.
V ersatile	We will be resourceful and capable of performing a variety of tasks in order to get the job done.
I nnovative	We will identify ways to continuously improve our processes and policies to meet the needs of our members. We will welcome feedback from our members as a means to improve the service we provide.
C lear	We will actively listen to our members and respond in a clear and concise manner. We will communicate through available channels, providing accurate information in a manner that is easy to understand.
E ncouraging	We will support employee creativity and teamwork to promote an open and collaborative work environment that encourages employees to excel in every aspect of their job, especially customer service.

Training Member Services Staff

MCNA understands the critical nature of each incoming call we receive from our members. Our intensively trained call center staff is the heart of our business operation. MCNA’s corporate philosophy recognizes that each member is unique and special, and we treat them with the same courtesy and respect we would want our family members to receive. We strive continuously to ensure that our Member Services Representatives are thoroughly trained and know how to handle the various situations that may arise ensuring that our MSRs present themselves with skill and professionalism at all times. We start by using the **GROW** model to acquire stellar talent. MCNA recruits a diverse workforce that mirrors the populations we serve. The **GROW** model uses a collaborative approach to determine if candidates are a good fit for our call center.

Goal	Recruit	Options	Welcome
Leadership discusses recruiting goals and how to achieve them.	Proactively seek out qualified candidates to ensure the right talent is hired to meet business needs.	Utilize experienced call center leadership to interview and conduct “round-table” discussion to determine which candidates are a good fit.	Onboarding process including employment verification, background checks, reference checks, and new-hire orientation.

Marty Bailey, MCNA’s Senior Director of Call Center Operations, is responsible for educating, monitoring, and ensuring ongoing staff training as needed to maintain professional competency and the highest standards of customer service.

MCNA has a skilled training team led by Shawn Zielinske. Our training team continuously updates a library of training materials, desk reference materials, and our online knowledge database to ensure all MSRs have the most up-to-date program, benefit, and operational information. Each MSR receives formal training during the initial 90 days of employment with MCNA and is required to attend four additional supplemental training sessions per year.

MCNA’s Customer Service Leaders

Marty Bailey
Senior Director of Call Center Operations

Marty Bailey is an accomplished operations leader with more than 15 years of experience driving organizational change in call center and customer care environments.

Shawn Zielinske
Project Manager and Training Analyst

Shawn Zielinske is a 21-year veteran of the U.S. Air Force with 20 years of experience creating, developing, and implementing training programs and training personnel.

The formal training program consists of two weeks of classroom training and two weeks of “Bridge.” The classroom training phase covers various modules including plan specific training, systems training, compliance, and company policies and procedures. Early in this phase of training, agents spend time daily sitting side by side with tenured representatives and listen to live calls using a dual headphone jack splitter. After classroom training is completed, the trainees begin taking live calls in the “bridge”

phase while the tenured representatives listen and remain available to assist with questions and system navigation.

The “Bridge” training phase is conducted in a controlled environment which simulates a real call center setting where the trainees can practice all of the lessons learned in the classroom before transitioning full time onto the call center floor. This portion of training is led by a seasoned supervisor with the support of a team lead and quality analyst who are available to answer questions and provide real-time coaching and feedback. At the end of each day, the trainees regroup in the classroom to discuss the calls handled, ask questions and share best practices. Testing is administered throughout the four-week training program and a comprehensive exam is conducted on the final day. Trainees must score a 90% on the final exam before graduating.

Member Services Representatives are provided frequent updates called **GNUs Flashes** (General News Updates) to keep them informed. These updates are stored in a shared-drive accessible by all call center staff and posted on large TV screens visible to staff each time they enter and exit the call center.

Training materials specific to the Louisiana Dental Benefit Program Manager (DBPM) requirements have been developed and will be submitted for DHH approval. This training will be provided in print and electronic formats and will include:

- Detailed instructions for advising the member about the distribution of new member materials including Welcome Packets and Member Handbooks
- Description of Covered Dental Services including benefit limitations and exclusions
- Member Rights and Responsibilities
- A comprehensive review of the Louisiana Dental Benefit Program including attendant reference manuals and supporting materials
- Detailed instruction in the use of all MCNA customer service systems (phone, computers)
- Cross-training from all MCNA operational departments
- Explanation of prior authorizations and member referrals
- Provider Network and Access and Availability Requirements
- Education covering CMS guidelines, and all Member Services department policies and procedures
- Detailed education on the identification of Fraud and Abuse and all related reporting requirements
- Review of the MCNA Mission, QI Program, Risk Management Program, Cultural Competency Program, Grievances and Appeals processes, incident reporting protocols, and the Business Continuity and Disaster Recovery Plan within thirty days of hire for all new hires

All MSR's are recertified annually on these programs. Additionally, MSRs receive training on conflict resolution, DentalTrac™ features and functionality, and call center time management.

Call Routing and Escalation

MCNA's toll-free Member Hotline is available **24 hours a day, 7 days a week**, and staffed **Monday through Friday** between the hours of **7:00 a.m. to 7:00 p.m. CST**, excluding state-approved holidays. MCNA's Interactive Voice Response (IVR) system answers calls within **1 ring** and offers a series of prompts in the essential languages of the markets we serve to ensure calls are routed correctly. Members can request any of the following service options:

- Verify Member Eligibility
- Locate a Provider
- Choose a Primary Care Dentist
- Receive Benefits Information
- Inquire about Claims, Pre-Authorizations, or Referrals
- Submit Complaints, Grievances, or Appeals

Our MSRs are ready and willing to assist members with **understanding and accessing** their benefits and resolving any issues the member may encounter while utilizing our services. In a dynamic, ongoing, and problem-solving environment, the MSRs are responsible for:

- Fielding all inbound calls with a first-call resolution (FCR) approach
- Escalating issues to supervisors when applicable
- Referring callers to other departments appropriately
- Performing quality-focused outbound calls to educate new members on all services and the importance of good oral health
- Coordinating care with state, parish or city organizations when applicable

Our MSRs will be fully trained on DHH policies and procedures prior to the go-live date to ensure members are provided the latest, most accurate information about their dental benefits. All calls are documented in DentalTrac™ for tracking and trending. The DentalTrac™ system captures the date, time, member information, reason for the call, and the resolution of the call.

Limited English Proficiency and Persons with Hearing Impairment Functionality

MCNA serves the linguistic preferences of members whose primary language is not English by maintaining staff who are culturally competent and fluent in Spanish, French, Creole, Vietnamese, and other predominant regional languages. If a caller has limited English proficiency, the call is transferred to a representative who conducts the call in the member's preferred language. If there are no representatives that speak the member's preferred language, MCNA can access the translation services of Language Line, the largest interpretation service



company in the industry. Language Line provides translation services for over 200 languages not directly available from MCNA staff. This translation service is free to MCNA members and providers. A TTY line is also available for members with speech or hearing impairments. Members who are unable to push telephone buttons are prompted to remain on the line while the call is routed to an MSR.

Monitoring the Quality and Accuracy of Information Provided to Members

At MCNA, we understand that call handling has a significant impact on member satisfaction. We strive to increase member satisfaction by promptly responding to calls and providing a pleasant and informative interaction for each member. Our MSRs are thoroughly trained on dental benefits, policies and procedures, customer service, issue resolution and call handling skills. Our system records all member calls for quality assurance purposes.

MCNA's Quality Assurance program is called "**FORCE Factors**". Member Services Representatives are required to demonstrate a "Focus On Remembering the Customer Experience" throughout each and every call. MCNA has a team of 15 dedicated Quality Assurance Analysts who audit calls using our "FORCE Factors Quality Scoring Guide" and provide regular coaching and feedback. Quality attributes measured include:

- Adherence to scripts
- HIPAA Compliance
- Professionalism
- Decorum
- Accuracy of information
- Adherence to Policies and Procedures
- First Call Resolution

MCNA takes quality call handling very seriously and has implemented a very strict Zero Tolerance Indicator Policy used to enforce quality call handling. An infraction may be identified through daily call monitoring activities or as a result of a complaint from an external source, internal employee or member of the management team. Each Zero Tolerance Indicator is considered a serious offense and will result in immediate removal of the MCNA Dental employee from the phones. Upon review of the incident by the management team of the department, the infraction may result in remediation or termination of the employee.

The following are considered violations of MCNA's Zero Tolerance policy:

- Offensive, rude, and abusive language
- Call avoidance
- Disparaging remarks about any dental health plan, its affiliates, products, or competitors
- Disparaging remarks about MCNA, including its employees, products, equipment, systems, affiliates, or competitors

- Refusal to escalate a call to a supervisor or manager when requested to do so by a caller
- Placing a caller on hold/mute to conduct personal business or with the intention of extending the hold/mute time until the caller hangs up
- Inappropriate comments after placing the caller on hold/mute that can be heard through call monitoring
- Use of a personal cell phone while a caller is on the line or on hold/mute
- Unauthorized release of PHI or other confidential information defined as a HIPAA violation
- Inappropriate fraternization with callers or other MCNA employees

In conjunction with our Member Services department, our Quality Improvement department utilizes a variety of quality assurance techniques to monitor the performance of our Member Services staff, including reviewing recorded calls, silent audits and side-by-side call monitoring with MSRs. The training and quality team monitors a minimum of eight (8) calls per agent per month. MCNA's Training and Quality Manager coordinates additional training to any MSR that does not meet 100% of our performance standards. In addition, weekly calibration sessions are conducted with members of the leadership team, quality assurance team and MSRs to ensure consistency in application of the monitoring tool. Monitoring marathons are held monthly with focus groups to listen to calls from a member's perspective to ensure the customer experience exceeds member expectations.

Monitoring to Ensure Performance Standards

Monthly reports are generated and used by the Senior Director of Call Center Operations and Director of Quality Improvement to identify trends and ensure compliance with our contractual requirements. If a deficiency occurs, the Senior Director of Call Center Operations develops process improvement strategies to address the issue in question. Examples of process improvements include hiring additional staff and conducting additional Member Services training to improve performance.

The Member Services management team reviews daily performance reports and ensures the following call center key performance indicators (KPI) meet or exceed our contractual performance standards:

- 100% of inbound calls are answered by a live person or our automated call IVR system within 30 seconds
- No more than 1% of incoming calls receive a busy signal
- Call abandonment rate is 5% or less
- A caller on hold is acknowledged every 30 seconds
- Average wait time for a live person does not exceed 3 minutes

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Part Two: Technical Approach

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Interaction with Other Customer Service Lines

MCNA values our relationships with other social service and health care organizations. We routinely contact other agencies to gain their assistance for our members. Our MSR's contact other service lines maintained by state agencies, parish and local government units, and related community agencies to help assist our members with needs such as food, shelter, child care assistance, and other services where assistance may be available. MCNA looks forward to working with DHH to connect members to other partnering agencies.

We can remain on the call and establish a conference bridge with the other customer service center allowing a three party call to occur. This approach works best in situations where the member may need the assistance of our MSR in communicating with the other agency. If the MSR does not need to be part of the call to provide further assistance to the member, our MSR uses a "warm transfer" to connect the member directly to a customer service agent at the other entity.

After Hours Procedures

MCNA's call center operates Monday through Friday 7am to 7pm CST, excluding state-approved holidays. For after hours calls, including weekends and state-approved holidays, our members can access MCNA's toll-free IVR system. The voice-activated menu is available in the essential languages of the markets we serve, and can be easily modified to accommodate the language of any other additional population group. The IVR informs callers of our operating hours and what to do in cases of a dental emergency or natural disaster, and allows callers to leave messages. Our staff monitors the message queues and returns all calls within one (1) business day of receipt.

Section K.2

Provide member hotline telephone reports for your Medicaid or CHIP managed care contract with the largest enrollment as of January 1, 2013 for the most recent four (4) quarters, with data that show the monthly call volume, the trends for average speed of answer (where answer is defined by reaching a live voice, not an automated call system) and the monthly trends for the rate.

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Section K.3

Describe the procedures a Member Services representative will follow to respond to the following situations:

- A Member has received a bill for payment of covered services from a network provider or out-of-network provider;
- A Member is unable to reach his/her a provider within the network after normal business hours;
- A Member is having difficulty scheduling an appointment for preventive care with her primary care dentist; and
- A Member becomes ill while traveling outside of the state.

Situation 1

A member has received a bill for payment of covered services from a network provider or out-of-network provider.

MCNA's Member Services Representatives (MSRs) are thoroughly trained to understand covered services for members participating in the Dental Benefit Program and how to respond when a member receives a bill from an in-network or out-of-network provider. When an MSR receives a call from a member regarding receipt of a bill for covered dental services, the MSR will use DentalTrac™ to view the member's records and look specifically at the member's eligibility, benefits and claims history, and take the following actions:

1. The MSR advises the member that they do not have any financial responsibilities for covered services and that balance billing is never allowed.
2. The MSR inquires about the source of the bill and requests the member send a copy of the bill. If the member cannot provide a copy of the bill, the MSR will make an attempt to obtain any billing information from the member.
3. If it is a covered benefit:
 - The MSR determines if a claim has been received. If the claim has not been received and the timely filing period has not expired, the MSR will contact the provider, advise them to submit the claim to MCNA for payment and remind the provider that they are contractually prohibited from billing members for covered services.
 - If MCNA received a claim that had been denied, the MSR will notify our Provider Relations department to contact the dental office and advise them of the situation. The Provider Relations Representative will work directly with the provider to resolve the issue. The provider and their billing staff will be educated regarding MCNA's prohibition against balance billing.

- Once a final resolution has been reached, the MSR contacts the member and notifies him or her of the resolution.
4. If it is a non-covered benefit:
- The MSR will explain to the member that the procedure is not a covered service and assist the member in reviewing the benefits section of the Member Handbook.
 - The MSR will ask the member if they were offered a proposed treatment plan by the rendering dentist and signed it, and if they were advised that any non-covered services will be the member's liability.
 - If the member is not satisfied, he or she is advised of their right to file a grievance, and the MSR will offer assistance if needed.
5. The MSR will inform the member to contact MCNA if he or she experiences any further billing issues with the provider.

The Senior Director of Call Center Operations monitors all complaints categorized as "Member Received a Bill" in DentalTrac™ to identify patterns of balance billing so that targeted provider interventions can be performed as needed.

Situation 2

A member is unable to reach her PCD after normal business hours.

MCNA's Member Services Representatives understand the importance of **timely access** and are trained to assist members who have difficulties contacting their PCD after normal business hours. When a Member Services Representative (MSR) receives a call from a member who is reporting a problem with reaching their PCD after normal business hours, the MSR will ask questions to assess the member's condition and assist the member with scheduling an appointment within the following timeframes:

- Urgent care within 24 hours
- Non-urgent care within 72 hours or sooner if dental condition(s) deteriorates into an urgent or emergency condition
- Routine, non-urgent or preventive care visits within six (6) weeks

The MSR will comply with the following procedures:

1. In the case of an emergency, the MSR will advise the responsible party to contact 911 or go to the nearest emergency facility. A Member Services Team Lead will follow-up within 24 hours with the member and assist the member in scheduling an appointment with their PCD to ensure the needed services are received.

2. In an urgent situation, the MSR will make a three-way call to the provider's office. If contact is made, the MSR will assist the member in scheduling an appointment. If an appointment is secured, a Member Services Team Lead will follow-up with the PCD and the member within 24 hours to ensure the member received the needed services and determine if further assistance is required.
3. If the MSR is unsuccessful in contacting the member's PCD for urgent and non-emergency situations, the MSR will:
 - Refer the member to a contracted non-emergency facility to address member non-emergency care issues occurring after regular hours or on weekends.
 - Offer to assist the member with selecting and reassigning to a different PCD.
 - Assist the member in scheduling an appointment.
 - Notify the Provider Relations department to take appropriate action on the non-compliant provider. The PCD's assigned Provider Relations Representative will follow-up and educate the provider on after-hours protocols. The Provider Relations Representative will monitor the provider within thirty (30) days to ensure compliance.

On a weekly basis, the Senior Director of Call Center Operations monitors complaints regarding appointment availability and after-hours coverage to identify trends. Our Provider Relations department provides ongoing education and outreach to our PCD community regarding their responsibilities with respect to appointment access and availability.

MCNA's Provider Relations department monitors compliance with appointment standards through "secret shopper" calls and feedback from member satisfaction surveys. Opportunities for improvement and performance trends are identified and addressed accordingly. If the PCD is found to be non-compliant for contractual standards regarding appointment timeframes, our Provider Relations department will develop a corrective action plan in conjunction with the PCD. Continued failure to adhere to timeliness standards can result in provider termination.

Situation 3

A Member is having difficulty scheduling an appointment for preventive care with her PCD.

MCNA's Member Services Representatives understand the importance of preventive care to promote good oral health and prevent illness. When a Member Services Representative (MSR) receives a call from a member who is reporting difficulty scheduling an appointment for preventive care with her PCD, the MSR will ensure the member understands that providers are required to schedule appointments within six (6) weeks for non-urgent preventive care services.

1. The MSR will conduct a three-way call to the PCD to assist with scheduling the appointment for preventive care.
 - If the PCD cannot schedule an appointment within the required six (6) week time frame, the MSR will inquire about the appointment availability for other participating PCDs in the same office. If availability meets the six (6) week requirement, the MSR will ask the member if they agree to see the other provider.
 - If the member agrees, the MSR will schedule an appointment for the member.
 - If the member does not agree to see another provider in the same office, the MSR will offer to assist with selecting a different PCD that is convenient for the member. If the member agrees to the new selection, the MSR will update the member's record in DentalTrac™ with the new PCD information and conduct a three-way call to the new PCD office to assist with scheduling an appointment.
2. The MSR will inform the Provider Relations department to follow up with the non-compliant provider to educate and enforce access and availability standards. Our Provider Relations department will contact the provider for remedial education and conduct a follow-up process, including a "secret shopper" survey of the provider. If the PCD is found to be non-compliant with contractual standards for appointment timeframes, our Provider Relations department will develop a corrective action plan in conjunction with the PCD. Continued failure to adhere to timeliness standards can result in provider termination.

Situation 4

A Member becomes ill while traveling outside of the state.

MCNA understands that members may require dental services while traveling out of state and has policies and procedures in place to address these situations. When a Member Services Representative (MSR) receives a call from a member who is inquiring about dental services while traveling out of state, the MSR will ask questions to assess the member's condition.

1. If it is an emergency situation, the MSR will inform the member that emergency services are a covered benefit and do not require prior authorization. Furthermore, members will have no financial responsibilities for services received.
 - The MSR will then advise the member to go to the nearest emergency facility or call 911. If needed, the MSR will assist the member with locating the nearest emergency facility that is convenient to the member.
 - The MSR will obtain a contact number from the member for follow-up. Within 24 hours, a Member Services Team Lead will follow-up with the member and assist the member with scheduling an appointment with their PCD upon their return to the state.

2. If it is an urgent, but non-emergent situation, the MSR will inquire if the member needs their dental condition assessed right away or if he or she can wait until they can be seen by their PCD.
 - If the member cannot wait, the MSR will review our online Provider Directory to identify if there are any MCNA participating providers in the state that the member is currently in and will locate a provider convenient to the member.
 - If there are no participating providers in the state convenient to the member, the MSR will identify a suitable non-par provider and coordinate with the Provider Relations department to negotiate a Letter of Agreement (LOA) with the provider to render services to the member. Once the LOA has been established, a Member Services Team Lead will contact the member and assist the member with scheduling an appointment.
 - Within 24 hours, a Member Services Team Lead will follow-up with the member and assist the member with scheduling an appointment with their PCD upon their return to the state.
3. If the member can wait to receive services upon return to the state, the MSR will conduct a three-way call with the member and their PCD, and assist with scheduling an appointment.

MCNA's IVR system operates after hours, on weekends, and on state-approved holidays. The IVR informs callers of our operating hours, what to do in cases of an emergency, and allows callers the option to leave a message. All voice messages are returned within 24 hours. Our Manager of Call Center Operations is responsible for continually monitoring our after-hours messaging system.

Section K.4

Describe how you will ensure culturally competent services to people of all cultures, races, ethnic backgrounds, and religions as well as those with disabilities in a manner that recognizes values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each.

Our ongoing Cultural Competency Program is respectful of and responsive to the beliefs, practices and cultural and linguistic needs of our diverse members. We use “Person First” language in all written materials and verbal interactions.

We know that members who understand the dental health information we provide are better equipped to make good decisions about their oral health. MCNA is committed to providing services and information, both orally and in writing, in languages other than English. This action is taken in order to make certain that members with limited English proficiency and special health care needs have their communication needs met and are **effectively informed** on access to programs, benefits, and activities.

The objectives of the Cultural Competency Program are to:

- Ensure that services are provided in a culturally competent manner to all members including those with limited English proficiency and visual and hearing impairments
- Provide members access to quality dental services that are culturally and linguistically sensitive
- Address the physical and psychological needs of our members who have disabilities to ensure appropriate assistive devices are made available to them
- Identify members that may have cultural or linguistic barriers and ensure that resources are available to overcome the language barriers
- Utilize culturally sensitive and appropriate educational materials based on the member’s race, ethnicity and primary language spoken
- Make certain that providers care for and recognize the culturally diverse needs of the population
- Ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery

Our **network development** methods are designed to ensure that our network includes a diverse array of providers to care for the population served. MCNA recruits providers that value diversity and are committed to serving people of racial and ethnic minorities and those with disabilities. We strive to achieve the best match possible in each community. MCNA captures information from providers regarding their own and their staff’s language abilities. This information is maintained on our online Provider Directory so that members can choose providers who speak **their preferred language**.

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Our provider agreement **requires compliance with the ADA** (Americans with Disabilities Act) and our own non-discrimination policies.

MCNA employs a **diverse workforce** that represents the spectrum of cultural diversity of our membership. Our Member Services and Provider Relations departments can easily meet the linguistic needs of our population. MCNA hires staff that is committed to their community, represents a variety of cultural backgrounds, and is capable of communicating in cross-cultural situations.

All new MCNA **staff must attend cultural competency training** within thirty (30) days of the date of hire. Major elements of the training include:

- The rationale and need for providing culturally and linguistically competent services
- Effective approaches to communicating information to Medicaid and CHIP members
- Gauging members' perception (i.e., fearful versus trustful) of providers and their staff

MCNA also incorporates diversity exercises into staff meetings to ensure that staff appreciates and **respects diversity** within the organization and among the enrolled population. At each performance appraisal period, MCNA staff is evaluated on their respect for diverse backgrounds as a core value that MCNA measures. Staff will be assessed for their cultural competency through direct observation, and monitoring of member satisfaction with individual Member Service Representative encounters.

MCNA is committed to hiring a workforce in Louisiana that mirrors the community in which we serve. **Discrimination is not tolerated** and we require employees to conduct business in a manner that recognizes the values, and affirms and respects the worth of the individual, and protects and preserves the dignity of each.



Below please find the most recent MCNA Cultural Competency Program (CCP).

The CCP was evaluated and approved by the Florida Agency for Health Care Administration in 2013.

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Part Two: Technical Approach

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Section K.5

Describe how you will ensure that covered services are provided in an appropriate manner to members with Limited English proficiency and members who are hearing impaired, including the provision of interpreter services.

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MCNA providers are informed of the availability of the TTY number for the hearing impaired in MCNA's Provider Manual, website, Online Provider Portal, and through information distributed during provider orientation and training sessions. When providers access the TTY number, there is a representative that will provide relay to hearing impaired members.

Assistance is available to our members when care is being rendered in a provider's office. Our staff arranges **in-office interpreter services for our members** through Interpreters Unlimited, a national leading language provider. This assistance is available when the member's parent or guardian does not speak the language spoken in the provider's office or is hearing impaired allowing care to be facilitated in a culturally competent manner and ensuring the family understands the nature of the dental treatment being provided.



MCNA's Quality Improvement team identifies patterns of care for those with limited English proficiency or other communication barriers. The quality staff created an Interpreter Services Log (ISL) to monitor and track members with limited English proficiency who are assisted by MCNA.

The ISL contains the following components:

- Member name
- ID number
- Date of birth
- Name of parent/guardian
- Relationship to member
- Member phone number (if applicable)
- Language needed
- Type of service needed
- Date of appointment
- Appointment time
- Name of facility
- Facility address
- Facility phone number
- Company name of interpreter service
- Interpreter service phone number
- Name of interpreter assigned
- Confirmation number
- Notes

The requested information listed above is entered into the ISL and the Quality Improvement (QI) staff arranges for an interpreter to either assist via phone or be present at the member's dental appointment. The ISL is reviewed to track and trend the type of language and services that were provided on behalf of MCNA. The QI staff also confirms that the member received the requested interpreter services.

For community outreach events, the Community Outreach Coordinator or Member Advocate and Outreach Specialist (MAOS) accommodates members with limited English proficiency and attendees who may be visually or hearing impaired by altering or changing the technique in which oral health

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presentations and/or demonstrations are delivered. For example, for visually impaired members, the outreach specialist will use the touch feel method (stereognosis) to stimulate other sensory motor skills. The interpreter services are also used for community outreach events where a hearing impaired or limited English proficient audience may be present.

MCNA works with community-based organizations that support racial and ethnic minorities and the disabled to be sure that the community's resources for those with special needs are utilized. MCNA takes advantage of the relationships our members have with other community-based entities and we coordinate our outreach efforts with those agencies. **We call this concept "linking arms with the Caring Community."**

Section L.1

Describe your emergency response continuity of operations plan. Attach a copy of your plan or, at a minimum, summarize how your plan addresses the following aspects of pandemic preparedness and natural disaster recovery:

- Employee training;
- Identified essential business functions and key employees within your organization necessary to carry them out;
- Contingency plans for covering essential business functions in the event key employees are incapacitated or the primary workplace is unavailable;
- Communication with staff and suppliers when normal systems are unavailable;
- Specifically address your plans to ensure continuity of services to providers and members; and
- How your plan will be tested.

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Section L.2

Describe your plan in the following Emergency Management Plan scenario for being responsive to DHH, to members who evacuate, to network providers, and to the community.

- You have thirty thousand (30,000) or more DBP members residing in hurricane prone parishes. Louisiana parishes include coastal and inland areas subject to mandatory evacuation orders during a major hurricane. A category 5 hurricane is approaching, with landfall predicted in 72 hours and certain parishes are under a mandatory evacuation order. State assisted evacuations and self-evacuations are underway. Members are evacuated to or have evacuated themselves to not only all other areas of Louisiana, but to other States.
- Your provider call center and member call center are both located in Baton Rouge and there is a high likelihood of high winds, major damage and power outages for 4 days or more in the Baton Rouge Area (reference Hurricane Gustav impact on Baton Rouge). It is expected that repatriation of the evacuated, should damages be minimal, will not occur for 14 days. If damage is extensive, there may be limited repatriation, while other members may be indefinitely relocated to other areas in Louisiana or other states.

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Section M.1

Provide a flowchart (marked as Chart C) and comprehensive written description of your member grievance and appeals process which comply with the RFP requirements, including your approach for meeting the general requirements and plan to:

- Ensure that the Grievance and Appeals System policies and procedures, and all notices will be available in the Member's primary language and that reasonable assistance will be given to Members to file a Grievance or Appeal;
- Ensure that individuals who make decisions on Grievances and Appeals have the appropriate expertise and were not involved in any previous level of review; and
- Ensure that an expedited process exists when taking the standard time could seriously jeopardize the Member's health. As part of this process, explain how you will determine when the expedited process is necessary.

Include in the description how data resulting from the grievance system will be used to improve your operational performance.

MCNA is **committed to ensuring prompt resolution** of all grievances and appeals. Our Grievances and Appeals department provides a fair, thorough, timely investigation and resolution of all grievances and appeals registered by our members and providers acting as their authorized representatives.

In 2013, MCNA resolved 99.9% of appeals within 30 days of receipt. 100% of grievances were resolved within 90 days of receipt.

MCNA has a proven track record of resolving grievances and appeals well in advance of state required time limits.

We will comply with all state, federal and DHH requirements.

Helping Members with Grievances and Appeals

MCNA's diverse and experienced staff creates a unique, solution-oriented, member-focused environment. We believe that every member should be treated with dignity, respect, and compassion. Our proven approach and years of experience allow our trained staff to provide the attention to detail that a strong grievance and appeals process requires.

We assist our members in accessing our grievances and appeals process. Copies of our grievances and appeals policies and procedures as well as all written notifications are provided in the primary language of the member. Additionally, all required notices and determinations are written **at or below a 6th grade reading level** to ensure ease of understanding.

Members are provided with a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. Anytime before and during the process, the member or an authorized representative may examine the case file, including dental records and any other material to be considered during the process.

There may be barriers that impede a member's ability to effectively maneuver the grievance and appeals process. **MCNA's highly trained and dedicated staff assists members and their representatives with fully understanding and accessing our process.** MCNA educates our members and providers about the process to file grievances and appeals via the Member Handbook, Provider Manual, any notices of action or inaction, and through our website which is available in English, Spanish, French, and Creole. MCNA provides information about accessing our grievance and appeals process to the member's authorized representative upon request. Our Member and Provider Service Representatives are thoroughly trained to assist members and providers in filing grievances and appeals via our toll-free hotlines.

In Texas, MCNA employs experienced **Member Advocate and Outreach Specialists (MAOS)** to ensure members receive appointment reminders, assistance with scheduling dental appointments, transportation assistance, oral health education, and **one-on-one personalized assistance** with submitting grievances and appeals and understanding plan benefits. **This proven, member-centered approach will be replicated in Louisiana.** MCNA also provides additional resources for members with disabilities and those requiring linguistic and translation services by utilizing the following:

- TTY/TDD line capability for hearing impaired members
- Member Services Representatives who speak English, French, Creole, Spanish and Vietnamese
- Free translation services available for 200 languages
- Large print or Braille materials for members with impaired sight
- Additional accommodations for members with special needs

Grievance Process

MCNA considers a grievance any expression of dissatisfaction about any matter other than an action. Members can file grievances orally or in writing, within 30 calendar days of the occurrence of the matter that is the subject of the grievance. MCNA sends an acknowledgement letter to the member outlining the member's rights.

When a grievance is received by our Grievances and Appeals department, the case is assigned to a Grievances and Appeals Administrator (Administrator). The Administrator enters the grievance into the Appeals and Grievances module of DentalTrac™ and assesses the nature and urgency of the case to determine the appropriate resolution path. Our Administrator **immediately researches** the issue and coordinates with dental offices, involved parties, and the staff of other MCNA departments such as Provider Relations and Quality Improvement. Upon receipt of all supporting documentation and findings, the Administrator analyzes the information and documents the findings in the Grievance and Appeals module of DentalTrac™ and creates a disposition letter that addresses the member's concern.

MCNA prides itself on ensuring prompt attention to all quality of care issues. Upon completion of the grievance review, the member is sent a disposition letter advising them that any quality of care issues have been referred to the Quality Improvement department for further investigation and resolution.

This comprehensive process ensures that grievances are resolved quickly and satisfactorily. For all grievances and appeals, an acknowledgement and disposition letter is sent within the timeframes

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best interest. In circumstances where MCNA requests the extension, members are provided with written notification of the reasons for the decision to extend the time frame. The notice informs the member of their right to file a grievance should he or she disagree with the extension. MCNA will make reasonable efforts to carry out the decision as expeditiously as the member's health status requires and no later than the expiration date of the extension.

Once a member exhausts MCNA's internal appeal process, our Grievances and Appeals department sends an appeal disposition letter that advises the member of their right to request a State Fair Hearing within 30 days from the date of the notice if they are dissatisfied with our disposition. MCNA works with DHH throughout the **State Fair Hearing** process ensuring that all required information is readily available to those reviewing the case.

In 2013 our average turnaround time (TAT) for appeals was 14.76 calendar days across all lines of business.

Expedited Appeal Process and Continuation of Services

If the turnaround timeframe for a standard appeal or a delay in the delivery of the service could jeopardize the life, health or ability of the member to attain, maintain or regain maximum function, the member or provider can request an expedited appeal orally or in writing. MCNA's toll-free Member and Provider Hotline Representatives will assist members and providers with this process. The following steps are taken when MCNA receives a request for an expedited appeal:

- The request is scanned and entered into the DentalTrac™ Grievance and Appeals module
- All supporting documentation from the provider explaining the rationale for the expedited review is also attached to the file and maintained in the member's record
- Within 24 hours of receipt, the Administrator reviews the file and sends the case to a Clinical Reviewer with appropriate expertise who was not involved in the initial determination
- The Clinical Reviewer evaluates the case and determines if the request meets expedited criteria
- If the request for an expedited appeal is denied, the appeal will be handled according to the standard appeals process and timeframes
 - MCNA will provide written notice of the reason to the member within two (2) calendar days
 - Should the member disagree with the determination, information regarding the member's additional rights including the right to a State Fair Hearing is contained in the notice
- If the case meets expedited appeal criteria, MCNA will notify the provider and member, orally and in writing, of the determination to approve or deny the appeal within **72 hours**, unless the timeframe is extended in accordance with DHH requirements

- Should the member disagree with the determination, information regarding the member's additional rights including the right to a State Fair Hearing is contained in the notice

At any time during the appeals process, the member may request the continuation of services if applicable criteria are met. The request must be made within 10 calendar days of MCNA's mailing of the notice of action, or the intended effective date of MCNA's proposed action. The Administrator contacts the member to inform them that the benefits will continue until the appeal determination is made. The member will also be informed that if the appeal is overturned by MCNA or the State Fair Hearing, MCNA will pay for or authorize the services, and if the appeal is upheld by MCNA or the State Fair Hearing, the member may have to pay for the services, in accordance with the provisions of this RFP.

Improving Our Performance

As part of MCNA's Quality Improvement activities all key performance indicators (KPIs) for our grievance and appeals processes are tracked and trended. The activities involved in researching and resolving the case, including all documentation and communications exchanged, are recorded in the DentalTrac™ system for easy reference and superior tracking. The DentalTrac™ Grievances and Appeals module includes the following details in each grievance and appeal record:

- Complete description of the grievance or appeal
- Complaining or appealing party's name and address
- Provider's name and address
- Complete description of MCNA's findings
- Name of the Administrator or Clinical Reviewer that conducted the review
- Final disposition and recommendations

DentalTrac™ time stamps each grievance and appeal enabling the creation of a **complete audit trail to ensure compliance** with all timeliness requirements. MCNA maintains all data for a period of no less than 10 years. Our MIS generates extensive management reports that are used by MCNA's Grievance, Complaints and Appeals Committee to identify trends and root cause analysis. The Committee reviews reports to identify consistent patterns of complaints, formal grievances, and appeals filed by members and providers. When a pattern is identified, action is taken by the committee to designate members of the operational staff (Utilization Management, Quality Improvement, Provider Relations, and Grievances and Appeals departments) to investigate the pattern and provide a written report to the committee detailing the nature of the issue or issues and recommend corrective actions. All activities conducted by the Complaints, Grievances and Appeals Committee are reported to the Quality Improvement Committee.

Our Quality Improvement Committee (QIC), in conjunction with the Director of Grievances and Appeals, reviews reports to identify trends and implement Performance Improvement Projects (PIPs) to improve our processes. MCNA uses data to conduct root cause analysis in order to improve our Grievance and Appeals processes. For example, in our Florida market a particular oral surgeon was identified due to his high volume of appeal submissions in relation to extractions of healthy third molars. The QIC recommended a peer-to-peer training session with the provider. One of our Clinical Reviewers, who is

Part Two: Technical Approach

Section M: Grievances and Appeals



also an oral surgeon, met with the provider and discussed MCNA's Oral Surgery Guidelines which do not encourage removal of asymptomatic teeth. Our guidelines follow the recommendations of the American Association of Oral and Maxillofacial Surgeons. The meeting was successful, and the volume of member appeals for that provider has significantly decreased since.

MCNA's grievances and appeals process is designed to resolve open issues in a timely and sensitive manner, and complies with all requirements outlined in the Grievance System Section of the RFP. Our current policies and procedures have already been revised and updated to reflect the requirements of DHH and will be submitted for review and approval by DHH no more than 30 days prior to the effective date of the contract. Please see Chart C on the following page for a flowchart of MCNA's Grievance and Appeal process.

MCNA looks forward to providing our new Louisiana Medicaid enrollees with the same high level of service we provide to our nearly 3 million members throughout the nation.

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Section N.1

Describe your approach for meeting the program integrity requirements including a compliance plan for the prevention, detection, reporting, and corrective action for suspected cases of Fraud and Abuse in the administration and delivery of services. Discuss your approach for meeting the coordination with DHH and other agencies requirement.

Culture of Compliance

MCNA is committed to ensuring a culture of compliance and that all reasonable efforts are made to identify, prevent, and correct any instances of fraud and abuse. Our relationship with DHH will reflect these values.

MCNA's Board of Directors oversees the development and implementation of our Compliance Program and our Fraud and Abuse Program. Our Compliance Program guides the manner in which we conduct our business. Corporate compliance policies and procedures are specific to each business area within the company. MCNA's Compliance department strives to ensure the company maintains full compliance with all laws, regulations, policies, and guidelines through ongoing education and continuous monitoring.

Our Chief Compliance Officer, Mayre Herring, oversees MCNA's Compliance Program, as well as our Fraud and Abuse Program.

Mandatory Training Modules

All employees and contractors receive mandatory training on the following topics within 30 days of hire:

- Compliance
- HIPAA
- Fraud and Abuse
- Risk Management
- Member Rights and Responsibilities
- Cultural Competency
- Disaster Recovery

Upon completion of each training module, trainees receive certifications attesting that they have completed and understand the training. When it is identified that an employee has not completed the mandatory training, the employee is removed from their job function until training is complete. Each employee must undergo annual training for all mandatory modules at the time of their annual performance review.

MCNA has a dedicated hotline for reporting compliance, fraud and abuse issues. We ensure that all employees understand their role in identifying and preventing fraud and abuse. MCNA ensures that all employees understand that "whistleblowers" are safe from retaliation, and disclosure of any suspect

activity can be made without fear.

MCNA's Fraud and Abuse Program

Combating fraud and abuse is an essential part of the business ethos of MCNA. Our CEO and Board of Directors oversee the Fraud and Abuse Program and provide the Chief Compliance Officer with the resources needed to execute the program. MCNA's program incorporates all program integrity requirements and combines prevention, vigilant monitoring, investigation, enforcement, training and communication to foster a culture of ethics and compliance in our provider networks. Our entire organization is responsible for implementing and carrying out the Fraud and Abuse Program.

MCNA's Fraud and Abuse Program is comprised of the following elements:

- Suspicious Activity Detection
- Verification of Services Billed
- Withholding Payments Due to Credible Evidence of Willful Misrepresentation or Fraud
- Reporting Insurance Fraud
- Monthly and Quarterly Reporting Requirements
- Responding to OIG Requests and Inquiries
- Education and Training
- Tracking and Trending Encounter Data
- Disciplinary Actions for Infractions
- Whistleblower Protection
- Review and Updates to the Fraud and Abuse Program
- Collaborating with Regulatory Agencies

Our Special Investigations Unit (SIU)

MCNA's Special Investigations Unit (SIU) is responsible for the day-to-day implementation of the Fraud and Abuse Program. The SIU is committed to detecting, investigating, and reporting suspected or confirmed cases of fraud and abuse of participating and non-participating providers. **Our SIU is a dedicated team of Certified Fraud Examiners (CFEs), profiling analysts, investigators and clinical reviewers with over 100 years of combined experience in detecting and investigating fraud and abuse.**

Many of our SIU employees have prior law enforcement experience and possess certifications from

MCNA's SIU Leaders

Mayre Herring, M.H.A.

Chief Compliance Officer

Former Program Analyst for the Bureau of Managed Care at the Florida Agency for Health Care Administration overseeing Medicaid Managed Care health plan operations.

Vicki Grudzinski, C.L.E.A.

SIU Manager

Former Senior Medicaid Fraud Analyst with the Florida Office of Attorney General Medicaid Fraud Control Unit (MFCU). Former Special Auditor Investigator for the New York Medicaid Fraud Control Unit (MFCU). Certified Law Enforcement Analyst (CLEA) through the Florida Department of Law Enforcement.

Christian Fondeur, C.F.E.

Senior Fraud and Profiling Analyst

Former Senior Fraud Analyst for MBNA America. Former Fraud Analyst for Mercantil Commerce Bank. Lean Six Sigma, Green Belt.

such organizations as the Association of Certified Fraud Examiners and the Florida Department of Law Enforcement. The SIU staff reports to our Chief Compliance Officer who serves as MCNA's point of contact for all DHH fraud related matters. Our SIU team will meet with DHH and the Attorney General's Medicaid Fraud Control Unit (MFCU), at DHH's request, to discuss fraud, abuse, neglect and overpayment issues.

We will provide the State of Louisiana an unparalleled level of dental fraud prevention and mitigation capabilities that will help preserve the fiscal and operational integrity of the DBPM. **MCNA has identified and prevented in excess of \$5.9 million in dental related fraud in Texas and Florida.**

Fraud Prevention and Detection Measures

MCNA's advantage in detecting fraud and abuse activities lies in our ability to perform sophisticated analysis of claims data and provider profiles. The sophistication, flexibility and modularity of MCNA's proprietary management information system, DentalTrac™, allows for powerful, **data-driven predictive analytics**.

DentalTrac™'s proven proprietary fraud rules and robust clinical code edit engines look for outliers, reduce the amount of false positives, minimize costs and protect the health and safety of our members. DentalTrac™ generates trends and predictive models that are critical indicators used on a daily basis by our SIU for combating fraud and abuse.

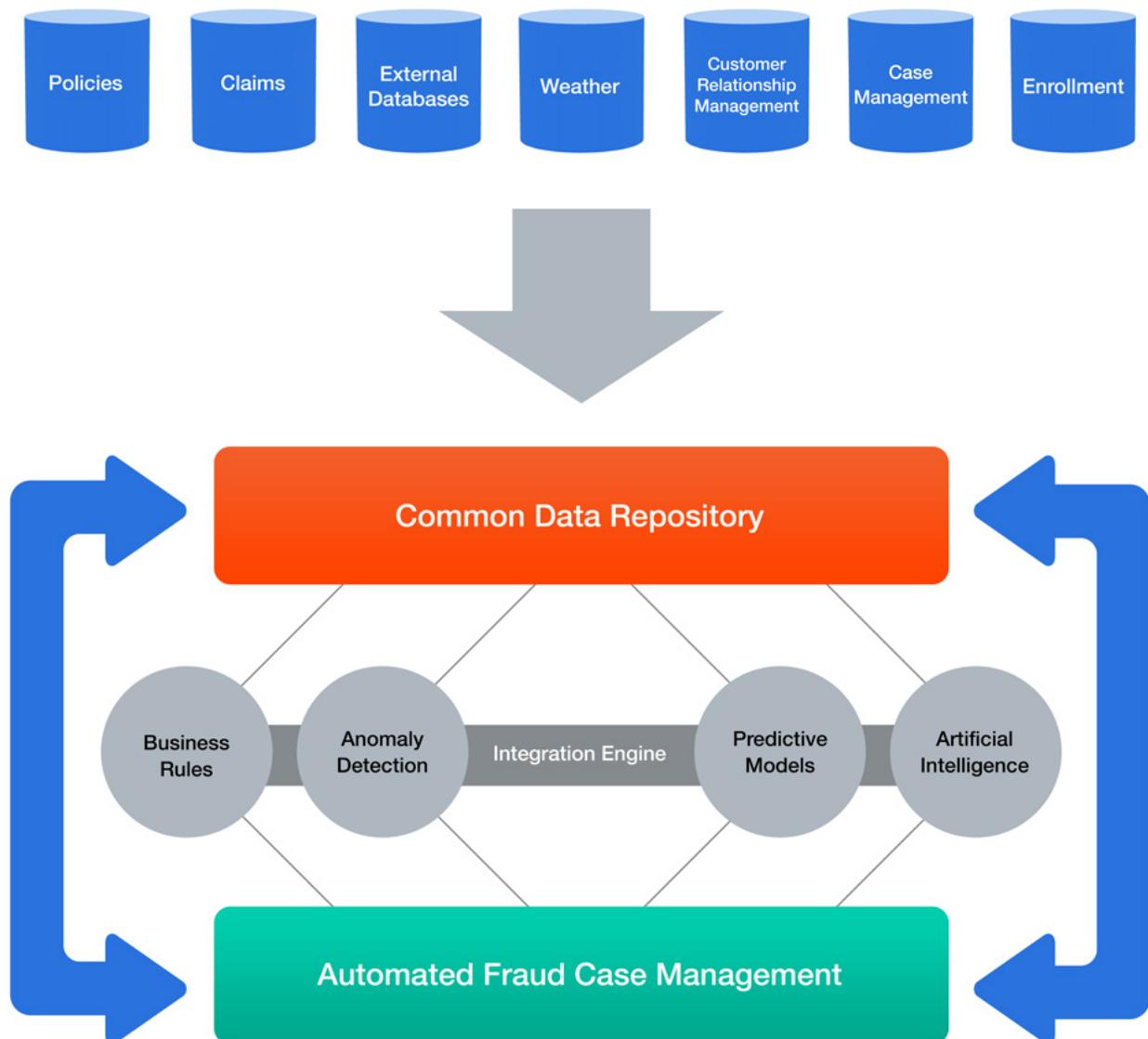
DentalTrac™ comprehensive fraud identification and detection tactics include:

- Proprietary database-driven technology that analyzes providers with suspect billing activity
- Consistent data mining that flags qualified cases for investigation
- Data-driven predictive analytics (algorithm and statistical)
- Custom rules and alerts that drive contract-specific workflow and payment policies
- Supplemental clinical code edits, updated in real-time
- National Correct Coding Initiative rules and methodologies

The following diagram outlines our comprehensive detection approach:

Part Two: Technical Approach

Section N: Fraud and Abuse



Fraudulent behavior is constantly changing form in an effort to evade fraud prevention measures. Every claim is passed through a series of intelligent filters in the DentalTrac™ management information system for a complete profiling analysis. Our management information system applies the proven algorithms in real time throughout the life-cycle of the claims:

- Prior to adjudication
- Post-adjudication but prior to payment
- Post-payment (retrospective)

MCNA's profiling analysis takes into account all claims data including new, resubmitted and adjusted claims (for items such as date of service or procedure code). Also included in the profiling analysis are

both paid and denied claims. Denied claims, although they pose no monetary loss, can indicate the intent to defraud. Outlined below are examples of the profile indicators monitored as part of claim-specific profiling:

- **Volume of Services Rendered:** The number of procedures performed on one or a group of members exceeding acceptable standard deviations from the norm and any statistical deviation is assessed to determine if it warrants further review.
- **Changes in service dates or procedure codes:** There are several ways in which the dates and types of dental services rendered impact claims payment. Identifying previously denied claims for the same member that are later rebilled but with a different date of service such that the services now fall within the defined parameter. Below are two examples:
 - **Date change-frequency denial:** Member's cleaning was denied due to frequency limitations. At a later time, a claim for the cleaning was resubmitted with a different date of service outside of the frequency limits.
 - **Procedure code change-frequency denial:** A sealant was submitted, but the claim was denied due to the three (3) year frequency limitation. An adjusted claim modifying the procedure code to a permanent filling was resubmitted for the same date of service.

MCNA uses Peer Outlier Reports to compare provider statistics against industry-defined benchmarks for Medicaid, CHIP, and other programs. The reports compare treatment patterns in procedures and service types using a wide range of filters such as facility, dental group, service code, provider type, member age, geography, date of service, and service area. Any noted deviations from industry norms are reviewed for potential fraud and abuse. Examples of this type of profiling reports are:

- Ratios of preventive procedures to periodontal care, including cleanings to gross debridement, and scaling and root planing services
- Extraction analysis, including surgical extractions vs. simple extractions
- Sedation procedure utilization by provider specialty
- Average amount paid per member
- Average number of services billed per member
- Number of members billed per day
- Claims volume by provider by month

One of MCNA's most sophisticated tools is the DentalTrac™ **Cluster Analysis** module. Cluster Analysis looks at aggregated data in different ways to identify and quantify additional irregularities that are not available with standard rules-based detections. It calls for non-biased groupings of large data sets that have few parameters, but form comparable clusters of data. Examples of different elements that may be clustered together include:

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An example of a provider education intervention related to improper billing practices recently occurred in one of our Florida Medicaid plans. Several Federally Qualified Health Centers (FQHCs) were found to be abusing the billing of their inclusive encounter rate. MCNA's Chief Dental Officer, Chief Compliance Officer, Chief Operating Officer and General Counsel met with representatives of the FQHC to discuss:

- Billing guidelines and patterns
- The necessity of narratives when more than one visit is necessary per quadrant
- Documentation of behavioral issues if they will cause multiple visits to be required to complete treatment
- Exams and x-rays should be completed on the same date of service

The education session yielded positive results by decreasing the inappropriate billing of multiple encounter rates for services that should be completed in a single visit.

MCNA views our relationship with providers as a partnership. Our increased provider education as a corrective action has greatly reduced abuse and over utilization, and strengthened the professional relationships we enjoy with our providers.

Establishing a Partnership with DHH and Other State Agencies

At MCNA we work hard every day to be an excellent partner to the states we serve. We have established close working relationships with the Inspector General offices (OIG) and Attorneys General (OAG) in the states where we currently operate. MCNA staff cooperates fully with law enforcement agencies and is always available for interviews, consultations regarding grand jury proceedings, hearings, trials, and other processes if called upon.

We are committed to maintaining close relationships with DHH and other Louisiana state agencies. In Texas, our SIU and clinical review teams have routinely met with the Texas Health and Human Services Commission (HHSC) and Medicaid Fraud Control Unit (MFCU) staff to assist them with their investigation efforts and participate in training sessions with the agencies.

Due to MCNA's proven experience in dental managed care, we are frequently asked to provide training and education on fraud, waste and abuse in the managed care environment by state agencies. This past year, **the Texas Attorney General invited MCNA's SIU Manager to train the MFCU investigators** on our provider enrollment process, claims analysis, provider profiling techniques, case investigation, and case referral process. MCNA received positive feedback from the education opportunity and was requested to conduct another session for MFCU's audit staff.

MCNA will **meet at least quarterly with DHH** and will support DHH efforts to combat fraud and abuse. MCNA's SIU team is also an active participant at quarterly fraud and abuse meetings in our current service areas. These meetings foster networking and the sharing of information including best practices

Part Two: Technical Approach

Section N: Fraud and Abuse



and trending fraud schemes. MCNA will cooperate and assist DHH and any state or federal agency charged with identifying, investigating, sanctioning, or prosecuting suspected fraud and abuse in Louisiana. Originals and copies of all records and information requested will be provided, and MCNA will allow access to our premises and provide records to DHH or its authorized agents, the Centers for Medicare and Medicaid Services (CMS), the U.S. Department of Health and Human Services (DHHS), Federal Bureau of Investigation, and other units of state or federal government.

It is MCNA's mission to support and aid state agencies in their fight against fraud, waste and abuse. MCNA commits to employing the highest ethics and scrutiny in the course of its business to prevent the occurrence of fraud and abuse of Louisiana Medicaid resources. Every dollar saved benefits those members that are truly in need of Medicaid and CHIP program assistance. Please see the following draft version of MCNA's Louisiana Fraud and Abuse Program.

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Section O.1

Describe how you will coordinate with DHH and comply with the requirements for cost avoidance and the collection of third party liability (TPL) specified in this RFP, including:

- How you will conduct diagnosis and trauma edits, including frequency and follow-up action to determine if third party liability exists; (2) How you will educate providers to maximize cost avoidance;
- Collection process for pay and chase activity and how it will be accomplished;
- How subrogation activities will be conducted;
- How you handle coordination of benefits in your current operations and how you would adapt your current operations to meet contract requirements;
- Whether you will use a subcontractor and if so, the subcontractor's responsibilities; and
- What routine systems/business processes are employed to test, update and validate enrollment and TPL data.

Cost Avoidance and TPL Recovery

MCNA will utilize our **dedicated Recovery and Subrogation Unit (RSU)**, staffed by skilled professionals experienced in cost avoidance and third party liability (TPL) programs, to ensure the Louisiana Medicaid Dental Benefit Program is the payer of last resort. This capture of third party resources is essential in keeping Medicaid dental benefits available to those who depend upon them most. Our recovery activities adhere to all DHH requirements to assure that liable third parties are billed whenever their responsibilities for payment exist.

Our success in providing **sound fiscal management** for all of our affiliated plans while upholding our commitment to providing member-centered care is attributable to two distinct resources:

- A staff of qualified, experienced individuals who understand the industry and leverage that knowledge to identify overpayments, to recoup funds, and to collaborate with other supporting business units to improve cost-containment and subrogation processes, proactively reducing future overpayments.
- An enterprise-wide management information system (MIS), DentalTrac™, fully integrated throughout our organization that houses TPL information and is capable of supporting all processes through the efficient exchange of data with states and other health plans, as required.

MCNA's recovery activities support our overall strategy to manage plan funds in such a way that we minimize the impact our actions have on members and providers. RSU staff expertly utilize the analytical capabilities of our MIS, which **aggregates data to develop predictive analysis**. This process ultimately accelerates the identification of coordination of benefits (COB) situations and TPL cases.

Coordination with DHH

MCNA currently coordinates with multiple state Medicaid agencies for the exchange of TPL information. The functionality available in our MIS, in particular our Electronic Data Interchange (EDI) and Claims Management modules, allows us to manage diverse methods of handling TPL data to support our RSU staff and business operations in meaningful ways.

DentalTrac™ is capable of routinely exchanging TPL data and COB information with DHH as specified in the Dental Benefits Plan System Companion Guide. Our RSU staff will also utilize the TPL Discovery Web Application as presented in Appendix K of the Dental Benefits Plan System Companion Guide. The flexibility inherent in our MIS and the qualifications of our staff ensure that all required coordination efforts will meet and exceed the expectations of the DHH.

Gathering TPL Information Using Diagnosis and Trauma Edits

MCNA identifies the existence of alternate coverage by examining information from several sources. We review provider claims for evidence of alternate carriers. We also communicate with providers and members to determine if there is third party coverage, and obtain TPL data from state agencies such as DHH.

We store this information in member eligibility records within our MIS to aid in the analysis performed by RSU staff. Specifically, the Eligibility and Enrollment and EDI modules play the central role in identifying potential COB and TPL data. When we receive and process Benefit Enrollment and Maintenance files, our MIS automatically builds electronic case files that are dynamically routed to RSU staff in real time following the business process and rules that have been defined to support this critical operation.

MCNA uses the latest American Dental Association (ADA) Current Dental Terminology (CDT) codes to identify trauma, which indicates that a claim was submitted as a result of an accident. Our system scrubs dental claims data for codes that could indicate trauma, such as treatment rendered on a member's front teeth (upper teeth 6-11 and lower teeth 22-27). Further review of this data determines whether subrogation efforts are appropriate. Although we have been handling ICD-9 and ICD-10 Diagnosis codes, they are not widely used in dental claims. Federal requirements, however, will enforce the use of ICD-10 beginning on October 1, 2014. MCNA's staff and systems are prepared to operate accordingly, having already implemented claim edits to utilize such diagnosis codes and trauma indicators to identify potential TPL cases.

RSU staff members examine information collected from electronic transmissions and transcriptions of paper claims to determine if Coordination of Benefits (COB) is applicable. Our MIS applies extensive National Correct Coding Initiative (NCCI) edits in conjunction with MCNA's proprietary edits to every claim. We perform retrospective analysis on claims data to locate indicators of positive patterns of coverage with other carriers.

Provider Education

Provider education is a powerful tool in the detection of TPL and the avoidance of unnecessary cost. Well-informed providers are strong allies in the prevention of inappropriate billing. MCNA engages providers in TPL detection and cost avoidance activities by educating them about the importance of their role in the process and by clarifying the actions they can take to resolve the root causes of this issue.

Typically, Medicaid members do not have alternate dental coverage, but in the case of automobile accidents or facial trauma, alternate coverage may be available through their auto insurance policy, school liability insurance, or medical insurance carrier. A provider who is aware of the possibility of alternate coverage and trained in how to ask their patients whether it exists becomes an integral part of TPL detection, and a factor in MCNA's **progressive reduction** in the occurrence of overpayments.

Multiple channels of communication allow for various levels of connection with our network providers. MCNA uses communication tools including webinars, monthly newsletters, onsite training sessions, and materials published via the Provider Portal. In addition to these active forms of communication, all provider requirements and responsibilities are outlined in their contracts with MCNA. We cover topics including claim submission guidelines, the process for reporting COB cases, and best practices when asking patients if their insurance coverage has changed or if coverage with another insurance carrier applies.

MCNA ensures that **face-to-face communication** takes place regularly through on-site office visits. Our Quality Improvement (QI) staff and Provider Relations Representatives work in tandem to perform these visits. MCNA's Provider Relations Representatives routinely offer focused training sessions when changes in policies take place or when deficiencies are identified during their course of operations.

MCNA's QI staff visits providers to complete **routine dental record chart audits**. We use chart audits as another tool to verify the presence of information that identifies other insurance coverage. Our QI staff then checks to see if the provider communicated the information either on claims submitted to MCNA or as supporting documentation. If a discrepancy is found at that point, we take that opportunity to inform the provider of the proper method for communicating third party insurer information and his or her obligation to do so.

As a last step in maintaining communication and education with our providers, all identified and processed information related to TPL is documented in our Explanation of Payments (EOP) and Remittance Advice (RA). The EOP/RA clearly indicates the activity and relevant financial adjustments triggered by the presence of TPL. We understand that providers may sometimes need further clarification of these actions, which is why we make our Provider Hotline Representatives readily available to assist them through our dedicated Provider Hotline.

Pay and Chase & Subrogation Activities

Pay and chase scenarios may be rare when it comes to dental benefits, but MCNA's staff remains alert to claims payment patterns and circumstances that indicate an overpayment. MCNA's pay and chase activities are triggered when we identify that a member had coverage with another insurer after paying a provider for services rendered. We contact the liable third party insurer and initiate the Coordination of Benefits (COB), adhering to all state and federal regulations governing our pay and chase activities. MCNA will collect any monies due from the liable third-party insurer. MCNA **maintains transparency** in all recovery efforts. We seek to minimize the involvement of members and providers in our recovery effort in order to avoid causing them unnecessary aggravation.

Our protocols for handling pay and chase and subrogation activities follow the same objectives as defined in our Cost Containment Initiatives. Our RSU team and our DentalTrac™ system verify any change of status in our member demographics as related to TPL to identify any current or historical claim that may need review. For claims that have already been adjudicated and paid, DentalTrac™ automatically initiates the subrogation and recovery process the moment RSU staff confirms the information about other insurance availability.

The RSU staff ensures that the primary carrier is contacted and billed within 60 days after confirming the payment hierarchy and their payment responsibility. MCNA sends letters to all parties involved. Our MIS ensures that our handling of all written notices complies with DHH and federal regulations.

Our MIS routinely exchanges TPL data with external vendors and other state Medicaid agencies, which triggers this process. All cases where claims in the aggregate equal to or exceed \$500 are pursued during our recovery efforts. MCNA will also consider pursuing those claims with an aggregate value of less than \$500. Additionally, and in accordance with the requirements set forth in this RFP, we will seek DHH approval for all settlement cases in excess of \$25,000.

Coordination of Benefits

MCNA's DentalTrac™ system makes COB and TPL data available to all relevant business units and staff to increase our efficiency in cost avoidance and the recovery of overpayments. Our MIS captures all COB/TPL information at the member level within the member's eligibility record. By capturing this information in this way, it carries over to all activities related to a member (e.g., multiple claims instead of only one claim). Sources of this information include enrollment data, claims data, and statements recorded directly from members or providers during discussions with our call center representatives.

In 2013, MCNA's Recovery and Subrogation Unit recovered and cost avoided approximately \$1.48 Million.

The advanced business process mapping (BPM) and rules-based engine in DentalTrac™ automatically flags claims where the member record indicates the presence of COB or TPL information. In cases where the member does not have that information documented in the member level record but a claim indicates its existence, DentalTrac™ automatically builds an electronic COB/TPL case file for that

member. MCNA's claims examiners may also identify a need for COB when manually processing a claim. The claims examiner moves forward at that time to create a case file with the pertinent information for the member.

In all situations, these case files are **routed in real time** to the RSU staff for further review. If our RSU staff determines that TPL cannot be established or third party benefits are not available for the case in question, we will process the claim for payment to the provider.

In the event the COB/TPL information does not match the information documented in the member record, the claim is routed using our **automated workflow** process to the RSU staff. The RSU staff verifies COB/TPL data from the carrier and updates the member's record accordingly. Once the COB/TPL is established, our RSU staff review the other carrier's EOB and claim image information captured during claim submission. The other carrier's allowed amounts at the line level are captured before finalizing the adjudication of the claim. This information is entered into the member record and the claim record. MCNA then includes that claim as a part of regular reporting on cost-avoided dollars and provider-reported savings to DHH.

MCNA facilitates coverage and appropriate payment in all COB situations. Our comprehensive coordination of benefits process provides access to coverage and care for the member while **ensuring that Medicaid is the payer of last resort**.

Subcontracting

MCNA does not use a subcontractor for COB or TPL activities. Our expert, in-house team works in conjunction with DentalTrac™ to handle all COB and TPL activities.

Testing, Updating, and Validating Enrollment and TPL Data

MCNA dedicates substantial resources to maintaining its comprehensive process for handling COB and/or TPL cases. We are ready to investigate and seek resolution at any time we identify a case. Our Cost Containment Initiatives, Recovery and Subrogation Unit, and superior MIS, DentalTrac™, are the means by which MCNA provides for responsible fiscal management for the Louisiana Medicaid Dental Benefit Program.

Our fully integrated MIS provides for the functionality that ensures when we receive COB/TPL information from any source it is captured and made available to all appropriate business units. This level of efficiency is only possible through our exceptional data integration capabilities with relevant entities, our coordination with other carriers and vendors, and our collaboration with state Medicaid agencies. These capabilities are extensively verified and tested routinely to ensure we meet and exceed the expectations of our clients, including DHH.

Member demographic information is exchanged as frequently as daily with DHH and its Fiscal Intermediary (FI). Our Eligibility and Enrollment, Member Services, and RSU staff maintains member demographic information internally, ensuring the most current COB/TPL information is always available.

Our MIS also interfaces with national databases to provide additional identification of COB/TPL. Database matching allows us to identify other coverage using key identification information such as subscriber ID and name, as well as secondary information such as telephone numbers, email address, and home address.

With this information, our system and RSU staff makes systematic or manual determinations about the need for further investigation. The **dynamic and intelligent rules-based business process** and workflows implemented in our MIS ensure that all existing and potential cases of COB/TPL are routed to our RSU staff. This routing occurs on a regular basis so that COB with other insurance carriers can take place as soon as possible.

Additionally, MCNA's Business Intelligence module within DentalTrac™, coupled with our advanced heuristic and natural language processing engines, constantly review all of our data in real time creating **dynamic aggregations of relevant information** and predictively building potential cases of COB/TPL. These cases are then routed electronically to our RSU staff for further investigation and validation. The RSU staff logs the results back into our MIS and uses the information during claims adjudication and other operational functions. The system feeds all data back to our **heuristic algorithms** to continually improve our automatic detection processes.

MCNA also relies on staff members in several departments as sources of COB/TPL information. Quality Improvement staff and Provider Relations Representatives engage in activities including visiting provider offices and reviewing dental records to further identify and verify cases of COB/TPL. Our Claims department routes all claims containing an EOB, or other COB/TPL information, to the RSU staff for validation and entry into our member eligibility records.

MCNA balances our fiscal responsibility with access to care for members, carrying out investigation and overpayment recoupments to ensure Louisiana Medicaid is always the payer of last resort.

Please see the following chart that outlines our comprehensive approach to coordination of benefits:

Part Two: Technical Approach

Section O: Third Party Liability



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Section P.1

Describe the capabilities of your claims management systems as it relates to each of the requirements as specified in Electronic Claims Management Functionality Section and the Adherence to Key Claims Management Standards Section. In your response explain whether and how your systems meet (or exceed) each of these requirements. Cite at least three examples from similar contracts.

Reliable, Accurate, and Knowledge Driven Claims Processing System

Understanding claims processing and adjudication requires an extensive understanding of program benefits, proper standards of care, provider practice patterns, and member needs and behaviors. **In 2013, MCNA processed over 15 million dental claims (96% electronically) with an accuracy level above 99.9%. We also processed over 98% of clean claims within 15 business days of receipt.**

MCNA currently processes more than 15 million claims annually.

The expertise and knowledge cultivated throughout our organization ensures that MCNA operates in a cohesive manner without the “silo” effect you find in other organizations. Our claims management system, an essential component of our fully-integrated, proprietary, and enterprise-wide management information system (MIS), DentalTrac™, and our experienced staff ensure accurate, prompt payment of claims while maintaining a high degree of provider satisfaction.

MCNA’s claims management system and processes are supported by well-documented policies and procedures designed specifically to address the needs of our state clients. MCNA is currently “in-process” to achieve full health plan and claims processing accreditation from the Utilization Review Accreditation Commission (URAC). Our highly trained claims management team is able to operate efficiently and reliably against the strictest guidelines without compromising quality or performance metrics.

The DentalTrac™ Claims module is designed specifically to operate public sector programs such as the Louisiana Medicaid Dental Benefit Program. DentalTrac™ enables us to deliver exceptional service levels across all of our claims capability core competencies and integrated components (CCIC), including:

- Administrative and financial adjudication accuracy
- Clean claims payment turnaround
- Cost avoidance and third party recovery
- Systematic detection of fraud, waste, and abuse
- Accurate, timely, and complete encounter submissions

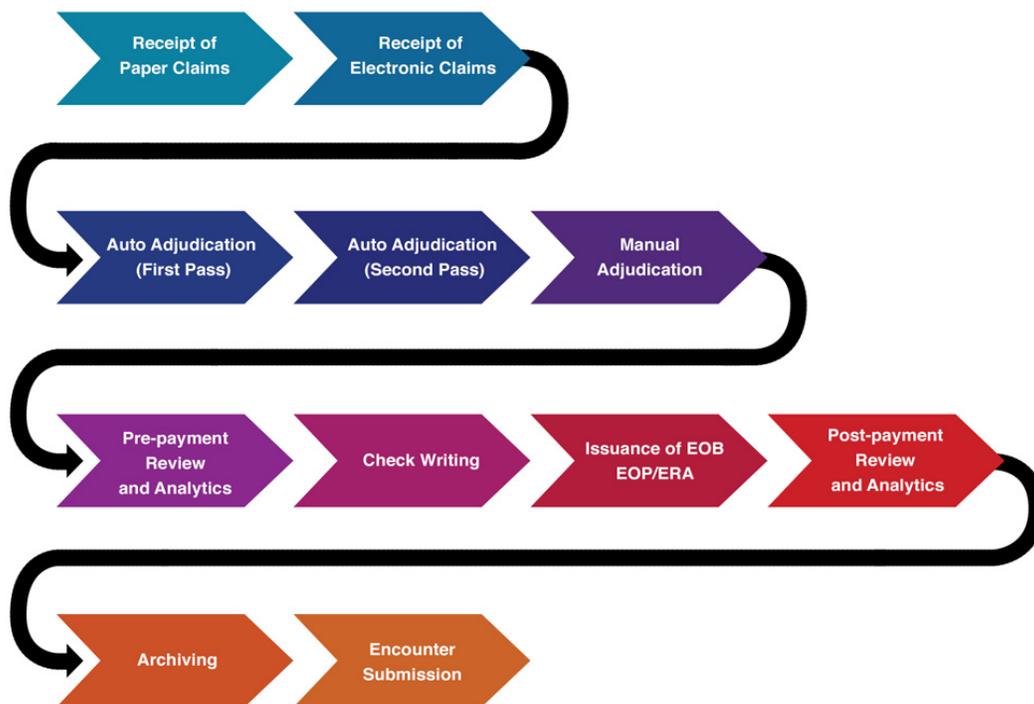


Through our modern, rules-based MIS, we rapidly create new and adapted products and business processes to **meet evolving business needs**. Our claims management information system capabilities are in production today managing all of our lines of business, including the dental managed care programs in Florida and Texas, where we have met or exceeded the performance requirements specified in this RFP.

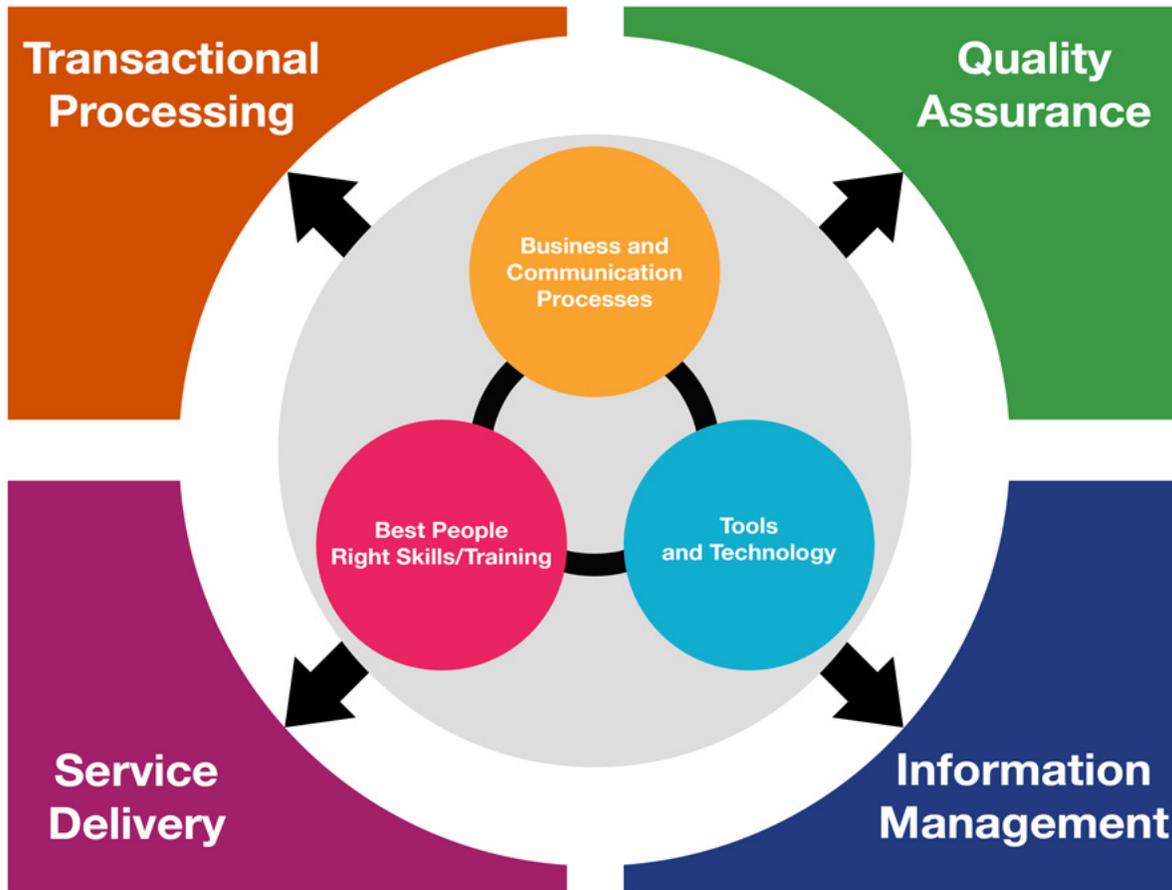
Claims Management Overview

MCNA's state-of-the-art claims management system supports all modern claims capabilities, including electronic data interchanges (EDI), HIPAA transactions and a DHH compliant claims adjudication process. We seamlessly process claims from receipt to issuance of payment and explanation of benefits (EOB) as outlined below:

- Receipt of electronically submitted claims through electronic data interchange (EDI)
- Receipt of paper claims
- Initial auto adjudication (first pass)
- Second-attempt auto adjudication following resolution of certain suspension edits
- Manual processing for claims that cannot be auto-adjudicated
- Check-writing process
- Issuance of EOB and/or remittance advice (RA)
- Completing appropriate prepayment and postpayment analytics
- Archiving claim records and data
- Encounter submission and reconciliation



We offer Louisiana a **comprehensive turnkey solution** to claims processing using industry best practices in workflow automation, dynamic case management, business process management, and rules management. These modern claims capabilities result in a highly efficient environment that is interwoven within all aspects of our operations to deliver continuous and self-improving quality outcomes. Our claims management system and processes are an integral component of our claims capability core competencies and integrated components (CCIC) model as shown below:



CCIC #1: Transactional Processing

Transactional processing is the primary competency of our claims capability and describes our ability to handle and adjudicate claims. We successfully execute this competency through the effective blend of proven business and communication processes, trained and motivated people, and supporting tools and technology.

MCNA's business and communication processes are **detailed, transparent, thorough, and integrated**. One process leads to the next in a comprehensive course of events that allows for all contingencies. Our technology and processes are tightly coupled to support the transactional

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“Upstream” are the processes and system files that govern and enable us to adjudicate claims automatically or manually. Our well-established processes allow us to manage upstream files that do not change much over time (e.g. group and subgroup structures, benefit plans, and CDT) as well as those that are continually updated (e.g. member and provider records, provider payment terms and rates, referral and authorization decisions, and third party liability details).

“Downstream” refers primarily to the claims capability itself. MCNA’s claims capability CCIC model’s primary goal is ensuring that claims processing error rates are kept as close to zero as possible while maintaining target production and meeting our contractual obligations. Our claims staff is primarily responsible for most downstream quality and process improvement efforts. We have developed extensive measures, clear policies and procedures, strong training programs, and solid management practices that enable our dedicated team of claims professionals to always deliver with the utmost level of quality and accuracy. We have also incorporated into our downstream process of claims adjudication extensive factors such as clinical management, third party liability, coordination of benefits, and retrospective reviews of payments.

CCIC #3: Information Management and Analysis

The last core competency of our claims capability CCIC is information management and analysis. MCNA’s premise on information management depends on good data stewardship and warehousing. DentalTrac™ enables appropriate security, standard and ad hoc analytics, care and disease management, fraud and abuse detection, third party liability administration, and financial functions such as forecasting and reporting. Our proven track record managing Medicaid and CHIP dental benefits demonstrates the strength of our claims capability core competencies and ensures we can seamlessly and flawlessly manage the Louisiana Medicaid Dental Benefit Program.

MCNA’s robust transactional processing system allows us to categorize and house encounter data in meaningful ways. Our MIS is equipped with robust capabilities for managing structured and unstructured data delivering an extensive reporting and analytics library, which effortlessly handles ad-hoc analytics on virtually all data elements we capture throughout our organization. DentalTrac™’s **Business Intelligence module**, described in more detail in section Q.10 of this RFP, delivers real-time informatics in multi-dimensional forms that allow us to achieve ever-deeper insight on retrospective analytics, develop strong predictive models to help improve the health outcomes of our members and exceed the needs of the Louisiana Medicaid Dental Benefit Program.

The flexibility and scalability embedded in our claims processing capabilities and supported by our MIS enables us to:

- Maintain an orderly and auditable system for processing claims on a first-in, first-out basis (all claims received are assigned an Internal Control Number (ICN) used to track every aspect of the claim life cycle from the moment they enter our system to the submission of the encounter data)
- Adjudicate claims in real-time as soon as they enter our system
- Apply program benefits and DHH-approved claim edits in real time, facilitating auto adjudication and ensuring payment in the next weekly payment cycle

Part Two: Technical Approach

Section P: Claims Management



- Intelligently route “pending” claims (e.g. claims that were not auto adjudicated) to our skilled processors for additional review
- Ensure we process claims within fifteen (15) business days of receipt of the clean claim
- Notify providers within five (5) days of receipt of claims when a claim does not meet the clean claim standard defined by DHH
- Ensure that providers in good standing (e.g. providers who are not excluded or suspended from the Medicare, Medicaid, or CHIP programs) receive payment for services rendered to the eligible population
- Generate DHH-approved Explanation of Benefits (EOB), Electronic Remittance Advice (ERA), and Electronic Funds Transfers (EFT) on finalized claims
- Submit Encounter Data and applicable reports to the DHH

The following flowchart illustrates our HIPAA compliant claims adjudication process.

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Providers who directly submit electronic claims via Secure File Transfer Protocol will be able to use our EDIFECs Ramp Manager (ERM) portal. Accessing our ERM portal allows providers to test their files before submission in order to ensure it meets the submission requirements defined in our Companion Guides as well as those established by DHH. Our EDIFECs Ramp Manager is the same application in use today by the DHH Fiscal Intermediary (FI) and regularly by our EDI department when exchanging encounter data with our clients.

Paper Claims

While the volume of paper claims has decreased significantly due to our continuous efforts educating and helping providers become ECM-enabled, we also manage the submission of paper claims in standardized American Dental Association (ADA) claim forms and formats and CMS-1500 claims forms. Our well-managed procedures to handle the paper, digitize it, and move it through the process ensure that the handling and processing of paper claims is done as securely and accurately as our electronic claims.

Upon receipt of paper claims, our mailroom and document management processors date stamp, sort, count, and batch them for processing. Once batched, all paper claims are digitized and assigned unique internal control numbers (ICNs), they are electronically converted to HIPAA ASC X12N 837D claims files using smart optical character recognition (OCR) technologies that deliver above 99.5% field-level conversion accuracy.

The OCR process computes accuracy levels for each character recognized and if any of these levels fall below our business-defined thresholds, our business process engine automatically routes the claim to a data entry processor for manual validation and correction if necessary. Once the paper claims are successfully converted to 837D file format, they are processed in the same way as our electronic claims, **ensuring promptness and accuracy**. In 2013, our average processing time for paper claim conversion to 837D was 27.04 hours, with 60.34% of paper claims processed in under 24 hours and the remaining 39.66% of paper claims processed in under 48 hours.

Claim Adjudication and Processing

We apply the same processing rules for all claims received, including:

- Determination of member eligibility
- Provider credentialing and eligibility status
- Validation of unique provider NPI
- Determination of covered services
- Verification of services requiring prior authorization
- Identification of third party liability
- Benefits administration
- Application of provider fee schedules
- Resubmissions
- Appeals
- Adjustments
- Fraud and abuse

DentalTrac™'s extensive data tracking capabilities are a core component of our successful claims management system. To ensure proper processing, tracking, and audit trail maintenance, our system timestamps every activity during the life cycle of a claim. As claims enter our system, they are assigned an Internal Control Number (ICN) that complies with our internally defined taxonomy model that links all information related to a claim in a single, uniquely identified, electronic file. This allows us to track our adherence to claims processing standards.

Once a claim enters our system, the real-time management processes within our claims management system guide the claim through its life cycle, performing a series of core edits and processes and then moving forward with more advanced processing of the claim.

MCNA's claims management system is configured with hundreds of claim edits strategically designed to prevent abuse from members or providers and ensure accurate claims processing compliant with contractual requirements. Additionally, the rules-based engine behind our claims management system also contains industry standard National Correct Coding Initiative (NCCI) claim edits that ensure correct coding methodologies and control improper coding leading to inappropriate payment of claims. Our DentalTrac™ system and associated claims payment procedures ensure that we meet and exceed all claims requirements specified in the RFP, the terms of the Contract, and the Systems Companion Guide.

Every claim processed within our claims management system is routed through flexible and configurable workflows that meet our business processes and contractual requirements. These workflows are designed to maximize our auto adjudication rate. Auto adjudication is the process of automatically determining eligibility and correctly applying benefits and payment terms for each claim using predetermined rules without any human intervention. Our workflows and claim edits are enhanced with clinical policy rules based on our approved clinical guidelines and criteria.

There is a hierarchy of decisions that our transactional processing and claims management system works through in order to determine if a claim is payable or if it should be denied or pended for further attention and claim examiner decision making. We will implement a specific claim "edit" hierarchy based on DHH regulations to meet the requirements in this RFP and the Systems Companion Guide.

Claims that do not meet the complex (but relatively clear) criteria for payment or denial are automatically pended and intelligently routed for manual review by a claims examiner. Claims that lack the necessary information to complete their processing are deemed "unclean" and pended. In such cases, the provider is notified within five (5) business days with detailed information, including but not limited to the date received of the rejected or denied batch, date of denial or rejection, reason for the rejection or denial in writing, in the HIPAA 835 Remittance Advice, via our online Explanation of Payment (EOP), paper EOP, and in real-time through our web-based Provider Portal. Other claims may pend because of intentional business configuration rules, such as:

- Inappropriate or illogical combinations of service type, procedure, or diagnosis codes for the patient's age or gender
- Services that require specific clinical management review
- Procedure codes that must be manually priced
- Missing or inappropriate codes

- Suspected third party liability
- Suspected fraud and/or billing abuse

MCNA's **committed and dedicated claims business analysts** have decades of experience working with dental providers, administering benefits, and ensuring compliance with Medicaid billing guidelines. We design and implement custom claim edits and rules to ensure we comply with state-specific rules and regulations. Our expertise guarantees that the business rule configuration and auto adjudication process, a normally complicated process, is maximized to its fullest potential yielding the highest levels of processing accuracy and contract compliance. The same team of professionals remains vigilant to changes in procedure and diagnosis guidelines and updates our transactional processing system accordingly.

Claims Payment and Issuance of Explanation of Benefits and Remittance Advices

Claims that are determined to be payable are batched and paid automatically during our twice-weekly payment cycles. MCNA is keenly aware of the concerns facing Louisiana providers during the transition from a fee-for-service model to dental managed care. Our **proven track record** in similar transitions in Florida and Texas are true testaments to our ability to successfully transition providers and ensure positive results for DHH. As part of our implementation process, transition plan, and ongoing relationships with our Louisiana providers, we provide **extensive training** sessions, bulletins, newsletters, educational videos, and other reference materials to help our providers familiarize themselves with the program, standard operating procedures documented in our provider manual, and all contractual requirements. During these training sessions, we review in detail the claims life cycle process with providers to help them understand all aspects of our claims processing methodologies and how they can benefit from the services we offer them.

We ensure our providers understand the reimbursement options we make available to them. We also **allow our providers to choose** to receive an Explanation of Payment (EOP) or Electronic Remittance Advice (ERA) in the form of a HIPAA ASC X12N 835 file, a paper check or Electronic Funds Transfer (EFT), or any combination of these options. We always encourage providers to choose electronic forms of payment and documentation. Providers benefit from EFT and ERA because they receive payment quicker and the electronic format facilitates easier reconciliation for office staff. In Texas, Kentucky, and Florida, 67%, 62%, and 39% of MCNA providers respectively are paid by EFT.

Additionally, by educating our providers on the content and process for sending Explanation of Payments (EOPs), they are also able to explain Explanations of Benefits (EOBs) to our members because both documents are designed in a similar manner. If our members ever contact the providers about their EOBs, the providers are able to provide assistance. Please see the following Quick Reference Guide that explains how to read an EOP, EOB, or RA.

Quick Reference Guide: Reading EOPs (EOBs, RAs) [1/3]

Quick Reference Guide: Reading Explanations of Payments (EOPs)

MCNA Dental - For All Providers



Introduction

Welcome to MCNA's Quick Reference Guide for reading **Provider Remittance Advices** or **Explanations of Payments (EOPs)**. Use this guide as an introduction to explain each component found on an EOP. It will also provide you with information about how special circumstances, like claims reversals, appear on an EOP.

Provider Remittance Advice

IF YOU HAVE ANY QUESTIONS CONTACT: 200 WEST CYPRESS CREEK ROAD SUITE 500 FORT LAUDERDALE FL 33309-3429 (800) 494-6262

1

JONES FAMILY DENTAL ASSOCIATES
1234 BUFFALO ROAD, SUITE #100
AUSTIN TX 12345

2 Office: 12345 / JONES FAMILY DENTAL ASSOCIATES
Plan: ABC DENTAL PLAN
Provider: 456 / JUDY JONES, DDS
Subscriber ID/Name: 1234567890 / SANDRA MORALES

DOB: 01/01/2005

Claim #	DOS	T/A	Surt	CDT / Description	Qty	Billed	Allowed	Copy	Deductible	COB	Interest	Denied	Paid	Remarks
000012345678900	12/23/2013	I		710-EXTRACTION BRPFD	1	124.00	35.70	0.00	0.00	0.00	0.00	0.00	35.70	329,344
3 Total Subscriber						124.00	35.70	0.00	0.00	0.00	0.00	0.00	35.70	
4 Total Provider						124.00	35.70	0.00	0.00	0.00	0.00	0.00	35.70	
Total Office						124.00	35.70	0.00	0.00	0.00	0.00	0.00	35.70	
Total Location OFFICE						124.00	35.70	0.00	0.00	0.00	0.00	0.00	35.70	

5

EXPLANATION OF REMARKS

329 / THIS REPRESENTS AN ADJUSTMENT TO THE ORIGINAL REQUEST.
344 / THIS REQUEST HAS BEEN APPROVED AFTER FURTHER REVIEW THROUGH THE APPEAL PROCESS.

MEMBER RESPONSIBILITY STATEMENT

ONLY SERVICES THAT ARE DENIED AS NON-COVERED CHARGES CAN BE BILLED TO THE MEMBER.
ALL OTHER COVERED SERVICES THAT HAVE BEEN DENIED ARE NOT THE RESPONSIBILITY OF THE MEMBER.

I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents, or concealment of a material fact, may be prosecuted under applicable federal and/or state laws.

YOUR APPEAL RIGHTS

You may submit any x-ray(s), narrative(s), or charting(s) within 30 days of receiving the request on this Remittance Advice for reconsideration.

Please note that if you do not submit the requested information within 30 days of receiving this Remittance Advice, you may still exercise your Appeal Rights as outlined below.

You may request a formal review of our decision within 120 days of receiving this Remittance Advice. Your appeal request must be in writing. You may use the appeal form that can be found in the Provider Portal. In lieu of the appeal form, a letter may be submitted that contains the member's name, sufficient information to reasonably identify the claim or claims being appealed, such as date of service, provider name, procedure, and claim number, and a statement that the request is for an appeal. Please be sure to include a copy of the Remittance Advice identifying the claim, and any supporting documentations, such as narratives, radiographs or models as appropriate to the review.

All provider appeals and supporting documentation should be submitted to:

MCNA Grievance and Appeal Department
Attn: Provider Appeals
200 West Cypress Creek Road, Suite 500
Fort Lauderdale, FL 33309

If you have any questions about the appeal process, please call our Provider Hotline at 1-855-PRO-MCNA (1-855-776-6262). Our hours of operations are Monday - Friday, 8:00 a.m. to 7:00 p.m. CST.

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RFP # 305PUR-DHHRFP-DENTAL-PAHP-MVA

Prepared for the State of Louisiana Department of Health and Hospitals

Part Two, Page P-13

Quick Reference Guide: Reading EOPs (EOBs, RAs) [2/3]

Quick Reference Guide: Reading Explanations of Payments (EOPs)

MCNA Dental - For All Providers



EOP Components

1: Header

At the top of each EOP is **MCNA's contact number and address** in case you have a question that needs to be answered.

You will also see the **mailing address** for your office.

If you have elected to receive claims payments from MCNA by electronic funds transfer (EFT), you will see a confirmation message near the top of the EOP indicating the funds were transferred electronically. If you have chosen to receive claims payments by check, the check will be included in the same envelope as the EOP.

2: Office - Plan - Provider - Subscriber

MCNA's EOPs are organized to present you with information about your claims as clearly as possible.

The claims detail is first grouped by:

- **Office** (the office ID number and office name are listed), then by
- **Plan** (the plan name is listed), then by
- **Provider** (the treating provider's ID number and full name is listed), and finally by
- **Subscriber** (the subscriber's ID number, full name, and date of birth is listed).

3: Services Grids

Each claim submitted by a provider generates a claims grid that lists each service (CDT code) line-by-line. The columns provide you with all identification and payment information for each service. The columns from left to right are as follows:

- **Claim #** – The claim number appears in the first column. This number is generated by MCNA's system when the claim is first submitted and will remain with the claim, even when the claim must be altered. If any action must be taken that alters the claim, the original claim number will be appended with a suffix to indicate that a change has been made. Services on the same claim will each have the same claim number.
- **DOS** – The date of service (DOS) is the date on which the respective provider rendered the service for the subscriber.
- **T./A.** – If applicable, the tooth or area of oral cavity treated during the service is indicated.
- **Surf.** – If applicable, the surface of the tooth treated during the service is indicated.
- **CDT/Description** – For each line of the claim, the CDT code of the service provided to the subscriber is listed. A short description of the CDT code appears next to it.
- **Qty.** – The quantity of the service provided is listed.
- **Billed** – The billed amount is the amount the office customarily bills for the CDT code. The office provided this amount when the claim was submitted.
- **Allowed** – The allowed amount is the amount MCNA pays for the service rendered. This amount comes from your fee schedule.
- **Copay** – The copay amount is any amount owed by the subscriber for the service. Generally, MCNA subscribers do not have a copay.
- **Deductible** – The deductible amount lists the subscriber's deductible amount, if applicable.
- **COB** – If the payment of the claim includes any coordination of benefits with another insurance plan, that amount is listed.
- **Interest** – In such case where a clean claim is not processed within contractual guidelines, this column would list any applicable interest.
- **Denied** – The denied amount is the dollar amount not paid by MCNA to the provider for the service.
- **Paid** – The paid amount is the final dollar amount paid by MCNA to the provider for the service.

Quick Reference Guide: Reading EOPs (EOBs, RAs) [3/3]

Quick Reference Guide: Reading Explanations of Payments (EOPs)

MCNA Dental - For All Providers



- **Remarks** – The remarks column lists any code that was used to deny or pend payment of the claim. It can also include any additional information pertinent to understanding MCNA's payment of the claim. Definitions for each code appearing on the EOP can be found in the **Explanation of Remarks** section found at end of the EOP.

4: Totals

Each services grid grouping has its own totals for each column under the respective grid. You will see totals for the **subscriber**, then for the **provider**, and then for the **office**.

Finally, you will see a breakdown of total payment by Place of Service (POS), which is most commonly "OFFICE" (e.g. "Total Location OFFICE").

5: Endnotes and Explanations

Sometimes you will see a notation within a services grid that indicates an explanation from MCNA about our decision. You can find the full explanation in the **Explanation of Remarks** section at the end of the EOP. For each code that is listed in the remarks column of a services grid, a corresponding explanation is listed in this section. You will also find at the end of the EOP is MCNA's statement of member responsibility for the payment of claims.

With each EOP your office receives, you will also receive a copy of your rights with regard to appealing any claims decision made by MCNA. This comes as a separate page from the EOP, usually the last page in the total packet you receive. The statement explicitly states the information that must be included in your appeal should you choose to submit one, and the address to which you can send it.

Special Circumstances

MCNA utilizes the EOP as a way to document actions we take that affect previously paid claims. By using the EOP to accomplish this task, we confirm for you the action we have taken and provide you with documentation without sending out extra documents. Our goal is to keep all of this information for you in one place for easier record keeping and, if you receive paper EOPs, less paper to deal with at your office!

If we reverse or correct a claim, you will see that claim listed on the next EOP sent to your office. The information within the claims grid for that claim will appear different than what you usually see:

- The original claim number will appear, but it may be appended with a suffix. The suffix will consist of the letter "A" followed by a sequential number (e.g., A1, A2, A3).
- If the claim has been reversed, all lines of the claim will be listed and the amount(s) appearing in the Paid column will be negative. The total amount of that claim will appear as a negative number.
- If the claim has been corrected, only the individual lines of the claim that were affected appear listed in the claims grid. If the payment for a service has been reversed, the amount appearing in the Paid column will be negative.

Contact MCNA for More Information

We are here to help you! If you have any questions about reading an EOP, please contact our Provider Relations Hotline for assistance. You can find your dedicated Provider Relations Hotline number near the beginning of your Provider Manual, or you can call our main hotline at 1-800-494-6262.

Claims Payment Accuracy

One core component of the claims capability CCIC model of MCNA and our technology is quality assurance (QA). QA is an integral part of everything we do and being enforced by our systems is yet another degree of our commitment to delivering the highest quality standards. As part of our internal quality initiatives, we have established corporate objectives for the accuracy standards across our entire operation, but specifically those related to claims accuracy.

MCNA's claim management system incorporates all applicable National Correct Coding Initiatives standards. Additionally, it performs **sophisticated claim edits** enhanced with proprietary heuristics and business rules to achieve the highest levels of adjudication accuracy and prompt payment of clean claims.

Our approach to **continuous quality improvement** is ingrained in MCNA's corporate culture. We implement checks and balances such as regular review and audit of our claims processes to ensure accuracy and timeliness. Our quality approach is defined by role. The chart below illustrates the accuracy requirements for claims automatically adjudicated by the DentalTrac™ system as well as by each level of claims examiner.

Role	Procedural Accuracy	Financial Accuracy
Auto Adjudication	99%	99%
Examiner Level 1	95%	98%
Examiner Level 2	96%	98%
Senior Examiner	98%	99%

We have multiple quality assurance processes and audit standards in place to ensure we are constantly meeting and exceeding our internal standards and contractual requirements. Please refer to our response in Section P.2 for a more detailed description of these processes.

Claims Dispute Process Management

Our EOBs and EOPs include detailed claims dispute and appeal procedures for members and providers to follow when they disagree with the adjudication of their claims. We offer our providers access to an easy to follow payment dispute resolution process. Providers may submit disputes within 90 days from the date a claims payment is made.

We have developed a Claims Reconsideration Unit (CRU) to act as our internal claims dispute team to process and manage complaints from providers about claims payment. The CRU team performs extensive reviews of each case presented to them, verifying the complete audit trail of the claims involved and providing a system-agnostic re-evaluation of the claim in consideration to the providers'

request. Any dispute requiring clinical review is automatically routed by our Business Process Management Engine (BPME) to an MCNA Clinical Reviewer who is a licensed dentist with the requisite expertise.

We offer all of our providers free access to our Provider Portal, where they are able to submit claims payment concerns and monitor in real time the status of their submissions. Our BPME ensures that all disputes are routed to the most appropriate examiner in order to minimize the response time. In 2013, the average processing time for provider claim disputes was **1.22 days**.

If a provider is dissatisfied with the resolution of their case, they may appeal the matter to MCNA's Grievances and Appeals department. A provider can also request a review by a private, independent arbitrator who is certified by a nationally recognized association. MCNA will honor the decision of the arbitrator and reimburse the provider for half of the cost of the arbitration, exclusive of attorney's fees, which shall be borne by the respective parties.

COB, TPL, and Subrogation

As part of our due diligence in the proper management and administration of Medicaid and CHIP programs, MCNA investigates every claim that may be subject to coordination of benefits (COB) or the subrogation process using DentalTrac™'s COB and third-party liability (TPL) module.

The COB/TPL module is capable of exchanging member information with state agencies and TPL contractors to **identify members with third-party dental insurance** coverage. MCNA's claims management system flags claims with potential COB, TPL, or subrogation issues. These claims are routed to our Recovery and Subrogation Unit (RSU) for additional review and processing.

Another COB/TPL function in DentalTrac™ is the auto-generation of letters of inquiry to our members or providers regarding the possibility of other third-party liability. Our system tracks letters of inquiry that are sent but not returned in order to send a second request in a timely manner to complete any open claims.

Once the correct order of benefits is determined in these COB/TPL cases, our claims management system automatically applies such determination when processing claims. When MCNA is the primary payer, it will process the claim. If the order of benefits determination shows we are other than primary, our business processes and system rules will prompt for the entry of the amount paid by the primary payer before it will calculate our liability. The system enforces third-party recovery by ensuring Medicaid is the payer of last resort, including alerting MCNA staff when COB situations are identified post-payment.

Encounter Data Transmission

MCNA will transmit to DHH full encounter data and change history on a monthly basis or on any other frequency required by DHH. The data format is HIPAA ASC X12N 837D-compliant and will be extended by specific mapping requirements from DHH, the FI, or in the Systems Companion Guide. We recognize the importance of complete and accurate encounter data and we commit to providing it to DHH in a timely manner as specified in the RFP. We currently have robust processes, flexible and

Part Two: Technical Approach

Section P: Claims Management



scalable technologies, and staff to ensure a smooth transition for the Louisiana Medicaid Dental Benefit Program.

Encounter data includes all new claims and claim adjustments performed during the reporting period. The extensive and HIPAA-approved audit trail mechanisms in place as part of the core of our Management Information System (MIS) allow us to track down to a second when new claims arrive or adjustments are performed in order to properly report complete data in the encounter data files we submit. All encounter data elements delivered comply with industry standard code sets for procedure codes, diagnosis codes, and provider identifiers, and will comply with any other code set requirement specified by DHH.

DentalTrac™'s EDI module has **built-in quality assurance capabilities** that automatically validate the structure and content of any encounter data file generated to ensure compliance with state and federal standards, as well as assessment standards that will be developed jointly with DHH. After an encounter data file has been generated, MCNA EDI specialists review the system validation results and perform additional manual verification of file accuracy and completeness. State partners have full access to all original records from which transmissions are generated to perform their own validation. Additionally, the information reported in our encounter data files is cross referenced with payment reports and financial information which further certifies the accuracy and completeness of the data provided.

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Section P.2

Describe your methodology for ensuring that claims payment accuracy standards will be achieved per, Adherence to Key Claims Management Standards Section. At a minimum address the following in your response:

- The process for auditing a sample of claims as described in Key Claims Management Standards Section;
- The sampling methodology itself;
- Documentation of the results of these audits; and
- The processes for implementing any necessary corrective actions resulting from an audit.

Auditing is a fundamental part of MCNA's fiduciary and corporate governance strategy. Our decades of experience managing state and federal health care programs for Medicaid and CHIP clients have provided us with practical knowledge to develop the most appropriate and effective claim audits methodologies to ensure we always exceed our goals and obligations.

MCNA's Process for Auditing Claims

MCNA's auditing process is focused on ensuring that Medicaid is the payer of last resort, and that all dollars allocated to the Medicaid and CHIP programs are used to benefit our members through appropriate coverage of dental care services. Our commitment to continuous process improvement permeates throughout our organization. Our comprehensive auditing policies and procedures address elements that ensure compliance with all internal key performance metrics and regulatory requirements.

We have established dedicated teams reporting at different and independent levels of management as follows:

- **Claims Audit Unit (CAU)** reports to our Director of Claims and is dedicated to continuously monitoring the claims payment accuracy standards of MCNA's claims examiners and system-adjudicated claims
- **Compliance Audit Team (CAT)** reports to our Chief Compliance Officer and is focused on financial, administrative, and contractual claims processing and payment standards
- **External Auditors** review our claims process and internal controls, providing both MCNA and our clients an independent, third-party assurance that we are taking the appropriate steps to implement best practices (via SOC 2 / SSAE 16 audit), and protect our systems and our clients' data.



Our layered internal and external auditing construct ensures that strict

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- Subscriber Student Status
- Other Coverage Information
- Provider Office
- Provider Identification Number
- Provider NPI
- Orthodontic Treatment Information
- Provider Specialty/Taxonomy Code
- Proper coding consistent with Taxonomy Code
- Signed Authorization
- Image Attached Correctly
- CDT Code
- Date of Service
- Tooth Number/Letter
- Area of Oral Cavity
- Diagnosis Codes (ICD-9, ICD-10)
- Billed Amounts
- Priced Amounts
- Deductibles
- Co-Insurance
- Interest
- Appropriateness of Claim Adjudication Reason Code
- Benefits Paid to Correct Party
- Provider Reimbursement According to Contractual Rates
- Third Party Liability Investigation
- Subscriber Eligible on Date of Service
- Duplicate Claim Submission

Event-Driven Audits

Our audit teams test compliance with our plan designs prior to making any changes available in our claims management system. These audits are critical to test our accuracy and readiness before the go-live date.

Pre-Implementation Audit

To ensure we are ready to process the benefits of any new program, such as the Louisiana Medicaid Dental Benefit Program, we take a number of critical pre-implementation steps, including:

- Test the interpretation of the benefits against our Summary Plan Description provisions
- Provide an action plan and timeline for resolving any issues
- Serve as the liaison to clarify plan design discrepancies and direct corrections

Post-Implementation Audit

As beneficial as pre-implementation audits can be, they do have limitations. The purpose of the pre-implementation audits is to ensure that all configuration parameters are setup correctly prior to go-live, they are performed in a test environment and the scope of what is reviewed is restricted by the number and thoroughness of the scenarios presented. As comprehensive as our pre-implementation

scenarios are, there are always remote cases that take place during the daily operations of the program.

As a best practice, MCNA performs a 360° post-implementation audit 90 days following the go-live date or the effective date of any material change to the program specifications. We have found this to be a most rigorous and complete approach to testing benefits interpretation, setup, accuracy standards, and compliance with our contractual requirements, and will be a key contributor to the success of the implementation of the Louisiana Medicaid Dental Benefit Program.

Continuous Monitoring

Our approach to continuous monitoring provides early detection of unusual utilization patterns and potential issues, and assesses compliance with plan design. By assessing all claims on an ongoing basis, we proactively identify and correct errors while minimizing detrimental consequences to the operation of our programs, satisfaction of our members and providers, and oral health outcomes. Quarterly reports are reviewed by our Compliance Audit Team (CAT) who document any findings and analysis, and generate a list of areas for further investigation.

Fraud, Waste, and Abuse Algorithms

MCNA's state-of-the-art MIS delivers the most advanced predictive models and algorithms to allow our staff to identify and reduce claims fraud, waste, and abuse. Our proven detection methods and powerful analytics help us stay on top of ever-emerging and cleverly concealed schemes.

Our **proprietary algorithms and models** are extensive and current with embedded clinical intelligence and flexibility for tailoring to specific characteristics. Each algorithm contains the rules, clinical constructs, and statistical processes best suited for the administration of dental benefit programs for the vulnerable populations we serve.

The combined efforts of our auditing and compliance processes are part of our commitment to combat waste, fraud and abuse. Each of our detection algorithms is categorized into varying degrees of vulnerability: recoverable, potential savings, requires further investigation, NCCI edits, or improper billing. Our Special Investigations Unit (SIU) is kept abreast of all findings that indicate potential fraudulent behavior.

Sampling Methodology

MCNA's sampling methodology for claims payment and financial accuracy meets and exceeds the requirements of DHH as documented in this RFP. The success of our audit efforts begins with the proper sample selection. The selection of a statistically-significant sample is integral to the proper extrapolation of accurate audit results. The sample selection methodology is directly dependent on the audit methodologies to be used and the objective of the audit efforts. DentalTrac™ can select a sample of claims using sophisticated algorithms to ensure our random samples are as unbiased as possible and provide a high degree of stratification to be able to account for all cases handled.

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Section P.3

Describe your methodology for ensuring that the requirements for claims processing, including adherence to all service authorization procedures, are met.

MCNA is committed to meeting and exceeding all DHH claims processing requirements, including adherence to all service authorization procedures. MCNA's proven dental benefit management expertise coupled with leading edge technology has been key to our success and growth. Our uniform, concise methodologies and practices are the core of our accomplishments.

We will leverage our vast experience in Texas and Florida transitioning millions of members from statewide fee-for-service systems, and from other dental plans that abruptly ceased operations due to material performance issues to ensure that we will meet and exceed all RFP requirements and DHH goals.

MCNA's record of successful and prompt implementations has been flawless throughout our transitions for Medicaid and CHIP programs in Texas and Florida. Our project implementation team coordinates with all critical MCNA business units to ensure that project-specific key resources are aligned and in place for a successful implementation. Our project implementation team will apply our methodologies using our structured approach to success.

MCNA's proprietary management information system, DentalTrac™, and our best-in-class technology infrastructure are designed for performance, inter-operability, security, and flexible business modeling.

Our staff uses DentalTrac™'s extensive functionality to load and configure the plan benefits using the definitions documented in DHH Covered Services as part of this RFP along with any additional documentation provided by DHH. DentalTrac™'s built-in support for National Correct Coding Initiatives (NCCI) leveraged with our staff's combined experience of over 200 years administering dental insurance plans and patient care have resulted in advanced and accurate system edits that enforce clinically approved standards and benefit limitations.

DentalTrac™ is already configured with claim edits and business rules to allow MCNA to process Medicaid and CHIP dental claims for Louisiana providers.

The flexibility in DentalTrac™ and its HIPAA compliant EDI module establish the foundation required for effective claims processing and maximum payment accuracy. DentalTrac™'s EDI module will automatically, as well as on demand, load and process electronic claims files submitted by our Louisiana providers. DentalTrac™'s EDI module will perform up to Strategic National Implementation Process (SNIP) Level 7 edits to confirm that all business rules and data dictionary elements are in compliance with the requirements of DHH. Files that do not pass the validation process and accuracy edits are denied back to the provider with an explanation of the reason for denial.

MCNA's implementation team has configured business rules and validation edits that ensure all DHH claims and encounter requirements documented in this RFP are met, including but not limited to:

- Member Name
- Subscriber ID
- Date of Service
- Rendering Provider
- Billing Provider
- Procedure Code
- Diagnosis Code
- Tooth ID and Surface ID
- Billing Amount
- Place of Service

DentalTrac™'s claims management system will also apply edits that verify member eligibility at the time of service, identify duplicate claims, identify the need for prior authorization, and verify provider participation. MCNA configures other edits as needed to support the business needs of our clients.

Our DentalTrac™ system allows for the dynamic changing needs of the dental industry. MCNA's implementation team, led by our Chief Information Officer, Daniel Salama, has carefully reviewed the specifications in this RFP and developed a gap analysis of edits and business rules that are required for the effective processing of claims for DHH. **These edits are already implemented in a Louisiana dedicated environment of our management information system in preparation for the Readiness Review process.**

The implementation team has prepared a comprehensive and rigorous set of test scenarios as part of our internal Quality Assurance process to ensure all requirements for claims processing, including service authorizations, have been developed in accordance with the requirements of this RFP. The test scenarios will be presented to the DHH for approval prior to Readiness Review.

In anticipation of Readiness Review, we have created sample member information, eligibility and enrollment data, prior authorization information, and additional required data needed to verify the accuracy of the test cases. During the Readiness Review, we will use the enrollment and eligibility information provided by DHH and its FI.

The test scenarios allow us to verify that DentalTrac™ is capable of processing the following transactions for our Louisiana members:

- Eligibility and Enrollment processes, including retro-terminations and retro-activations
- Prior Authorizations and validation of procedures that require prior authorization and clinical review
- Utilization Management and Clinical Review
- Provider Loading

- Fee Schedule and Reimbursement
- EOB and Remittance Advice compliance
- COB/TPL

During the configuration and implementation phase, MCNA will assign dedicated business and Information Systems resources that will be involved throughout the life of the contract to guarantee the continuous and smooth operation of the program beyond the initial implementation phase.

All claims staff and other critical business units participate in our training classes to ensure a thorough understanding of all the program benefits, claim edits, and business rules applicable to the DBPM. Our Provider Relations Representatives also attend training sessions in order to better communicate with our providers and ensure the transition to the new program does not adversely affect their existing payment cycles.

Our continuous quality improvement and claims monitoring processes **implement best practices** to ensure compliance with all key performance indicators (KPIs) identified during the planning and implementation phase. Together, the Information Systems department and the Quality Improvement department designed custom dashboards to continuously monitor the proper execution and performance of the program in the areas of claims processing timeliness, claims volume, distribution of claims volume by transmission methods, Provider Portal utilization, electronic funds transfer (EFT) acceptance by providers, prior authorization utilization, and enrollment metrics, among others. All processes and metrics will be audited to identify deficiencies and develop corrective action plans on a continuous basis.

Designing and implementing the right success formula for ensuring that all requirements for claims processing, including service authorization, are met is one of the primary strengths of our technology infrastructure and talented staff. **Every MCNA employee is committed to the continual success of our program and improving the oral health outcomes of the vulnerable population we serve. MCNA delivers efficient solutions to our clients.** Every aspect of the planning, design, implementation, and execution of our contract is done by the company as a whole.

Our proprietary and state-of-the-art management information system, DentalTrac™, offers our staff, analysts, members, and providers rich functionality that enables the delivery of critical and non-critical information when it's needed and in real time. The flexible and scalable support of business process definitions and execution within our MIS is made possible by our Service Oriented Business Architecture (SOBA). The SOBA framework in our MIS allows our business analysts to create simple spreadsheet-like definitions of benefit and contractual requirements which immediately feed and support all relevant business processes to operate the Louisiana Medicaid Dental Benefit Program as set forth in this RFP.

Our implementation team will execute the work plan defined for the operation of this program. All activities have been inventoried and documented in our project management tool and resources have been pre-assigned to ensure a successful implementation. **MCNA has successfully implemented large-scale programs in very aggressive time frames and we are certain that our experience and**

expertise will help make the Louisiana Medicaid Dental Benefit Program transition from fee-for-service to dental managed care a success.

Our certified Business Analysts and Project Managers will coordinate directly with key personnel from DHH and its FI to:

- Document the critical success factors
- Establish performance requirements during Readiness Review
- Establish all transitional data that will be made available by the FI prior to go-live
- Finalize the test cases prior to Readiness Review
- Identify and coordinate the development of training sessions and materials for internal staff and our Louisiana providers
- Coordinate with the contracted and prospective provider population

MCNA will coordinate with DHH to ensure members in active treatment continue receiving care during the transition process as seamlessly as possible. Our claims management system will apply all claim edits and business rules that are defined specifically for the Louisiana Medicaid Dental Benefit Program, including but not limited to:

- Validate billing and treating provider
- Validate member and eligibility as of the date of service
- Validate procedure and diagnosis codes
- Enforce field sizes and acceptable values using reference values provided by DHH, its FI, and any other HIPAA or industry approved code set
- Validate service authorization if present and if previously provided to MCNA by the provider, DHH, or its FI

We will also work with providers during the transition period to ensure continuity of care. We will coordinate with the treating providers to submit a prior authorization if treatment will exceed thirty days after the go-live date. The flexibility in our MIS allows us to customize these edits seamlessly and without any adverse effect on the smooth operation of the program.

After the go-live date, our focus will immediately shift to our ongoing process monitoring and quality improvement efforts. As part of our commitment to excellence in management and operational performance, we will begin our post-implementation audits on day one after the go-live date. Our process monitoring and continuous quality improvement efforts will focus on monitoring claims volume, claims processing standards, call center call volumes, call nature trends, member and provider

Part Two: Technical Approach

Section P: Claims Management



satisfaction surveys, and a wealth of other indicators in our performance dashboards that help us monitor the operational health of the program.

Our performance dashboards are equipped with key performance indicators (KPI) that tell us how the program is performing in relation to our contractual performance measures. KPIs are aligned with our corporate and contractual performance goals, and provide us with insight to make any necessary adjustments in our operations to meet our performance requirements.

MCNA's extensive experience in state-sponsored dental benefits management and our ability to implement managed care programs on a large scale and under short time frames is unparalleled in the industry. **Our qualified staff, exemplary technology, business process knowledge, and claims processing and service authorization capability make MCNA the right choice for DHH to ensure a smooth and successful implementation.**

Section Q.1

Describe your approach for implementing information systems in support of this RFP, including:

- Demonstrate capability and capacity assessment to determine if new or upgraded systems, enhanced systems functionality and/or additional systems capacity are required to meet contract requirements;
- Configuration of systems (e.g., business rules, valid values for critical data, data exchanges/interfaces) to accommodate contract requirements;
- System setup for intake, processing and acceptance of one-time data feeds from the State and other sources, e.g., initial set of DBP enrollees, claims/service utilization history for the initial set of DBP enrollees, active/open service authorizations for the initial set DBP enrollees, etc.; and
- Internal and joint (DBP and DHH) testing of one-time and ongoing exchanges of eligibility/enrollment, provider network, claims/encounters and other data.
- Provide a Louisiana Medicaid DBP-Program-specific work plan that captures:
 - Key activities and timeframes and
 - Projected resource requirements from your organization for implementing information systems in support of this contract.
- Describe your historical data process including but not limited to:
 - Number of years retained;
 - How the data is stored; and
 - How accessible is it.

The work plan should cover activities from contract award to the start date of operations.

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Section Q.2

Describe your processes, including procedural and systems-based internal controls, for ensuring the integrity, validity and completeness of all information you provide to DHH and the Enrollment Broker. In your description, address separately the encounter data-specific requirements in, Encounter Data Section of the RFP as well as how you will reconcile encounter data to payments according to your payment cycle, including but not limited to reconciliation of gross and net amounts and handing of payment adjustments, denials and pend processes. Additionally, describe how you will accommodate DHH-initiated data integrity, validity and provide independent completeness audits.

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Section Q.3

Describe in detail how your organization will ensure that the availability of its systems will, at a minimum, be equal to the standards set forth in the RFP. At a minimum your description should encompass: information and telecommunications systems architecture; business continuity/disaster recovery strategies; availability and/or recovery time objectives by major system; monitoring tools and resources; continuous testing of all applicable system functions, and periodic and ad-hoc testing of your business continuity/disaster recovery plan.

Identify the timing of implementation of the mix of technologies and management strategies (policies and procedures) described in your response to previous paragraph, or indicate whether these technologies and management strategies are already in place.

Elaborate, if applicable, on how you have successfully implemented the aforementioned mix of technologies and management strategies with other clients.

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Section Q.4

Describe in detail:

- How your *key production systems* are designed to *interoperate*. In your response address all of the following:
 - How identical or closely related data elements in different systems are named, formatted and maintained:
 - Are the data elements named consistently;
 - Are the data elements formatted similarly (# of characters, type-text, numeric, etc.);
 - Are the data elements updated/refreshed with the same frequency or in similar cycles; and
 - Are the data elements updated/refreshed in the same manner (manual input, data exchange, automated function, etc.).
 - All exchanges of data between key production systems.
 - How each data exchange is triggered: a manually initiated process, an automated process, etc.
 - The frequency/periodicity of each data exchange: “real-time” (through a live point to-point interface or an interface “engine”), daily/nightly as triggered by a system processing job, biweekly, monthly, etc.
- As part of your response, provide diagrams that illustrate:
 - point-to-point interfaces,
 - information flows,
 - internal controls and
 - the networking arrangement (AKA “network diagram”) associated with the information systems profiled.

These diagrams should provide insight into how your Systems will be organized and interact with DHH systems for the purposes of exchanging Information and automating and/or facilitating specific functions associated with the Louisiana Medicaid DBP Program.

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Part Two: Technical Approach

Section Q: Information Systems



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Section Q.5

Describe your ability to provide and store encounter data in accordance with the requirements in this RFP. In your response:

- Explain whether and how your systems meet (or exceed) each of these requirements.
- Cite at least three currently-live instances where you are successfully providing encounter data in accordance with DHH coding, data exchange format and transmission standards and specifications or similar standards and specifications, with at least two of these instances involving the provision of encounter information from providers with whom you have capitation arrangements. In elaborating on these instances, address all of the requirements in the Technical Requirements section. Also, explain how that experience will apply to the Louisiana Medicaid DBP Program.
- If you are not able at present to meet a particular requirement contained in the aforementioned section, identify the applicable requirement and discuss the effort and time you will need to meet said requirement. (4) Identify challenges and “lessons learned” from your implementation and operations experience in other states and describe how you will apply these lessons to this contract.

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Section Q.6

Describe your ability to receive, process, and update eligibility/enrollment, provider data, and encounter data to and from the Department and its agents. In your response:

- Explain whether and how your systems meet (or exceed) each of these requirements.
- Cite at least three currently-live instances where you are successfully receiving, processing and updating eligibility/enrollment data in accordance with DHH coding, data exchange format and transmission standards and specifications or similar standards and specifications. In elaborating on these instances, address all of the requirements in the Technical Requirements section. Also, explain how that experience will apply to the Louisiana Medicaid DBP Program.
- If you are not able at present to meet a particular requirement contained in the aforementioned sections, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.
- Identify challenges and “lessons learned” from implementation in other states and describe how you will apply these lessons to this contract.

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Section Q.7

Describe the ability within your systems to meet (or exceed) each of the requirements in the Technical Requirements section. Address each requirement. If you are not able at present to meet a particular requirement contained in the aforementioned section, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.

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Section Q.8

Describe your information systems change management and version control processes. In your description address your production control operations.

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Section Q.9

Describe your approach to demonstrating the readiness of your information systems to DHH prior to the start date of operations. At a minimum your description must address:

- provider contract loads and associated business rules;
- eligibility/enrollment data loads and associated business rules;
- claims processing and adjudication logic; and
- encounter generation and validation prior to submission to DHH.

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Section Q.10

Describe your reporting and data analytic capabilities including:

- generation and provision to the State of the management reports prescribed in the RFP;
- generation and provision to the State of reports on request;
- the ability in a secure, inquiry-only environment for authorized DHH staff to create and/or generate reports out of your systems on an *ad-hoc* basis; and
- Reporting back to providers within the network.

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Section Q.11

Provide a detailed profile of the key information systems within your span of control.

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Section Q.12

Provide a profile of your current and proposed Information Systems (IS) organization.

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Section Q.13

Describe what you will do to promote and advance electronic claims submissions and assist providers to accept electronic funds transfers.

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Section Q.14

Indicate how many years your IT organization or software vendor has supported the current or proposed information system software version you are currently operating. If your software is vendor supported, include vendor name(s), address, contact person and version(s) being used.

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Section Q.15

Describe your plans and ability to support network providers' "meaningful use" of Electronic Health Records (EHR) and current and future IT Federal mandates. Describe your plans to utilizing ICD-10 and 5010.

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Section Q.16

Describe the procedures that will be used to protect the confidentiality of records in DHH databases, including records in databases that may be transmitted electronically via e-mail or the Internet.

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Section R.1

Certified Veteran or Hudson Initiative small entrepreneurship or who will engage the participation of one or more certified Veteran or Hudson Initiatives small entrepreneurships as subcontractors.

(See Attachment I)

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Part Two: Technical Approach

Section R: Veteran or Hudson Initiative



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Part Two: Technical Approach

Section R: Veteran or Hudson Initiative



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