STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
1 of 2	06/23/20
BUSINESS UNIT	BUYER
25710178	JULIE SCHILTZ (AS)

CONTRACT NUMBER
75640 O4

VENDOR NUMBER: 2373353

VENDOR ADDRESS:

MCNA INSURANCE COMPANY
200 W CYPRESS CREEK RD STE 500
FORT LAUDERDALE FL 33309-2338

THE CONTRACT PERIOD IS:

SEPTEMBER 01, 2017 THROUGH DECEMBER 31, 2022

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 5427 Z1

Contract to supply and deliver Medicaid Dental Benefit Program to the State of Nebraska as per the attached specifications for the contract period September 1, 2017 through December 31, 2022. The contract may be renewed for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Shannon Boggs-Turner
Office Phone: 954-730-7131 x252
Cell Phone: 859-948-7667
Fax Number: 210-745-4271
Email: STurner@mcna.net

(04/18/17 sc)

Amendment One as attached. (8/31/17 sc)

Amendment Two as attached. (2/8/18 sc)

Amendment Three as attached. (ml 05/08/18)

Amendment Four as attached. (09/11/18 ml)

Amendment Five as attached. (09/27/18 ml)

Amendment Six as attached. (07/11/19 ml)

Amendment Seven as attached. (04/10/20 mel)

Amendment Eight as attached. (06/05/20 mel)

Amendment Nine as attached. (06/23/20 ml)

Julie Schiltz pk
BUYER

7/1/2020
MATERIEL ADMINISTRATOR

DHHS DIVISION DIRECTOR

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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
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2	DENTAL MANAGED CARE SFY19	58,902,410.0000	$	1.0000	58,902,410.00
3	DENTAL MANAGED CARE SFY20	60,681,263.0000	$	1.0000	60,681,263.00
	Total Order				**177,708,550.00**

JS
BUYER INITIALS

AMENDMENT NINE
Contract 75640 (O4)
Medicaid Dental Managed Care for the State of Nebraska
Between the State of Nebraska and MCNA Insurance Company

The State of Nebraska and MCNA Insurance Company make this Amendment (the "Amendment") to Contract 75640 (O4) (the "Contract"), and, upon mutual agreement and other valuable consideration, the parties agree to and hereby amend the contract as follows:

The contract language in Attachment 8 - Rates is superseded with:

The capitation rates for the Contractor have been adjusted for the time period of July 01, 2020 through June 30, 2021, and are set forth in the revised Attachment 8 attached hereto and incorporated into this amendment.

This Amendment becomes part of the Contract. Except as set forth in this Amendment, the Contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is a conflict between this Amendment and the Contract or any earlier amendment, the terms of this Amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this amendment as of the date of execution by both parties below.

State of Nebraska

By: _____

Printed Name: Douglas D Carlson

Title: Materiel Administrator

Date: 7/1/2020

MCNA Insurance Company

By: _____

Printed Name: Shannon Boggs-Turner

Title: Executive Vice President

Date: 06/15/2020

Department of Health and Human Services
Division of Medicaid and Long-Term Care

By: _____

Name: Jeremy Brunssen

Title: Interim Director

Date: _____

Attachment 8 – Rates

July 2020 - June 2021 Dental Capitation Rates

Age Band	Original SFY21 Rate	UNMC* PMPM	Final Rate
0-1	$2.83	$0.23	$3.06
2-5	$21.12	$2.41	$23.52
6-18	$21.76	$1.53	$23.29
19-24	$11.92	$0.68	$12.60
25-54	$16.55	$0.98	$17.52
55-64	$16.31	$0.96	$17.27
65+	$12.33	$0.71	$13.04

October 2020 - June 2021 Expansion Dental Capitation Rates

Age Band	Original SFY21 Rate	UNMC* PMPM	Final Rate
19-24 Exp.	$11.30	$0.64	$11.95
25-54 Exp.	$16.29	$0.96	$17.25
55-64 Exp.	$19.88	$1.17	$21.05

** 438.6(c) Uniform Percentage Payment Initiative*

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CONTRACT NUMBER
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VENDOR NUMBER: 2373353

VENDOR ADDRESS:

MCNA INSURANCE COMPANY
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FORT LAUDERDALE FL 33309-2338

THE CONTRACT PERIOD IS:

SEPTEMBER 01, 2017 THROUGH DECEMBER 31, 2022

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Original/Bid Document 5427 Z1

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Cell Phone: 859-948-7667
Fax Number: 210-745-4271
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(04/18/17 sc)

Amendment One as attached. (8/31/17 sc)

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Amendment Six as attached. (07/11/19 ml)

Amendment Seven as attached. (04/10/20 mel)

Amendment Eight as attached. (06/05/20 mel)

BUYER

6/22/2020
MATERIEL ADMINISTRATOR

DHHS DIVISION DIRECTOR

R43500|NISH0003|NISH0003 20150901

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VENDOR NUMBER: 2373353

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3	DENTAL MANAGED CARE SFY20	60,681,263.0000	$	1.0000	60,681,263.00
	Total Order				**177,708,550.00**

BUYER INITIALS

AMENDMENT EIGHT
Contract 75640 (O4)
Medicaid Dental Managed Care for the State of Nebraska
Between the State of Nebraska and MCNA Insurance Company

The State of Nebraska and MCNA Insurance Company make this Amendment (the "Amendment") to Contract 75640 (O4) (the "Contract"), and, upon mutual agreement and other valuable consideration, the parties agree to and hereby amend the contract as follows:

I. **ADDITIONS:** The following sections are hereby added:

A. Glossary of Acronyms

HHA: Heritage Health Adult

B. Glossary of Terms

Prime coverage: Provides benefits equivalent to the current state plan including dental services, vision services, and over-the-counter medications.

C. Section IV.A.7. Included Populations
Medicaid populations who are mandated to participate in the Nebraska Medicaid managed care program include:

a. Families, children, and pregnant women eligible for Medicaid under Section 1931 of the Social Security Act or related coverage groups.

b. Children, adults, and related populations who are eligible for Medicaid due to blindness or disability.

c. Medicaid beneficiaries who are age 65 or older and not members of the blind/disabled population or members of the Section 1931 adult population.

d. Low-income children who are eligible to participate in Medicaid in Nebraska through Title XXI, the Children's Health Insurance Program (CHIP).

e. Medicaid beneficiaries who are receiving foster care or subsidized adoption assistance (Title IV-E), are in foster care, or are otherwise in an out-of-home placement.

f. Medicaid beneficiaries who participate in a HCBS Waiver program. This includes adults with intellectual disabilities or related conditions; children with intellectual disabilities and their families, aged persons, and adults and children with disabilities; members receiving targeted case management through the DHHS Division of Developmental Disabilities; Traumatic Brain Injury Waiver participants; and any other group covered by the State's 1915(c) waiver of the Social Security Act.

g. Women who are eligible for Medicaid through the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Every Woman Matters).

h. Medicaid beneficiaries for the period of retroactive eligibility, when mandatory enrollment for managed care has been determined.

i. Members eligible during a period of presumptive eligibility.

j. Members eligible for the Refugee Medical Assistance Program (RMAP).

k. Members eligible for the State Disability Program-Medical (SDP Medical).

l. Members with continuous eligibility that have a share of cost.

m. Members eligible for Heritage Health Adult (HHA) expansion Prime coverage.

D. Section IV.G.14.f.xxxii – MEMBER SERVICES AND EDUCATION
xxxii. HHA Prime Benefit Tier Requirements

E. Section IV.J.1.d.iv.q. – PROVIDER SERVICES
q. HHA Prime Benefit Tier Requirements

F. Section IV.X. HHA - Heritage Health Adult Expansion

Effective October 1, 2020, all eligible HHA 18 to 64 year old members will receive integrated medical, behavioral health, and pharmacy benefits through the Heritage Health managed care program.

Members who meet the criteria for the Prime benefits package will receive vision and OTC benefits through their Heritage Health plan and dental benefits through the dental prepaid ambulatory health program (PAHP). Members who do not meet the criteria for Prime benefits will receive services equivalent to the current state plan with the exception of dental services, vision services, and over the counter medications.

All members newly eligible for Medicaid under the HHA program will receive the Basic benefits package.

HHA members will receive the Prime benefits package only if:

- They are medically frail; or
- They are age 19 or 20; or
- They are a pregnant woman eligible under expansion

This Amendment becomes part of the contract. Except as set forth in this Amendment, the Contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is a conflict between this Amendment and the Contract or any earlier amendment, the terms of this Amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this amendment as of the date of execution by both parties below.

State of Nebraska

By: _____

Printed Name: Douglas D Carlson

Title: Materiel Administrator

Date: 6/22/2020

MCNA Insurance Company

By: _____

Printed Name: Shannon Boggs-Turner

Title: Executive Vice President

Date: 6-3-2020

Department of Health and Human Services
Division of Medicaid and Long-Term Care

By: _____

Name: Jeremy Brunssen

Title: Interim Director

Date: _____

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
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BUSINESS UNIT	BUYER
25710178	JULIE SCHILTZ (AS)

CONTRACT NUMBER
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VENDOR NUMBER: 2373353

VENDOR ADDRESS:

MCNA INSURANCE COMPANY
200 W CYPRESS CREEK RD STE 500
FORT LAUDERDALE FL 33309-2338

THE CONTRACT PERIOD IS:

SEPTEMBER 01, 2017 THROUGH DECEMBER 31, 2022

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Original/Bid Document 5427 Z1

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Fax Number: 210-745-4271
Email: STurner@mcna.net

(04/18/17 sc)

Amendment One as attached. (8/31/17 sc)

Amendment Two as attached. (2/8/18 sc)

Amendment Three as attached. (ml 05/08/18)

Amendment Four as attached. (09/11/18 ml)

Amendment Five as attached. (09/27/18 ml)

Amendment Six as attached. (07/11/19 ml)

Amendment Seven as attached. (04/10/20 mel)

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
1	DENTAL MANAGED CARE	58,124,877.0000	$	1.0000	58,124,877.00

BUYER

4/15/2020

DHHS DIVISION DIRECTOR

MATERIEL ADMINISTRATOR

R43500(NPI0003)(NSI10003 20150801

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25710178	JULIE SCHILTZ (AS)

VENDOR NUMBER: 2373353

CONTRACT NUMBER
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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	SFY18				
2	DENTAL MANAGED CARE SFY19	58,902,410.0000	$	1.0000	58,902,410.00
3	DENTAL MANAGED CARE SFY20	60,681,263.0000	$	1.0000	60,681,263.00
	Total Order				**177,708,550.00**

JS
BUYER INITIALS

AMENDMENT SEVEN
Contract 75640 (O4)
Medicaid Dental Managed Care for the State of Nebraska
Between the State of Nebraska and MCNA Insurance Company

The State of Nebraska and MCNA Insurance Company make this Amendment (the "Amendment") to Contract 75640 (O4) (the "Contract"), and, upon mutual agreement and other valuable consideration, the parties agree to and hereby amend the contract as follows:

The contract language in Attachment 9 – *Quality Performance Program (QPP) Measures* is superseded with:

The quality performance program measures (QPP) for the Contractor have been adjusted for the time period of January 1, 2020 through June 30, 2020, and are set forth in the revised Attachment 9 attached hereto and incorporated into this amendment

The contract language in in IV.N.23.b is superseded with:

b. The DBPM UM Program policies and procedures must include service authorization policies and procedures consistent with 42 CFR §438.210, 438.905, 438.910, and state laws and regulations for initial and continuing authorization of services that include, but are not limited to, the following:

i. Written policies and procedures for processing requests for initial and continuing authorizations of services, where a provider does not request a service in a timely manner or refuses a service.

ii. Mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider as appropriate.

iii. Requirement that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by the DBPM Dental Director.

iv. Provide a mechanism in which a member may submit, whether oral or in writing, a service authorization request for the provision of services. This process must be included in its member manual and incorporated in the grievance procedures.

v. The DBPM's service authorization system must provide the authorization number and effective dates for authorization to participating providers and applicable non-participating providers.

vi. The DBPM's service authorization system must have capacity to electronically store and report all service authorization requests, decisions made by the DBPM regarding the service requests, clinical data to support the decision, and time frames for notification of providers and members of decisions.

The contract language in in IV.P.2.i is superseded with:

Any adjusted rates will be actuarially sound and consistent with requirements set forth in 42 CFR438.6(c) and 42 CFR 457.1203(a). Adjusted rates will require an amendment to the contract, mutually agreeable by both parties.

The contract language in in IV.T.c.iii is superseded with:

Annual reports, files, and other deliverables due annually must be submitted within 30 calendar days after December 31st of each calendar year, except those reports that are specifically exempted from the 30-calendar day deadline by this RFP or by written agreement between MLTC and the DBPM.

This amendment becomes part of the contract. Except as set form in this amendment, the contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is a conflict between this amendment and the contract or any earlier amendment, the terms of this amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this amendment as of the date of execution by both parties below.

State of Nebraska

By: _____

Printed Name: Douglas D Carlson

Title: Materiel Administrator

Date: 4/15/2020

MCNA Insurance Company

By: _____

Printed Name: Shannon Turner

Title: Executive Vice President

Date: April 2, 2020

Department of Health and Human Services
Division of Medicaid and Long-Term Care

By: _____

Name: Jeremy Brunssen

Title: Interim Director

Date: _____

Quality Performance Program (QPP) Measures –
January 1, 2020 to June 30, 2020

Base Performance Requirement	Payment Threshold	% of Payment Pool
Claims Processing Timeliness - 15 Days: Process and pay or deny, as appropriate, at least 90% of all clean claims for dental services provided to members within fifteen (15) days of the date of receipt. The date of receipt is the date the MCO receives the claim.	≥ 95% within 15 days	5%
Reporting timeliness: Contractually required report submissions and resubmittals, when requested by MLTC, must be submitted on or before the applicable deadline	90% submitted on or before due date	10%
Report Accuracy: Reports submitted must be accepted by MLTC pursuant to MLTC specifications.	90% accepted by MLTC	10%
Encounter Acceptance Rate: 95% of encounters submitted must be accepted by MLTC's Medicaid Management Information System pursuant to MLTC specifications.	≥ 98%	15%
MEASURE PDENT-CH: PERCENTAGE OF ELIGIBLES WHO RECEIVED PREVENTIVE DENTAL SERVICES Percentage of individuals ages 1 to 20 who are enrolled in Medicaid or CHIP Medicaid Expansion programs for at least 90 continuous days, are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, and who received at least one preventive dental service during the reporting period.	43%	25%
Adult Annual Dental Visit The percentage of members 19 years of age and older who had at least one dental visit during the measurement year.	25%	20%
Appeal Resolution Timeliness: The DBPM must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within twenty (20) calendar days from the day the DBPM receives the appeal.	≥ 95% within 20 days	15%

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Original/Bid Document 5427 Z1

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(04/18/17 sc)

Amendment One as attached. (8/31/17 sc)

Amendment Two as attached. (2/8/18 sc)

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DHHS DIVISION DIRECTOR

7/12/19 7/18/19
BUYER

7/19/19
MATERIEL ADMINISTRATOR

R43500|N|SH0003|N|SH0003 20150901

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BUYER INITIALS

AMENDMENT SIX
Contract 75640 (O4)
Medicaid Dental Managed Care for the State of Nebraska
Between the State of Nebraska and MCNA Insurance Company

The State of Nebraska and MCNA Insurance Company make this Amendment (the "Amendment") to Contract 75640 (O4) (the "Contract"), and, upon mutual agreement and other valuable consideration, the parties agree to and hereby amend the contract as follows:

The contract language in Attachment 5 – *Reporting Requirements* is superseded with:

The annual deliverables due dates for the Contractor have been adjusted to the calendar year, and are set forth in the revised Attachment 5 attached hereto and incorporated into this amendment.

The contract language in Attachment 8 – *Rates* is superseded with:

The capitation rates for the Contractor have been adjusted for the time period of July 1, 2019 through June 30, 2020, and are set forth in the revised Attachment 8 attached hereto and incorporated into this amendment.

The contract language in Attachment 9 – *Quality Performance Program (QPP) Measures* is superseded with:

The quality performance program measures (QPP) for the Contractor have been adjusted for the time period of January 1, 2018 through December 31, 2019, and are set forth in the revised Attachment 9 attached hereto and incorporated into this amendment.

The contract language in IV.G.14.f., *Member Handbook*, is superseded with:

14. Member Handbook

a. The DBPM must develop, maintain, and post to the member portal of its website a member handbook in both English and Spanish. In addition to the requirements described in this RFP, the handbook must comply with the requirements in 42 CFR 438.10.
b. The draft member handbook must be submitted to MLTC for review and approval a minimum of thirty (30) calendar days after date of award.

c. The DBPM must publish the member handbook on its website in the member portal. It must also have hard copies available and inform members how to obtain a hard copy member handbook if they want it.

d. At a minimum, the DBPM must review and update the member handbook annually. The DBPM must submit the updated handbook to MLTC for review and approval a minimum of 45 calendar days before it is to be implemented. If the DBPM wishes to make changes to the handbook more frequently than annually, the revised language must still be submitted to MLTC a minimum of 45 calendar days prior to proposed implementation.

e. The DBPM's updated member handbook must be made available to all members on an annual basis, through its website. When there is a significant change in the Member Handbook, the DBPM must provide members written notice of the change a minimum of 30 calendar days before the effective date of the change, that they may receive a new hard copy if they want it, and the process for requesting it.

f. At a minimum, the member handbook must include:

    i. A table of contents.

    ii. A general description of basic features of how the DBPM operates and information about the DBPM in particular.

    iii. A description of the Member Services department, what services it can provide, and how member services representatives (MSRs) may be reached for assistance. The member handbook shall provide the toll-free telephone number, fax number, email address, and mailing address of the Member Services department as well as its hours of operation.

    iv. A section that stresses the importance of a member notifying Medicaid Eligibility of any change to its family size, mailing address, living arrangement, income, other health insurance, assets, or other situation that might affect ongoing eligibility.

    v. Member rights/protections and responsibilities, as specified in 42 CFR 438.100 and this RFP.

    vi. Appropriate and inappropriate behavior when seeing a DBPM provider. This section must include a statement that the member is responsible for protecting his/her ID cards and that misuse of the card, including loaning, selling, or giving it to another person, could result in loss of the member's Medicaid eligibility and/or legal action.

    vii. Instructions on how to request no-cost multi-lingual interpretation and translation services. This information must be included in all versions of the member handbook.

    viii. A description of the dental home selection process and the dental home's role as coordinator of services.

    ix. The member's right to select a different dental home within the DBPM network.

    x. Any restrictions on the member's freedom of choice of DBPM providers.

    xi. A description of the purpose of the Medicaid and DBPM ID cards, why both are necessary, and how to use them.

    xii. The amount, duration and scope of benefits available to the member under the contract between the DBPM and MLTC in sufficient detail to ensure that members understand the benefits for which they are eligible.

xiii. Procedures for obtaining benefits, including authorization requirements.

xiv. The extent to which, and how, members may obtain benefits, including from out-of-network providers.

xv. Information about health education and promotion programs, including chronic care management.

xvi. Appropriate utilization of services including not using the ED for non-emergent conditions.

xvii. How to make, change, and cancel dental appointments and the importance of cancelling or rescheduling an appointment, rather than being a "no show".

xviii. Information about a member's right to a free second opinion per 42 CFR 438.206(b)(3) and how to obtain it.

xix. The extent to which, and how, after-hours and emergency coverage are provided, including:

a) What constitutes an emergency medical condition, emergency services, and post-stabilization services, as defined in 42 CFR 438.114(a) and 42 CFR 422.113(c).

b) That prior authorization is not required for emergency services.

c) The process and procedures for obtaining emergency services, including use of the 911-telephone system.

d) That, subject to provisions of 42 CFR Part 438, the member has a right to use any hospital or other setting for emergency care.

e) That when necessary, members should refer to their Heritage Health plan's member information for medical emergencies relating to the member's physical, behavioral, or pharmaceutical services, as those benefits would not be reimbursed by the DBPM.

xx. The policy about referrals for specialty care and for other benefits not furnished by the member's dental home.

xxi. How to obtain emergency and non-emergency medical transportation.

xxii. Information about the EPSDT program and the importance of children obtaining these services.

xxiii. Information about member copayments. The charging of a copayment is at the discretion of the DBPM. If the DBPM chooses to ask its providers to charge copayments, this cost-sharing must be in compliance with 42 CFR 447.50 through 447.57, and cannot exceed the amounts specified at 471 NAC 3-008.

xxiv. The importance of notifying the DBPM immediately if the member files a workers' compensation claim, has a pending personal injury or medical malpractice lawsuit, or has been involved in an accident of any kind.

xxv. How and where to access any benefits that are available under the Medicaid State Plan that are not covered under the DBPM's contract with MLTC, either because the service is carved out or the DBPM will not provide the service because of a moral or religious objection.

xxvi. That the member has the right to refuse to undergo any medical service, diagnosis, or treatment or to accept any health service provided by the DBPM if the member objects (or in the case of a

child, if the parent or guardian objects) on religious grounds.

xxvii. Member grievance, appeal, and state fair hearing procedures and timeframes, as described in 42 CFR 438.400-424 and this RFP, as follows:

a) For grievances and appeals:
   1.) Definitions of a grievance and an appeal.
   2.) The right to file a grievance or appeal.
   3.) The requirements and timeframes for filing a grievance or appeal.
   4.) The availability of assistance in the filing process.
   5.) The toll-free number(s) the member can use to file a grievance or an appeal by telephone.
   6.) The fact that, when requested by a member, benefits can continue if the member files an appeal within the timeframes specified for filing at 477 NAC 10-001. Pursuant to the same regulation, the member should also be notified that the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.

b) For state fair hearing:
   1.) Definition of a state fair hearing.
   2.) The right to request a hearing.
   3.) The requirements and timeframes for requesting a hearing.
   4.) The availability of assistance to request a fair hearing.
   5.) The rules on representation at a hearing.
   6.) The fact that, when requested by a member, benefits can continue if the member files a request for a state fair hearing within the timeframes specified for filing at 477 NAC 10-001. Pursuant to the same regulation, the member should also be notified that the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.

xxviii. How a member may report suspected provider fraud and abuse, including but not limited to, the DBPM's and MLTC's toll-free telephone number and website links created for this purpose.

xxix. Any additional information that is available upon request, including but not limited to:
   a) The structure and operation of the DBPM.
   b) The DBPM physician incentive plan (42 CFR 438.6).
   c) The DBPM service utilization policies.
   d) How to report alleged marketing violations to MLTC.
   e) Reports of transactions between the DBPM and the parties in interest (as defined in section 1318(a) of the Public Health Service Act) provided to the State.

xxx. A minimum of once a year, the DBPM must notify members of the option to receive the Member Handbook and the provider directory in either electronic or paper format.

xxxi. Information that describes the transition of care policies for enrollees and potential enrollees.

This amendment becomes part of the contract. Except as set form in this amendment, the contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is a conflict between this amendment and the contract or any earlier amendment, the terms of this amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this amendment as of the date of execution by both parties below.

State of Nebraska

By: _____

Printed Name: Douglas P Corth

Title: Materiel Administrator

Date: 7/19/19

MCNA Insurance Company

By: Shannon Turner

Printed Name: Shannon Turner

Title: Executive Vice President

Date: 7-9-19

Department of Health and Human Services
Division of Medicaid and Long-Term Care

By: _____

Name: Matthew Van Patton

Title: Director

Date: 18 July 2019

Attachment 5 – Reporting Requirements

This attachment is intended as a summary of periodic reporting requirements included in the RFP. The RFP contains additional reporting requirements that may be triggered by specific events (e.g. instances of fraud discovery). The DBPM must comply with all reporting requirements found in the RFP, attachments, and addenda.	
Monthly Deliverables	Due on the 15th day of the following calendar month unless otherwise noted in the RFP or agreed to in writing by the DBPM and MLTC.
Quarterly Deliverables	Due 45 calendar days after the end of the most recent quarter unless otherwise noted in the RFP or agreed to in writing by the DBPM and MLTC.
Semi-Annual Deliverables	Due as specified in this attachment.
Annual Deliverables	Reports, files, and other deliverables due annually must be submitted within 30 calendar days following the 12th month of the calendar year, except those reports that are specifically exempted from the 30-calendar day deadline by this RFP or by written agreement between MLTC and the DBPM.
Ad Hoc Deliverables	Ad hoc reports must be submitted within five business days from the date of request, unless otherwise specified by MLTC.

If a due date falls on a weekend or State-recognized holiday, the deliverable is due the next business day. All reports must be submitted in an MLTC provided template or in a format approved by MLTC.

Monthly Deliverables	Description	Due Date
Claims Processing and Timely Payment of Claims	Summary data on claims payment activity and reasons for claims denials, per reporting requirements provided by MLTC. Include the disposition of every adjudicated and adjusted claim for each claim type.	15th day of the following calendar month
Provider Termination	All provider terminations by category and termination cause.	15th day of the following calendar month
Third-Party Liability	All instances in which a TPL is identified for a member as described in Section IV.R – Claims Management.	15th day of the following calendar month
Claims Payment Accuracy	Claims payment accuracy percentages as described in Section IV.R - Claims Management.	15th day of the following calendar month

Member Grievance System (Grievance)	Summary of new grievances, resolved grievances, and status of unresolved grievances. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter
Member Grievance System (Appeals)	Summary of new appeals, completed appeals, and status of each ongoing appeal. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter
Member Grievance System (Expedited Appeals)	Summary of new expedited appeals, completed expedited appeals, and status of each ongoing expedited appeal. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter
Member Grievance System (State Fair Hearings)	Summary of new state fair hearings, concluded state fair hearings, and status of each ongoing state fair hearing. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter
Provider Grievance System (Grievances)	Summary of new grievances, resolved grievances, and status of unresolved grievances. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter
Provider Grievance System (Appeals)	Summary of new appeals, completed appeals, and status of each ongoing appeal. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter

Provider Grievance System (State Fair Hearings)	Summary of new state fair hearings, concluded state fair hearings, and status of each ongoing state fair hearing. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter

New Referrals of Potential Fraud, Waste, Abuse and Erroneous Payments	Summary of new referrals as described in Section IV.O - Program Integrity.	Second Friday of the following calendar month
All Referrals of Fraud, Waste, Abuse, and Erroneous Payments Under Review by the MCO	Summary of all referrals as described in Section IV.O - Program Integrity.	Second Friday of the following calendar month
Overpayments Identified and Collected	Summary of overpayments as described in Section IV.O - Program Integrity.	Second Friday of the following calendar month
Provider Who Have Left the MCO Network	Summary of provider network departures as described in Section IV.O - Program Integrity.	Second Friday of the following calendar month
Miscellaneous Fraud Prevention Efforts	Summary of the MCO's fraud prevention efforts as described in Section IV.O - Program Integrity.	Second Friday of the following calendar month
Claims Adjudicated	Data summarizing claims adjudicated to finalization in the previous calendar month as described in Section IV.O - Program Integrity.	Second Friday of the following calendar month
Member/Provider Call Center	Data summarizing DBPM member/provider call center performance, including call abandonment rate and average speed to answer.	15th day of the following calendar month
Service Authorizations	Data summarizing DBPM compliance with timely service authorization requirements as detailed in Section IV.N. – Utilization Management.	15th day of the following calendar month
Enrollment and Disenrollment Report	Summary of disenrollments as described in Section IV.B - Eligibility and Enrollment.	15th day of the following calendar month

Quarterly Deliverables	Description	Due Date
Member Grievance System (Grievance)	Summary of new grievances, resolved grievances, and status of unresolved grievances. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Member Grievance System (Appeals)	Summary of new appeals, completed appeals, and status of each ongoing appeal. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Member Grievance System (Expedited Appeals)	Summary of new expedited appeals, completed expedited appeals, and status of each ongoing expedited appeal. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Member Grievance System (State Fair Hearings)	Summary of new state fair hearings, concluded state fair hearings, and status of each ongoing state fair hearing. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Provider Grievance System (Grievances)	Summary of new grievances, resolved grievances, and status of unresolved grievances. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Provider Grievance System (Appeals)	Summary of new appeals, completed appeals, and status of each ongoing appeal. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Provider Grievance System (State Fair Hearings)	Summary of new state fair hearings, concluded state fair hearings, and status of each ongoing state fair hearing. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter

Care Coordination Report	Summary data and metric results as determined by MLTC.	45 calendar days following the most recent quarter
Out of Network Referrals	Data and analysis summarizing out of network provider authorizations.	45 calendar days following the most recent quarter
Provider Network Access	Summary data and metrics on network access as determined by MLTC and described in Attachment 4 – Dental Access Standards.	45 calendar days following the most recent quarter
Provider Network Adequacy	Summary data and metrics demonstrating network adequacy as determined by MLTC and described in Attachment 4 – Dental Access Standards.	45 calendar days following the most recent quarter

Provider Network Cultural Competency Access	Summary data and metrics on cultural competency access as determined by MLTC.	45 calendar days following the most recent quarter
Provider Credentialing	Data and metrics summarizing the number of providers credentialed by licensure type, their location, and the status of pending credentials.	45 calendar days following the most recent quarter
Service Verification Detail	Data detailing service verifications as described in Section IV.S - Claims Management and Section IV.O - Program Integrity.	45 calendar days following the most recent quarter
Service Verification Summary	Service verification summary as described in Section X - Claims Management and Section IV.O - Program Integrity.	45 calendar days following the most recent quarter
Utilization Management Reviews	Summary data and analysis as detailed in Section IV.N – Utilization Management and as determined by MLTC.	45 calendar days following the most recent quarter

Utilization Management Committee	Summary and meeting minutes for UM Committee meetings as described in Section IV.N – Utilization Management.	45 calendar days following the most recent quarter
Quality Performance	Summary data and metric results as determined by MLTC.	45 calendar days following the most recent quarter
Quarterly Financial Reporting	Data and analysis summarizing financial results as determined by MLTC and as described in Section IV.T - Reporting and Deliverables.	45 calendar days following the most recent quarter
Value-Added Services	Summary of value added services as agreed upon by the MCO and MLTC.	45 calendar days following the most recent quarter
Indian Health Services	Data and metrics summarizing Indian Health Service delivery.	45 calendar days following the most recent quarter
Subrogation	Data summarizing new and ongoing instances of subrogation.	45 calendar days following the most recent quarter

Administrative Performance Measures	Data and analysis summarizing results of Administrative Performance Measures as identified by MLTC.	45 calendar days following the most recent quarter
Semi-Annual Deliverables	**Description**	**Due Date**
Paid Claims Audit	Results of error rate measurement data processing, medical necessity, and provider documentation audit of a statistically valid random sample of paid claims as described in Section IV.O - Program Integrity.	June 30 and December 31

Attachment 5 – Reporting Requirements

Annual Deliverables	Description	Due Date
Quality Management Program Description and Work Plan	Discussion of the MCO's quality goals, initiatives and work plan as described in Section IV.M – Quality Management.	30 calendar days following the 12th month of the calendar year
Quality Management Program Evaluation	Data and analysis summarizing the results of the annual quality work plan as described in Section IV.M - Quality.	30 calendar days following the 12th month of the calendar year
Member Satisfaction Survey	Data and analysis summarizing results of the annual member satisfaction survey.	120 calendar days following the 12th month of the calendar year
Deficiency CAP Reports (All Provider Types)	Results and status of all corrective action plans by provider type.	30 calendar days following the 12th month of the calendar year
Performance Improvement Projects	Data summarizing annual results of each new and ongoing PIP.	30 calendar days following the 12th month of the calendar year
Quality Performance Measures	Quality performance results as listed in Attachment 6 – Performance Measures.	Due dates to be provided prior to contract start and in accordance with reporting schedules for the governing entities.
Provider Survey	Data and analysis summarizing results of the annual provider satisfaction survey. The provider satisfaction survey tool and methodology must be submitted to MLTC for approval at least 90 calendar days prior to its administration.	120 calendar days following the 12th month of the calendar year

Attachment 5 – Reporting Requirements

Annual Financial Reporting	Data and analysis summarizing financial results as determined by MLTC and as described in Section IV.T - Reporting and Deliverables.	30 calendar days following the 12th month of the calendar year
Fraud, Waste, Abuse, and Erroneous Payments Annual Plan	Compliance plan addressing requirements outlined in Section IV.O - Program Integrity.	Last day of the calendar year
Annual Program Integrity Confirmation	Signed form acknowledging responsibilities related to the receipt of State and federal funds as described in Section IV.O - Program Integrity.	December 31
Department of Insurance Financial Report	Copy of annual audited financial statement submitted to the Nebraska Department of Insurance.	June 1
Network Development and Management Plan	Details of the MCO's network, including GeoAccess reports, and a discussion of any provider network gaps and the MCO's remediation plans, as described in Section IV.I – Provider Network Requirements.	30 calendar days following the 12th month of the calendar year
Utilization Management Program Review	Data and analysis summarizing the MCO's annual evaluation of its UM program.	30 calendar days following the 12th month of the calendar year
Annual Staffing Report	Organization charts and staffing lists as detailed in Section IV.D – Staffing Requirements.	30 calendar days following the 12th month of the calendar year
QAPI Committee	Data and analysis addressing requirements detailed in Section IV.M – Quality Management.	30 calendar days following the 12th month of the calendar year

Attachment 8 – Rates

July 2019 - June 2020 Dental Capitation Rates

Age Band	Base SFY19 Rate	UNMC* PMPM	Final Rate
0-1	$2.13	$0.24	$2.37
2-5	$18.72	$2.28	$21.00
6-18	$22.89	$1.59	$24.48
19-24	$10.72	$0.86	$11.58
25-54	$14.53	$1.41	$15.94
55-64	$14.38	$1.42	$15.80
65+	$10.38	$1.03	$11.41

* 438.6(c) State Directed Minimum Fee Schedule

Attachment 9

Quality Performance Program (QPP) Measures –
October 1, 2017 to December 31, 2019

Base Performance Requirement	QPP Payment Threshold	% of QPP Pool
Claims Processing Timeliness - 15 Days: Process and pay or deny, as appropriate, at least 90% of all clean claims for dental services provided to members within fifteen (15) days of the date of receipt. The date of receipt is the date the MCO receives the claim.	≥ 95% within 15 days	20%
Standard Service Authorizations: Process 80% of standard service authorization determinations within two (2) business days of obtaining appropriate dental information that may be required regarding a proposed admission, procedure, or service requiring a review determination.	≥ 85% within 2 business days	20%
Encounter Acceptance Rate: 95% of encounters submitted must be accepted by MLTC's Medicaid Management Information System pursuant to MLTC specifications.	≥ 98%	20%
Call Abandonment Rate: Less than 5% of calls that reach the Member/Provider 800 lines and are placed in queue but are not answered because the caller hangs up before a representative answers the call. Measured using annual system-generated reports.	<3%	10%
Average Speed to Answer: Calls to Member/Provider lines must be answered on average within 30 seconds. Measured using annual system-generated reports.	30 seconds	10%
Appeal Resolution Timeliness: The DBPM must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within thirty (30) calendar days from the day the DBPM receives the appeal.	≥ 95% within 30 days	10%
Grievance Resolution Timeliness: The DBPM must dispose of each grievance and provide notice, as expeditiously as the member's health condition requires, within State-established timeframes not to Exceed ninety (90) calendar days from the day the DBPM receives the grievance.	≥ 95% within 60 days	10%

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
1 of 2	09/27/18
BUSINESS UNIT	BUYER
25710178	JENNIFER ELOGE (AS)

CONTRACT NUMBER
75640 O4

VENDOR NUMBER: 2373353

VENDOR ADDRESS:

MCNA INSURANCE COMPANY
200 W CYPRESS CREEK RD STE 500
FORT LAUDERDALE FL 33309-2338

THE CONTRACT PERIOD IS:

SEPTEMBER 01, 2017 THROUGH DECEMBER 31, 2022

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 5427 Z1

Contract to supply and deliver Medicaid Dental Benefit Program to the State of Nebraska as per the attached specifications for the contract period September 1, 2017 through December 31, 2022. The contract may be renewed for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Shannon Boggs-Turner
Office Phone: 954-730-7131 x252
Cell Phone: 859-948-7667
Fax Number: 210-745-4271
Email: STurner@mcna.net

(04/18/17 sc)

Amendment One as attached. (8/31/17 sc)

Amendment Two as attached. (2/8/18 sc)

Amendment Three as attached. (ml 05/08/18)

Amendment Four as attached. (09/11/18 ml)

Amendment Five as attached. (09/27/18 ml)

Line	Description	Estimated Quantity	Unit of Measure	Unit Price	Extended Price
1	DENTAL MANAGED CARE SFY18	58,124,877.0000	$	1.0000	58,124,877.00
2	DENTAL MANAGED CARE SFY19	58,902,410.0000	$	1.0000	58,902,410.00

10/26/18 PK

BUYER

10/26/18

MATERIEL ADMINISTRATOR

DHHS DIVISION DIRECTOR

R43500|NISI|0003|N:SH0003 20150901

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
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PAGE	ORDER DATE
2 of 2	09/27/18
BUSINESS UNIT	BUYER
25710178	JENNIFER ELOGE (AS)

VENDOR NUMBER: 2373353

CONTRACT NUMBER
75640 O4

Line	Description	Estimated Quantity	Unit of Measure	Unit Price	Extended Price
3	DENTAL MANAGED CARE SFY20	60,681,263.0000	$	1.0000	60,681,263.00
	Total Order				**177,708,550.00**

JEE
BUYER INITIALS

AMENDMENT FIVE
Contract 75640 (O4)
Medicaid Dental Managed Care for the State of Nebraska
Between the State of Nebraska and MCNA Insurance Company

The State of Nebraska and MCNA Insurance Company make this Amendment (the "Amendment") to Contract 75640 (O4) (the "Contract"), and, upon mutual agreement and other valuable consideration, the parties agree to and hereby amend the contract as follows:

The contract language in Attachment 8B – *Rates* is superseded with:

The capitation rates for the Contractor have been adjusted for the time period of July 1, 2018 through June 30, 2019, and are set forth in the revised Attachment 8 attached hereto and incorporated into this amendment.

The contract language in IV.I.1.a., *Provider Network Requirements*, is superseded with:

The DBPM must maintain and monitor a network of qualified, appropriate dental providers in sufficient numbers and locations to provide adequate access to all covered services for all enrollees, including those with limited English proficiency or physical or mental disabilities. The DBPM is expected to design a network that provides a geographically convenient flow of patients among network providers. The provider network must be designed to reflect the needs and service requirements of the DBPM's member population. The DBPM must design its dental provider network to maximize the availability of primary dental services and specialty dental services.

The contract language in IV.I.1.c., *Provider Network Requirements*, is superseded with:

All providers must be in compliance with Americans with Disabilities Act (ADA) requirements; provide physical access; reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities.

The contract language in IV.Q.10.b., *Payments to Out-of-Network Providers*, is superseded with:

The DBPM must coordinate payment with out-of-network providers and ensure the cost to the member is no greater than it would have been if the services were furnished within the network.

The contract language in IV.I.11.a., *Provider Network Development Management Plan*, is superseded with:

The DBPM must develop and maintain a provider Network Development and Management Plan which ensures that the provision of core dental benefits and services will occur [42 CFR §438.207(b) and 42 CFR §438.207(c)]. The DBPM must submit documentation as specified by the state within The Network Development and Management Plan, but no less frequently than the following: 1) at the time it enters into a contract with the state; 2) on an annual basis; 3) at any time there has been a significant change (as defined by the state) in the DBPM's operations that would affect the adequacy of capacity and services, including changes in MCP services, benefits, geographic service area, composition of or payments to its provider network, or at the enrollment of a new population in the MCP.

The Network Development and Management Plan must include the DBPM's process to develop, maintain and monitor an appropriate provider network that is supported by written agreements and is sufficient to provide adequate access of all required services included in the contract. When designing the network of providers, the DBPM must consider the following (42 CFR §438.206):

i. Anticipated maximum number of Medicaid members.

ii. Expected utilization of services, taking into consideration the characteristics and healthcare needs of the members in the DBPM.

iii. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish Medicaid core dental benefits and services.

iv. The numbers of DBPM providers who are not accepting new DBPM members.

v. The geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for Medicaid enrollees with disabilities.

The contract language in IV.G.14.f.xix, *Member Handbook*, is superseded with:

1. Member Handbook

   a. The DBPM must develop, maintain, and post to the member portal of its website a member handbook in both English and Spanish. In addition to the requirements described in this RFP, the handbook must comply with the requirements in 42 CFR 438.10.
   b. The draft member handbook must be submitted to MLTC for review and approval a minimum of thirty (30) calendar days after date of award.
   c. The DBPM must publish the member handbook on its website in the member portal. It must also have hard copies available and inform members how to obtain a hard copy member handbook if they want it.
   d. At a minimum, the DBPM must review and update the member handbook annually. The DBPM must submit the updated handbook to MLTC for review and approval a minimum of 45 calendar days before it is to be implemented. If the DBPM wishes to make changes to the handbook more frequently than annually, the revised language must still be submitted to MLTC a minimum of 45 calendar days prior to proposed implementation.
   e. The DBPM's updated member handbook must be made available to all members on an annual basis, through its website. When there is a significant change in the Member Handbook, the DBPM must provide members written notice of the change a minimum of 30 calendar days before the effective date of the change, that they may receive a new hard copy if they want it, and the process for requesting it.
   f. At a minimum, the member handbook must include:
      i. A table of contents.
      ii. A general description of basic features of how the DBPM operates and information about the DBPM in particular.
      iii. A description of the Member Services department, what services it can provide, and how member services representatives (MSRs) may be reached for assistance. The member handbook shall provide the toll-free telephone number, fax number, email address, and mailing address of the Member Services department as well as its hours of operation.
      iv. A section that stresses the importance of a member notifying Medicaid Eligibility of any change to its family size, mailing address, living arrangement, income, other health insurance, assets, or other situation that might affect ongoing eligibility.
      v. Member rights/protections and responsibilities, as specified in 42 CFR 438.100 and this RFP.
      vi. Appropriate and inappropriate behavior when seeing a DBPM provider. This section must include a statement that the member is responsible for protecting his/her ID cards and that misuse of the card, including loaning, selling, or giving it to another person,

could result in loss of the member's Medicaid eligibility and/or legal action.

vii. Instructions on how to request no-cost multi-lingual interpretation and translation services. This information must be included in all versions of the member handbook.

viii. A description of the dental home selection process and the dental home's role as coordinator of services.

ix. The member's right to select a different dental home within the DBPM network.

x. Any restrictions on the member's freedom of choice of DBPM providers.

xi. A description of the purpose of the Medicaid and DBPM ID cards, why both are necessary, and how to use them.

xii. The amount, duration and scope of benefits available to the member under the contract between the DBPM and MLTC in sufficient detail to ensure that members understand the benefits for which they are eligible.

xiii. Procedures for obtaining benefits, including authorization requirements.

xiv. The extent to which, and how, members may obtain benefits, including from out-of-network providers.

xv. Information about health education and promotion programs, including chronic care management.

xvi. Appropriate utilization of services including not using the ED for non-emergent conditions.

xvii. How to make, change, and cancel dental appointments and the importance of cancelling or rescheduling an appointment, rather than being a "no show".

xviii. Information about a member's right to a free second opinion per 42 CFR 438.206(b)(3) and how to obtain it.

xix. Information that describes the transition of care policies for enrollees and potential enrollees.

The contract language in IV.G.1.j., *Member Services and Education, General Guidelines*, is superseded with:

The DBPM must use state developed enrollee notices, including those that describe the transition of care policies for enrollees and potential enrollees.

This amendment becomes part of the contract. Except as set form in this amendment, the contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is a conflict between this amendment and the contract or any earlier amendment, the terms of this amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this amendment as of the date of execution by both parties below.

State of Nebraska

By: _____

Printed Name: DAVID ZWABEL

Title: Materiel Administrator

Date: 10/26/18

MCNA Insurance Company

By: _____

Printed Name: Charles Lacasse

Title: Senior VP and General Counsel

Date: September 27, 2018

Department of Health and Human Services
Division of Medicaid and Long-Term Care

By: _____

Name: Matthew VanPatton

Title: Director

Date: 10/23/18

Attachment 8B – Rates

July 2018 - June 2019 Dental Capitation Rates

Age Band	Base SFY19 Rate	UNMC* PMPM	Final Rate
0-1	$1.98	$0.20	$2.18
2-5	$18.04	$2.42	$20.46
6-18	$26.52	$1.83	$28.35
19-24	$12.05	$0.70	$12.75
25-54	$14.65	$1.14	$15.79
55-64	$13.69	$1.11	$14.80
65+	$9.26	$0.76	$10.02

** 438.6(c) State Directed Minimum Fee Schedule*

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
1 of 2	09/11/18
BUSINESS UNIT	BUYER
25710178	JENNIFER ELOGE (AS)

CONTRACT NUMBER
75640 O4

VENDOR NUMBER: 2373353

VENDOR ADDRESS:

MCNA INSURANCE COMPANY
200 W CYPRESS CREEK RD STE 500
FORT LAUDERDALE FL 33309-2338

THE CONTRACT PERIOD IS:

SEPTEMBER 01, 2017 THROUGH DECEMBER 31, 2022

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 5427 Z1

Contract to supply and deliver Medicaid Dental Benefit Program to the State of Nebraska as per the attached specifications for the contract period September 1, 2017 through December 31, 2022. The contract may be renewed for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Shannon Boggs-Turner
Office Phone: 954-730-7131 x252
Cell Phone: 859-948-7667
Fax Number: 210-745-4271
Email: STurner@mcna.net

(04/18/17 sc)

Amendment One as attached. (8/31/17 sc)

Amendment Two as attached. (2/8/18 sc)

Amendment Three as attached. (ml 05/08/18)

Amendment Four as attached. (09/11/18 ml)

Line	Description	Estimated Quantity	Unit of Measure	Unit Price	Extended Price
1	DENTAL MANAGED CARE SFY18	58,124,877.0000	$	1.0000	58,124,877.00
2	DENTAL MANAGED CARE SFY19	58,902,410.0000	$	1.0000	58,902,410.00
3	DENTAL MANAGED CARE	60,681,263.0000	$	1.0000	60,681,263.00

DHHS DIVISION DIRECTOR

9-24-18

BUYER

9/26/18

MATERIEL ADMINISTRATOR

R43500|NISH0003|N:SH0003 20150901

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
2 of 2	09/11/18
BUSINESS UNIT	BUYER
25710178	JENNIFER ELOGE (AS)

VENDOR NUMBER: 2373353

CONTRACT NUMBER
75640 O4

Line	Description	Estimated Quantity	Unit of Measure	Unit Price	Extended Price
	SFY20				
	Total Order				**177,708,550.00**

BUYER INITIALS

R43500|NSI10003|NSI10003 20150901

AMENDMENT FOUR
Contract 75640 (O4)
Medicaid Dental Managed Care for the State of Nebraska
Between the State of Nebraska and MCNA Insurance Company

The State of Nebraska and MCNA Insurance Company make this Amendment (the "Amendment") to Contract 75640 (O4) (the "Contract"), and, upon mutual agreement and other valuable consideration, the parties agree to and hereby amend the contract as follows:

The contract language in Attachment 8A – *Rates* is superseded with:

The capitation rates for the Contractor have been adjusted for the time period of October 1, 2017 through June 30, 2018, and are set forth in the revised Attachment 8 attached hereto and incorporated into this amendment.

This amendment becomes part of the contract. Except as set forth in this amendment, the contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is a conflict between this amendment and the contract or any earlier amendment, the terms of this amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this amendment as of the date of execution by both parties below.

State of Nebraska

By: _____

Printed Name: David Zuwet

Title: Materiel Administrator

Date: 9/24/18

MCNA Insurance Company

By: _____

Printed Name: Carla Lucas

Title: Senior VP and General Counsel

Date: September 17, 2018

Department of Health and Human Services
Division of Medicaid and Long-Term Care

By: _____

Name: Matthew VanPatton

Title: Director

Date: 20 Sept 18

Attachment 8A – Rates

October 2017 - June 2018 Dental Capitation Rate Update

Age Band	Original Rate	HIPF PMPM	UNMC* PMPM	Final Rate
0-1	$1.80	$0.02	$0.23	$2.05
2-5	$17.05	$0.16	$2.31	$19.52
6-18	$26.99	$0.26	$1.80	$29.05
19-24	$11.54	$0.11	$0.47	$12.12
25-54	$13.91	$0.13	$0.86	$14.90
55-64	$12.45	$0.12	$1.02	$13.59
65+	$8.38	$0.08	$0.63	$9.09

** 438.6(c) State Directed Minimum Fee Schedule*

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
1 of 1	05/08/18
BUSINESS UNIT	BUYER
25710178	VACANT (AS)

CONTRACT NUMBER
75640 O4

VENDOR NUMBER: 2373353

VENDOR ADDRESS:

MCNA INSURANCE COMPANY
200 W CYPRESS CREEK RD STE 500
FORT LAUDERDALE FL 33309-2338

THE CONTRACT PERIOD IS:

SEPTEMBER 01, 2017 THROUGH DECEMBER 31, 2022

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 5427 Z1

Contract to supply and deliver Medicaid Dental Benefit Program to the State of Nebraska as per the attached specifications for the contract period September 1, 2017 through December 31, 2022. The contract may be renewed for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Shannon Boggs-Turner
Office Phone: 954-730-7131 x252
Cell Phone: 859-948-7667
Fax Number: 210-745-4271
Email: STurner@mcna.net

(04/18/17 sc)

Amendment One as attached. (8/31/17 sc)

Amendment Two as attached. (2/8/18 sc)

Amendment Three as attached. (ml 05/08/18)

Line	Description	Estimated Quantity	Unit of Measure	Unit Price	Extended Price
1	DENTAL MANAGED CARE SFY18	58,124,877.0000	$	1.0000	58,124,877.00
2	DENTAL MANAGED CARE SFY19	58,902,410.0000	$	1.0000	58,902,410.00
3	DENTAL MANAGED CARE SFY20	60,681,263.0000	$	1.0000	60,681,263.00
	Total Order				**177,708,550.00**

5/11/18 AC

5/8/18

BUYER

5/11/18

MATERIEL ADMINISTRATOR

DHHS Division Director

R43500|NISH0003|NISI10003 20150901

AMENDMENT THREE
Contract 75640 (O4)
Medicaid Dental Managed Care for the State of Nebraska
Between the State of Nebraska and MCNA Insurance Company

The State of Nebraska and MCNA Insurance Company make this Amendment (the "Amendment") to Contract 75640 (O4) (the "Contract"), and, upon mutual agreement and other valuable consideration, the parties agree to and hereby amend the contract as follows:

The contract language in Section IV., Paragraph A. *PROGRAM DESCRIPTION*, Subparagraph 3. *Current Nebraska Medicaid Dental Program*, Subparagraph (a)(v) is superseded as follows:

Within the scope of the coverage criteria contained in 471 NAC 6.

The contract language in Section IV., Paragraph A. *PROGRAM DESCRIPTION*, Subparagraph 3. *Current Nebraska Medicaid Dental Program*, Subparagraph (a)(vii) is superseded as follows:

Within the limitations contained in 471 NAC 6-003.

The contract language in Section IV., Paragraph A. *PROGRAM DESCRIPTION*, Subparagraph 3. *Current Nebraska Medicaid Dental Program*, Subparagraph (a)(viii) is superseded as follows:

Provided in accordance with prior authorization requirements contained in 471 NAC 6-003

The contract language in Section IV., Paragraph E. *COVERED BENEFITS AND SERVICES*, Subparagraph 5. *Core Medicaid Dental Benefits and Services* is superseded as follows:

The core dental benefits and services listed in this section are described in 471 NAC 6-003.

The contract language in Section IV., Paragraph G. *MEMBER SERVICES AND EDUCATION*, subparagraph 14. *Member Handbook*, subparagraph (f)(xxix)(b) is superseded as follows:

The DBPM dentist incentive plan (42 CFR 438.6)

The contract language in Section IV., Paragraph M. *QUALITY MANAGEMENT, Subparagraph* 2. *QAPI Committee*, Subparagraph (b)(i)(c) is superseded with:

Ensure that QAPI activities are implemented throughout the DBPM.

The contract language in Section IV., Paragraph M. *QUALITY MANAGEMENT*, Subparagraph 5. *Annual Member Satisfaction Survey*, Subparagraph (d) is superseded with:

The surveys must provide valid and reliable data for results statewide and by county.

The contract language in Attachment 8 – *Rates* is superseded with:

The capitation rates for the Contractor have been adjusted for the time period of July 1, 2018 through June 30, 2019, and are set forth in the revised Attachment 8 attached hereto and incorporated into this amendment.

The contract language in Attachment 9 – *Quality Performance Program (QPP) Measures* - October 1, 2017 through December 31, 2018 is superseded with:

The QPP timeframe has been revised to extend through December 31, 2018 and accurately reflect the Appeal Resolution Timeliness requirement, the revisions are set forth in the revised Attachment 9 attached hereto and incorporated into this amendment.

The following subparagraphs are deleted from Section IV., Paragraph G. *MEMBER SERVICES and EDUCATION*:

14. *Member Handbook*

f.xxi. How to obtain emergency and non-emergency medical transportation.

15. *Member Website*

g.iv. A link to the enrollment broker's website and the enrollment broker's toll free number for questions about enrollment.

This amendment becomes part of the contract. Except as set form in this amendment, the contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is a conflict between this amendment and the contract or any earlier amendment, the terms of this amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this amendment as of the date of execution by both parties below.

State of Nebraska

By: _____

Printed Name: David D. Zuniga

Title: Materiel Administrator

Date: 5/11/18

MCNA Insurance Company

By: _____

Printed Name: Glen Feingold

Title: C.O.O

Date: 5/8/18

Department of Health and Human Services
Division of Medicaid and Long-Term Care

By: _____

Name: Matthew VanPatton

Title: Director

Date: 10 May 2018

Attachment B - Dental Rates

SFY2019 Rate Summary				
Age Band	**SFY17 MMs**	**Net Medical Rate**	**NML**	**Loaded Rate**
0-1	278,143	$ 1.80	9.0%	$ 1.98
2-5	454,390	$ 16.42	9.0%	$ 18.04
6-18	1,229,214	$ 24.13	9.0%	$ 26.52
19-24	117,314	$ 10.85	10.0%	$ 12.05
25-54	515,263	$ 13.18	10.0%	$ 14.65
55-64	133,457	$ 12.32	10.0%	$ 13.69
65+	220,982	$ 8.34	10.0%	$ 9.26
Total	**2,948,763**	**$ 16.68**	**9.2%**	**$ 18.37**

Attachment 9

Quality Performance Program (QPP) Measures –
October 1, 2017 to December 31, 2018

Base Performance Requirement	QPP Payment Threshold	% of QPP Pool
Claims Processing Timeliness - 15 Days: Process and pay or deny, as appropriate, at least 90% of all clean claims for dental services provided to members within fifteen (15) days of the date of receipt. The date of receipt is the date the MCO receives the claim.	≥ 95% within 15 days	20%
Standard Service Authorizations: Process 80% of standard service authorization determinations within two (2) business days of obtaining appropriate dental information that may be required regarding a proposed admission, procedure, or service requiring a review determination.	≥ 85% within 2 business days	20%
Encounter Acceptance Rate: 95% of encounters submitted must be accepted by MLTC's Medicaid Management Information System pursuant to MLTC specifications.	≥ 98%	20%
Call Abandonment Rate: Less than 5% of calls that reach the Member/Provider 800 lines and are placed in queue but are not answered because the caller hangs up before a representative answers the call. Measured using annual system-generated reports.	<3%	10%
Average Speed to Answer: Calls to Member/Provider lines must be answered on average within 30 seconds. Measured using annual system-generated reports.	30 seconds	10%
Appeal Resolution Timeliness: The DBPM must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within thirty (30) calendar days from the day the DBPM receives the appeal.	≥ 95% within 30 days	10%
Grievance Resolution Timeliness: The DBPM must dispose of each grievance and provide notice, as expeditiously as the member's health condition requires, within State-established timeframes not to Exceed ninety (90) calendar days from the day the DBPM receives the grievance.	≥ 95% within 60 days	10%

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
1 of 2	02/08/18
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)

CONTRACT NUMBER
75640 O4

VENDOR NUMBER: 2373353

VENDOR ADDRESS:

MCNA INSURANCE COMPANY
200 W CYPRESS CREEK RD STE 500
FORT LAUDERDALE FL 33309-2338

THE CONTRACT PERIOD IS:

SEPTEMBER 01, 2017 THROUGH DECEMBER 31, 2022

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

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Original/Bid Document 5427 Z1

Contract to supply and deliver Medicaid Dental Benefit Program to the State of Nebraska as per the attached specifications for the contract period September 1, 2017 through December 31, 2022. The contract may be renewed for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Shannon Boggs-Turner
Office Phone: 954-730-7131 x252
Cell Phone: 859-948-7667
Fax Number: 210-745-4271
Email: STurner@mcna.net

(04/18/17 sc)

Amendment One as attached. (8/31/17 sc)

Amendment Two as attached. (2/8/18 sc)

Line	Description	Estimated Quantity	Unit of Measure	Unit Price	Extended Price
1	DENTAL MANAGED CARE SFY18	58,124,877.0000	$	1.0000	58,124,877.00
2	DENTAL MANAGED CARE SFY19	58,902,410.0000	$	1.0000	58,902,410.00
3	DENTAL MANAGED CARE SFY20	60,681,263.0000	$	1.0000	60,681,263.00
	Total Order				**177,708,550.00**

DHHS Division Director

2/14/18 Michelle Thompson 2-13-18
BUYER

Douglas Weldon 14 FEB 18
MATERIEL ADMINISTRATOR

R43500|NISH0003|NISH0003 20150901

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
2 of 2	02/08/18
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)

VENDOR NUMBER: 2373353

CONTRACT NUMBER
75640 O4

MT 2.13.18
BUYER INITIALS

R43500|NISH0003|NISH0003 20150901

AMENDMENT TWO
Contract 75640 O4
Medicaid Dental Managed Care for the State of Nebraska
Between the State of Nebraska and MCNA Insurance Company

The State of Nebraska and MCNA Insurance Company make this Amendment (the "Amendment") to Contract 75640 O4 (the "Contract"), and, upon mutual agreement and other valuable consideration, the parties agree to and hereby amend the contract as follows:

The Parties hereto add the following sections effective upon execution of this Amendment:

Section IV.G. Member Services and Education

1. General Guidelines

j. The DBPM must use state developed enrollee notices.

Section IV.O. Program Integrity

18. Treatment of Recoveries Made by the DBPM of Overpayments to Providers.

a. The DBPM must submit to MLTC:

i. The retention policies for the recoveries of all overpayments from the DBPM to a provider, including specifically the retention policies for the recoveries of overpayments due to fraud, waste, or abuse.
ii. The process, timeframes, and documentation required for reporting the recovery of all overpayments.
iii. The process, timeframes, and documentation required for payment to the State of recoveries of overpayments in situations where the DBPM is not permitted to retain some or all of the recoveries of overpayments.
iv. This section does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.

b. The DBPM must submit to MLTC, and abide by, their policy for when they make an overpayment to a provider. The policy must include a mechanism for the provider to report to the DBPM the overpayment, to return the overpayment to the DBPM within sixty (60) calendar days after the date the provider identified the

overpayment, and to notify the DBPM in writing for the reason for the overpayment.

c. The DBPM will return overpayments the DBPM recovers from providers to the State.

Section IV.Q. Provider Reimbursement

4. Indian Health Protections

d. When the amount an I/T/U provider receives from the DBPM is less than the amount the I/T/U provider would have received under FFS or the applicable encounter rate published annually in the Federal Register by the IHS, the state will make a supplemental payment to the I/T/U provider to make up the difference between the amount the DBPM pays and the amount the I/T/U provider would have received under FFS or the applicable encounter rate.

IN WITNESS WHEREOF, the parties have executed this amendment as of the date of execution by both parties below.

State of Nebraska
Department of Health and Human Services
Division of Medicaid and Long-Term Care

By: _____

Printed Name: Thomas W Thompson

Title: Interim Director

Date: 2/13/2018

MCNA Insurance Company

By: _____

Printed Name: Shannon Turner

Title: VP of Operations

Date: 1-24-18

State of Nebraska

By: _____

Printed Name: DOUGLAS WILKEN

Title: Materiel Administrator

Date: 14 FEB 18

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
1 of 1	08/31/17
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)

CONTRACT NUMBER
75640 O4

VENDOR NUMBER: 2373353

VENDOR ADDRESS:

MCNA INSURANCE COMPANY
200 W CYPRESS CREEK RD STE 500
FORT LAUDERDALE FL 33309-2338

THE CONTRACT PERIOD IS:

SEPTEMBER 01, 2017 THROUGH DECEMBER 31, 2022

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 5427 Z1

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Vendor Contact: Shannon Boggs-Turner
Office Phone: 954-730-7131 x252
Cell Phone: 859-948-7667
Fax Number: 210-745-4271
Email: STurner@mcna.net

(04/18/17 sc)

Amendment One as attached. (8/31/17 sc)

Line	Description	Estimated Quantity	Unit of Measure	Unit Price	Extended Price
1	DENTAL MANAGED CARE SFY18	58,124,877.0000	$	1.0000	58,124,877.00
2	DENTAL MANAGED CARE SFY19	58,902,410.0000	$	1.0000	58,902,410.00
3	DENTAL MANAGED CARE SFY20	60,681,263.0000	$	1.0000	60,681,263.00
	Total Order				**177,708,550.00**

DHHS Division Director

9/11/17 Michelle Thompson 9-11-17
BUYER

Douglas Willers 13 Sep 17
MATERIEL ADMINISTRATOR

R43500|NISH0003|NISH0003 20150901

AMENDMENT ONE
Contract 75640 O4
Medicaid Dental Benefit Program for the State of Nebraska
Between the State of Nebraska and MCNA Insurance Company

The State of Nebraska and MCNA Insurance Company make this Amendment (the "Amendment") to Contract 75640 O4 (the "Contract"), and, upon mutual agreement and other valuable consideration, the parties agree to and hereby amend the contract as follows:

I. **ADDITIONS:** The following sections are hereby added upon execution by the parties hereto:

A. **Section IV.C – Business Requirements**

1. **Compliance with State and Federal Laws and Regulations**

d. The DBPM must have written policies guaranteeing each member's rights to be treated with respect and with due consideration for his or her dignity and privacy.

e. The DBPM must have written policies guaranteeing each member's right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.

f. The DBPM must have written policies guaranteeing each member's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

g. The DBPM must have written policies guaranteeing the member's right to request and receive a copy of his or her medical records, and to request that they be amended or corrected.

h. The DBPM must ensure that each member is free to exercise his or her rights without the DBPM or its providers treating the member adversely.

B. **Section IV.G – Member Services and Education**

14. **Member Handbook**

f. At a minimum, the member handbook must include:

xix. The extent to which, and how, after-hours and emergency coverage are provided, including:

e) That, when necessary, members should refer to their Heritage Health plan's member information for medical emergencies relating to the member's physical, behavioral, or pharmaceutical services, as those benefits would not be reimbursed by the DBPM.

16. Requirements for Member Materials

r. Member materials cannot contain any assertion or statement (whether written or oral) that the recipient must enroll in the MCE in order to obtain benefits or to avoid losing benefits.

s. Materials, for members or otherwise, cannot contain any assertion or statement (whether written or oral) that CMS, the Federal or State government, or similar entity endorses the DBPM.

t. MLTC prohibits the DBPM from directly or indirectly engaging in door-to-door, telephone, or other cold-call marketing activities.

C. Section IV.Q. – Provider Reimbursement

4. Indian Health Protections

b. The DBPM must exempt from premiums any Indian who is eligible to receive or has received an item or service furnished by an Indian health care provider or through referral under contract health services.

c. The DBPM must exempt from all cost sharing any Indian who is currently receiving or has ever received an item or service furnished by an Indian health care provider or through referral under contract health services.

11. Provider-Preventable Conditions

a. The DBPM must comply with the requirements mandating provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in §434.6(a)(12) and §447.26 of the CFR.

b. The DBPM must report all identified provider-preventable conditions in a form and frequency as specified by the State.

c. MLTC prohibits the DBPM from making payment to a provider for provider-preventable conditions that meet the following criteria:

i. That the State plan identifies.
ii. That the State has found, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.
iii. Has a negative consequence for the beneficiary.
iv. Is auditable.
v. Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

d. The DBPM must require all providers to report provider-preventable conditions associated with claims for payment or enrollee treatments for which the DBPM would otherwise pay.

12. Prohibition of Additional Payments

a. No payment shall be made to a network provider other than by the DBPM for services covered under the contract between MLTC and the DBPM, except when these payments are specifically required to be made by the State in Title XIX of the Act, in 42 CFR chapter IV, or when the State agency makes direct payments to network providers for graduate medical education costs approved under the State plan.

II. REMOVALS: The Parties hereto remove the following sections upon execution of this Amendment:

A. Section IV.C.7.c

B. Section IV.Q.7

III. MODIFICATIONS: The following sections are modified upon execution of this Amendment:

A. Glossary of Terms

Prepaid ambulatory health plan (PAHP): For purposes of this contract, a PAHP is an entity that:

1. Provides medical services to enrollees under contract with the State agency, and based on prepaid capitation payments, or other payment arrangements that do not use State plan payment rates.
2. Does not have a comprehensive risk contract.

B. Section IV.P DBPM Reimbursement

2. Capitation Rate Determination Process

c. Capitation Rates will initially be in effect from contractor start date through June 30, 2018. Capitation rates thereafter will be in effect for twelve (12) months or when programmatic changes require revised capitation rates.

C. Section IV.Q. – Provider Reimbursement

10. Payment to Out-of-Network Providers

d. The DBPM must pay for covered emergency services that are furnished by providers that have no arrangements with the DBPM for the provision of these dental services. The DBPM must reimburse emergency service providers one hundred percent (100%) of the Medicaid rate in effect on the date of service. In compliance with Section 6085 of the Deficit Reduction Act of 2005, this requirement also applies to out-of-network providers.

D. Attachment 8 – Rates Effective October 1, 2017

The capitation rates for the Contractor have been adjusted for the time period of October 1, 2017, through June 30, 2018, and are set forth in the revised Attachment 8 attached hereto and incorporated into this amendment.

Attachment 8-Revised Dental Rates Effective October 1, 2017-June 30, 2018

October 1, 2017 - June 30, 2018 Dental Rates		
Age Band	**FY16 MMs**	**Rate Selection**
0-1	213,572	$ 1.80
2-5	338,283	$ 17.05
6-18	906,995	$ 26.99
19-24	85,679	$ 11.54
25-54	370,654	$ 13.91
55-64	95,937	$ 12.45
65+	163,068	$ 8.38
Total	**2,174,188**	**$ 18.09**

This amendment becomes part of the contract. Except as set form in this amendment, the contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is a conflict between this amendment and the contract or any earlier amendment, the terms of this amendment will prevail.

IN WITNESS WHEREOF, the parties have executed this amendment as of the date of execution by both parties below.

State of Nebraska
Department of Health and Human Services
Division of Medicaid and Long-Term Care

By: _____

Name: Thomas "Rocky" Thompson

Title: Director

Date: 9/7/2017

MCNA Insurance Company

By: _____

Name: Shannon Turner

Title: VP of Operations

Date: 8-30-17

State of Nebraska

By: _____

Name: DOUGLAS WILKEN

Title: Materiel Administrator

Date: 13 SEPT 17

STATE OF NEBRASKA SERVICE CONTRACT AWARD

State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508

Telephone: (402) 471-6500
Fax: (402) 471-2089

PAGE	ORDER DATE
1 of 1	04/18/17
BUSINESS UNIT	BUYER
25710178	MICHELLE THOMPSON (AS)

CONTRACT NUMBER
75640 O4

VENDOR NUMBER: 2373353

VENDOR ADDRESS:

MCNA INSURANCE COMPANY
200 W CYPRESS CREEK RD STE 500
FORT LAUDERDALE FL 33309-2338

AN AWARD HAS BEEN MADE TO THE VENDOR/CONTRACTOR NAMED ABOVE FOR THE SERVICES AS LISTED BELOW FOR THE PERIOD:

SEPTEMBER 01, 2017 THROUGH DECEMBER 31, 2022

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 5427 Z1

Contract to supply and deliver Medicaid Dental Benefit Program to the State of Nebraska as per the attached specifications for the contract period September 1, 2017 through December 31, 2022. The contract may be renewed for two (2) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Shannon Boggs-Turner
Office Phone: 954-730-7131 x252
Cell Phone: 859-948-7667
Fax Number: 210-745-4271
Email: STurner@mcna.net

(04/18/17 sc)

Line	Description	Estimated Quantity	Unit of Measure	Unit Price	Extended Price
1	DENTAL MANAGED CARE SFY18	58,124,877.0000	$	1.0000	58,124,877.00
2	DENTAL MANAGED CARE SFY19	58,902,410.0000	$	1.0000	58,902,410.00
3	DENTAL MANAGED CARE SFY20	60,681,263.0000	$	1.0000	60,681,263.00
	Total Order				**177,708,550.00**

DHHS Division Director

5/5/17 OK Michelle Thompson 5-5-17
BUYER

MATERIEL ADMINISTRATOR

R43500|NISK0C02|NISK0002 20150901

For public information purposes only; not part of contract.

Request for Proposal Number 5427 Z1
Contract Number 75640 O4
Proposal Opening: Medicaid Dental Benefit Program

In accordance with Nebraska Revised Statutes §84.712.05(3), the following material(s) has not been included due to it being marked proprietary.

MCNA Insurance Company

1. Attachment B-1, Audited Financial Statements
1. Attachment B-2, Actuarial Opinion
2. Attachment B-3, Unaudited Financial Statements
3. Attachment B-4, Banking Reference #1
4. Attachment B-5, Banking Reference #2
5. Attachment B-6, Performance Bond Letter
6. Attachment B-7, Certificate of Insurance
7. Attachment B-8, SOC 2 Type 2 Report
8. Attachment I-1, Resumes
9. Attachment 3-1, Compliance Program
10. Attachment 22-1, Grievances & Appeals Flowchart
11. Attachment 24-2, Network Development Plan
12. Attachment 26-1, Dental Record Review Tool
13. Attachment 28-1, Provider site Audit Tool
14. Attachment 50-1, Prior Authorization Flowchart
15. Attachment 64-1, Information Data Security Policy
16. Attachment 64-2, Information Management Plan
17. Attachment 65-1, Disaster Recovery Plan
18. Attachment 78-1, Implementation Plan
19. Response, Section A, pages 31-32
20. Response, Section B, pages 35, 37
21. Response, Section D, page 39
22. Response, Section G, pages 42-44
23. Response, Section H, pages 46-47, 53-57
24. Response, Section I, pages 59, 64-69
25. Response, Section J, page 72
26. Response, Section 4, page 85
27. Response, Section 5, page 88
28. Response, Section 8, page 96
29. Response, Section 9, page 97
30. Response, Section 13, pages 108-109, 113, 115
31. Response, Section 14, page 119
32. Response, Section 15, page 124
33. Response, Section 18, pages 132-135
34. Response, Section 19, pages 136-138
35. Response, Section 21, page 146
36. Response, Section 24, pages 160-161
37. Response, Section 25, pages 165-169

38. Response, Section 27, page 173
39. Response, Section 28, pages 174-175
40. Response, Section 29, pages 177-178
41. Response, Section 33, pages 188-189
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43. Response, Section 36, pages 201-202
44. Response, Section 37, pages 203-205
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FP 5427 Z1: Medicaid Dental Benefit Program

ance Company for the Nebraska Department of Health and Human Services

mcnadental

Response to RFP 5427 Z1: Medicaid Dental Benefit Program

Prepared by MCNA Insurance Company for the Nebraska Department of Health and Human Services

REDACTED VERSION FOR PUBLIC RELEASE

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mcnadental

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Request for Proposal Form

BIDDER MUST COMPLETE THE FOLLOWING

By signing this Request for Proposal for Contractual Services form, the bidder guarantees compliance with the provisions stated in this Request for Proposal, agrees to the terms and conditions unless otherwise agreed to (see Section III) and certifies that bidder maintains a drug free work place environment

Per Nebraska's Transparency in Government Procurement Act, Neb. Rev Stat § 73-603 DAS is required to collect statistical information regarding the number of contracts awarded to Nebraska Contractors This information is for statistical purposes only and will not be considered for contract award purposes

_____ **NEBRASKA CONTRACTOR AFFIDAVIT**: Bidder hereby attests that bidder is a Nebraska Contractor "Nebraska Contractor" shall mean any bidder who has maintained a bona fide place of business and at least one employee within this state for at least the six (6) months immediately preceding the posting date of this RFP.

_____ I hereby certify that I am a **Resident disabled veteran or business located in a designated enterprise zone** in accordance with Neb. Rev. Stat. § 73-107 and wish to have preference, if applicable, considered in the award of this contract

FIRM: MCNA Insurance Company

COMPLETE ADDRESS: 200 West Cypress Creek Road, Suite 500, Fort Lauderdale, FL 33309

TELEPHONE NUMBER: 954-730-7131 x163 FAX NUMBER: 954-628-3337

SIGNATURE: _____ DATE: September 15, 2016

TYPED NAME & TITLE OF SIGNER: Carlos Lacasa, Senior Vice President and General Counsel

BIDDER MUST COMPLETE THE FOLLOWING

By signing this Request for Proposal for Contractual Services form, the bidder guarantees compliance with the provisions stated in this Request for Proposal, agrees to the terms and conditions unless otherwise agreed to (see Section III) and certifies that bidder maintains a drug free work place environment.

Per Nebraska's Transparency in Government Procurement Act, Neb. Rev Stat § 73-603 DAS is required to collect statistical information regarding the number of contracts awarded to Nebraska Contractors. This information is for statistical purposes only and will not be considered for contract award purposes.

_____ **NEBRASKA CONTRACTOR AFFIDAVIT**: Bidder hereby attests that bidder is a Nebraska Contractor. "Nebraska Contractor" shall mean any bidder who has maintained a bona fide place of business and at least one employee within this state for at least the six (6) months immediately preceding the posting date of this RFP.

_____ I hereby certify that I am a **Resident disabled veteran or business located in a designated enterprise zone** in accordance with Neb. Rev. Stat. § 73-107 and wish to have preference, if applicable, considered in the award of this contract.

FIRM: MCNA Insurance Company

COMPLETE ADDRESS: 200 West Cypress Creek Road, Suite 500, Fort Lauderdale, FL 33309

TELEPHONE NUMBER: 954-730-7131 x163 FAX NUMBER: 954-628-3337

SIGNATURE: _____ DATE: September 15, 2016

TYPED NAME & TITLE OF SIGNER: Carlos Lacasa, Senior Vice President and General Counsel

Form A: Bidder Contact Sheet

Form A: Bidder Contact Sheet

Form A
Bidder Contact Sheet
Request for Proposal Number 5427 Z1

Form A should be completed and submitted with each response to this Request for Proposal. This is intended to provide the State with information on the bidder's name and address, and the specific person(s) who are responsible for preparation of the bidder's response.

Preparation of Response Contact Information	
Bidder Name:	MCNA Insurance Company
Bidder Address:	200 West Cypress Creek Road, Suite 500 Fort Lauderdale, FL 33309
Contact Person & Title:	Carlos Lacasa, Senior Vice President and General Counsel
E-mail Address:	CLacasa@mcna.net
Telephone Number (Office):	954-730-7131 x163
Telephone Number (Cellular):	305-962-3911
Fax Number:	954-628-3337

Each bidder shall also designate a specific contact person who will be responsible for responding to the State if any clarifications of the bidder's response should become necessary. This will also be the person who the State contacts to set up a presentation/demonstration, if required.

Communication with the State Contact Information	
Bidder Name:	MCNA Insurance Company
Bidder Address:	200 West Cypress Creek Road, Suite 500 Fort Lauderdale, FL 33309
Contact Person & Title:	Shannon Boggs-Turner, Vice President of Operations
E-mail Address:	STurner@mcna.net
Telephone Number (Office):	954-730-7131 x252
Telephone Number (Cellular):	859-948-7667
Fax Number:	210-745-4271

Section III
Terms and Conditions

Section III Terms and Conditions

Section III Terms and Conditions [Page 1 of 23]

III. TERMS AND CONDITIONS

By signing the "Request for Proposal for Contractual Services" form, the bidder guarantees compliance with the provisions stated in this Request for Proposal, agrees to the Terms and Conditions unless otherwise agreed to, and certifies bidder maintains a drug free work place environment.

Bidders are expected to closely read the Terms and Conditions and provide a binding signature of intent to comply with the Terms and Conditions; provided, however, a bidder may indicate any exceptions to the Terms and Conditions by (1) clearly identifying the term or condition by subsection, and (2) including an explanation for the bidder's inability to comply with such term or condition which includes a statement recommending terms and conditions the bidder would find acceptable. Rejection in whole or in part of the Terms and Conditions may be cause for rejection of a bidder's proposal. **Bidders must include completed Section III with their proposal response.**

The State of Nebraska is soliciting bids in response to the RFP. The State of Nebraska will not consider proposals that propose the substitution of the bidder's contract, agreements, or terms for those of the State of Nebraska's. Any License, Service Agreement, Customer Agreement, User Agreement, Bidder Terms and Conditions, Document, or Clause purported or offered to be included as a part of this RFP must be submitted as individual clauses, as either a counter-offer or additional language, and each clause must be acknowledged and accepted in writing by the State. If the Bidder's clause is later found to be in conflict with the RFP or resulting contract the Bidder's clause shall be subordinate to the RFP or resulting contract.

A. GENERAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The contract resulting from this Request for Proposal shall incorporate the following documents:

1. Amendment to Contract Award with the most recent dated amendment having the highest priority;
2. Contract Award and any attached Addenda;
3. The Request for Proposal form and the Contractor's Proposal, signed in ink;
4. Amendments to RFP and any Questions and Answers; and
5. The original RFP document and any Addenda.

These documents constitute the entirety of the contract.

Unless otherwise specifically stated in a contract amendment, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference with number one (1) receiving preference over all other documents and with each lower numbered document having preference over any higher numbered document: 1) Amendment to Contract Award with the most recent dated amendment having the highest priority, 2) Contract Award and any attached Addenda, 3) the signed Request for Proposal form and the Contractor's Proposal, 4) Amendments to RFP and any Questions and Answers, 5) the original RFP document and any Addenda.

Any ambiguity in any provision of this contract which shall be discovered after its execution shall be resolved in accordance with the rules of contract interpretation as established in the State of Nebraska.

Once proposals are opened they become the property of the State of Nebraska and will not be returned.

Section III Terms and Conditions [Page 2 of 23]

B. AWARD

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

All purchases, leases, or contracts which are based on competitive proposals will be awarded according to the provisions in the Request for Proposal. The State reserves the right to reject any or all proposals, in whole or in part, or to award to multiple bidders in whole or in part, and at its discretion, may withdraw or amend the Request for Proposal at any time. The State reserves the right to waive any deviations or errors that are not material, do not invalidate the legitimacy of the proposal, and do not improve the bidder's competitive position. All awards will be made in a manner deemed in the best interest of the State. The Request for Proposal does not commit the State to award a contract. If, in the opinion of the State, revisions or amendments will require substantive changes in proposals, the due date may be extended.

By submitting a proposal in response to this Request for Proposal, the bidder grants to the State the right to contact or arrange a visit in person with any or all of the bidder's clients.

Once intent to award decision has been determined, it will be posted to the Internet at:
http://das.nebraska.gov/materiel/purchasing.html

Protest procedure is available on the Internet at:
http://das.nebraska.gov/materiel/purchase_bureau/docs/vendors/protest/ProtestGrievanceProcedureForVendors.pdf

Any protests must be filed by a vendor within ten (10) business days after the intent to award decision is posted to the Internet.

C. COMPLIANCE WITH CIVIL RIGHTS LAWS AND EQUAL OPPORTUNITY EMPLOYMENT / NONDISCRIMINATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall comply with all applicable local, state, and federal statutes and regulations regarding civil rights laws and equal opportunity employment. The Nebraska Fair Employment Practice Act prohibits Contractors of the State of Nebraska, and their Subcontractors, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions, compensation, or privileges of employment because of race, color, religion, sex, disability, marital status, or national origin (Neb. Rev. Stat. §§ 48-1101 to 48-1125). The Contractor guarantees compliance with the Nebraska Fair Employment Practice Act, and breach of this provision shall be regarded as a material breach of contract. The Contractor shall insert a similar provision in all Subcontracts for services to be covered by any contract resulting from this Request for Proposal.

Section III Terms and Conditions [Page 3 of 23]

D. PERMITS, REGULATIONS, LAWS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall procure and pay for all permits, licenses, and approvals necessary for the execution of the contract. The Contractor shall comply with all applicable local, state, and federal laws, ordinances, rules, orders, and regulations.

E. OWNERSHIP OF INFORMATION AND DATA

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State of Nebraska shall have the unlimited right to publish, duplicate, use, and disclose all non-proprietary information and data developed or derived by the Contractor pursuant to this contract.

The Contractor must guarantee that it has the full legal right to the materials, supplies, equipment, and other rights or titles (e.g. rights to licenses transfer or assign deliverables) necessary to execute this contract. The contract price shall, without exception, include compensation for all royalties and costs arising from patents, trademarks, and copyrights that are in any way involved in the contract. It shall be the responsibility of the Contractor to pay for all royalties and costs, and the State must be held harmless from any such claims.

F. INSURANCE REQUIREMENTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall not commence work under this contract until all the insurance required hereunder has been obtained and such insurance has been approved by the State. The Contractor shall maintain all required insurance for the life of this contract and shall ensure that the State Purchasing Bureau has the most current certificate of insurance throughout the life of this contract. If Contractor will be utilizing any Subcontractors, the Contractor is responsible for obtaining the certificate(s) of insurance required herein under from any and all Subcontractor(s). The Contractor is also responsible for ensuring Subcontractor(s) maintain the insurance required until completion of the contract requirements. The Contractor shall not allow any Subcontractor to commence work on any Subcontract until all similar insurance required of the Subcontractor has been obtained and approved by the Contractor. Approval of the insurance by the State shall not limit, relieve, or decrease the liability of the Contractor hereunder.

If by the terms of any insurance a mandatory deductible is required, or if the Contractor elects to increase the mandatory deductible amount, the Contractor shall be responsible for payment of the amount of the deductible in the event of a paid claim.

Insurance coverages shall function independent of all other clauses in the contract, and in no instance shall the limits of recovery from the insurance be reduced below the limits required by this section.

1. WORKERS' COMPENSATION INSURANCE
The Contractor shall take out and maintain during the life of this contract the statutory Workers' Compensation and Employer's Liability Insurance for all of the contactors' employees to be engaged in work

Section III Terms and Conditions [Page 4 of 23]

on the project under this contract and, in case any such work is sublet, the Contractor shall require the Subcontractor similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the Subcontractor's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work is to be performed, including Occupetional Disease. This policy shall include a waiver of subrogation in favor of the State. The amounts of such insurance shall not be less than the limits stated hereinafter.

2. **COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE**

The Contractor shall take out and maintain during the life of this contract such Commercial General Liability Insurance and Commercial Automobile Liability Insurance as shall protect Contractor and any Subcontractor performing work covered by this contract from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this contract, whether such operation be by the Contractor or by any Subcontractor or by anyone directly or indirectly employed by either of them, and the amounts of such Insurance shall not be less than limits stated hereinafter.

The Commercial General Liability Insurance shall be written on an occurrence basis, and provide Premises/Operations, Products/Completed Operations, Independent Contractors, Personal Injury, and Contractual Liability coverage. The policy shall include the State, and others as required by the contract documents, as Additional Insured(s). This policy shall be primary, and any insurance or self-insurance carried by the State shall be considered excess and non-contributory. The Commercial Automobile Liability Insurance shall be written to cover all Owned, Non-owned, and Hired vehicles.

3. **INSURANCE COVERAGE AMOUNTS REQUIRED**

COMMERCIAL GENERAL LIABILITY	
General Aggregate	$4,000,000
Products/Completed Operations Aggregate	$4,000,000
Personal/Advertising Injury	$1,000,000 per occurrence
Bodily Injury/Property Damage	$1,000,000 per occurrence
Medical Payments	$10,000 any one person
Damage to Rented Premises	$300,000 each occurrence
Contractual	Included
Independent Contractors	Included
Abuse & Molestation	Included
If higher limits are required, the Umbrella/Excess Liability limits are allowed to satisfy the higher limit.	
WORKER'S COMPENSATION	
Employers Liability Limits	$500K/$500K/$500K
Statutory Limits- All States	Statutory - State of Nebraska
USL&H Endorsement	Statutory
Voluntary Compensation	Statutory
COMMERCIAL AUTOMOBILE LIABILITY	
Bodily Injury/Property Damage	$1,000,000 combined single limit
Include All Owned, Hired & Non-Owned Automobile liability	Included
UMBRELLA/EXCESS LIABILITY	
Over Primary Insurance	$5,000,000
PROFESSIONAL LIABILITY	
Errors and Omissions	$7,000,000
COMMERCIAL CRIME	
Crime/Employee Dishonesty Including 3rd Party Fidelity	$7,000,000
CYBER LIABILITY	
Breach of Privacy, Security Breach, Denial of Service, Remediation, Fines and Penalties	$15,000,000
SUBROGATION WAIVER	
"Workers' Compensation policy shall include a waiver of subrogation in favor of the State of Nebraska."	
LIABILITY WAIVER	
"Commercial General Liability & Commercial Automobile Liability policies shall be primary and any insurance or self-insurance carried by the State shall be considered excess and non-contributory."	

Section III Terms and Conditions [Page 5 of 23]

4. **EVIDENCE OF COVERAGE**
The Contractor should furnish the State, with their proposal response, a certificate of insurance coverage complying with the above requirements to the attention of the Buyer at 402-471-2089 (fax)

Administrative Services
State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, NE 68508

These certificates or the cover sheet must reference the RFP number, and the certificates must include the name of the company, policy numbers, effective dates, dates of expiration, and amounts and types of coverage afforded. If the State is damaged by the failure of the Contractor to maintain such insurance, then the Contractor shall be responsible for all reasonable costs properly attributable thereto.

Notice of cancellation of any required insurance policy must be submitted to Administrative Services State Purchasing Bureau when issued and a new coverage binder must be submitted immediately to ensure no break in coverage

G. COOPERATION WITH OTHER CONTRACTORS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State may already have in place or choose to award supplemental contracts for work related to this Request for Proposal, or any portion thereof.

1. The State reserves the right to award the contract jointly between two or more potential Contractors, if such an arrangement is in the best interest of the State.
2. The Contractor must agree to cooperate with such other Contractors, and shall not commit or permit any act which may interfere with the performance of work by any other Contractor.

H. INDEPENDENT CONTRACTOR

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

It is agreed that nothing contained herein is intended or should be construed in any manner as creating or establishing the relationship of partners between the parties hereto. The Contractor represents that it has, or will secure at its own expense, all personnel required to perform the services under the contract. The Contractor's employees and other persons engaged in work or services required by the contractor under the contract shall have no contractual relationship with the State; they shall not be considered employees of the State.

All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination against the Contractor, its officers, or its agents) shall in no way be the responsibility of the State. The Contractor will hold the State harmless from any and all such claims. Such personnel or other persons shall not require nor be entitled to any compensation, rights, or benefits from the State including without limit, tenure rights, medical and hospital care, sick and vacation leave, severance pay, or retirement benefits.

Section III Terms and Conditions [Page 6 of 23]

I. CONTRACTOR RESPONSIBILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor is solely responsible for fulfilling the contract, with responsibility for all services offered and products to be delivered as stated in the Request for Proposal, the Contractor's proposal, and the resulting contract. The Contractor shall be the sole point of contact regarding all contractual matters.

If the Contractor intends to utilize any Subcontractor's services, the Subcontractor's level of effort, tasks, and time allocation must be clearly defined in the Contractor's proposal. The Contractor shall agree that it will not utilize any Subcontractors not specifically included in its proposal in the performance of the contract without the prior written authorization of the State. Following execution of the contract, the Contractor shall proceed diligently with all services and shall perform such services with qualified personnel in accordance with the contract.

J. CONTRACTOR PERSONNEL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor warrants that all persons assigned to the project shall be employees of the Contractor or specified Subcontractors, and shall be fully qualified to perform the work required herein. Personnel employed by the Contractor to fulfill the terms of the contract shall remain under the sole direction and control of the Contractor. The Contractor shall include a similar provision in any contract with any Subcontractor selected to perform work on the project.

Personnel commitments made in the Contractor's proposal shall not be changed without the prior written approval of the State. Replacement of key personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications.

The State reserves the right to require the Contractor to reassign or remove from the project any Contractor or Subcontractor employee.

In respect to its employees, the Contractor agrees to be responsible for the following:

1. any and all employment taxes and/or other payroll withholding;
2. any and all vehicles used by the Contractor's employees, including all insurance required by state law;
3. damages incurred by Contractor's employees within the scope of their duties under the contract;
4. maintaining workers' compensation and health insurance and submitting any reports on such insurance to the extent required by governing State law; and
5. determining the hours to be worked and the duties to be performed by the Contractor's employees.

Section III Terms and Conditions [Page 7 of 23]

K. CONTRACT CONFLICTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Contractor shall insure that contracts or agreements with sub-contractors and agents, and the performance of services in relation to this contract by sub-contractors and agents, does not conflict with this contract.

L. STATE OF NEBRASKA PERSONNEL RECRUITMENT PROHIBITION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall not recruit or employ any State employee or agent who has worked on the Request for Proposal or project, or who had any influence on decisions affecting the Request for Proposal or project, for a period of two years after the date of award.

M. CONFLICT OF INTEREST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

By submitting a proposal, bidder certifies that there does not now exist any relationship between the bidder and any person or entity which is or gives the appearance of a conflict of interest related to this Request for Proposal or project.

The bidder certifies that it shall not take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its services hereunder or which creates an actual or appearance of conflict of interest.

The bidder certifies that it will not employ any individual known by bidder to have a conflict of interest.

N. PROPOSAL PREPARATION COSTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State shall not incur any liability for any costs incurred by bidders in replying to this Request for Proposal, in the demonstrations and/or oral presentations, or in any other activity related to bidding on this Request for Proposal

Section III Terms and Conditions [Page 8 of 23]

O. ERRORS AND OMISSIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The bidder shall not take advantage of any errors and/or omissions in this Request for Proposal or resulting contract. The bidder must promptly notify the State of any errors and/or omissions that are discovered.

P. BEGINNING OF WORK

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The bidder shall not commence any billable work until a valid contract has been fully executed by the State and the successful Contractor. The Contractor will be notified in writing when work may begin.

Q. ASSIGNMENT BY THE STATE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State shall have the right to assign or transfer the contract or any of its interests herein to any agency, board, commission, or political subdivision of the State of Nebraska. There shall be no charge to the State for any assignment hereunder.

R. ASSIGNMENT BY THE CONTRACTOR

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor may not assign, voluntarily or involuntarily, the contract or any of its rights or obligations hereunder (including without limitation rights and duties of performance) to any third party, without the prior written consent of the State, which will not be unreasonably withheld.

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S. DEVIATIONS FROM THE REQUEST FOR PROPOSAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The requirements contained in the Request for Proposal become a part of the terms and conditions of the contract resulting from this Request for Proposal. Any deviations from the Request for Proposal must be clearly defined by the bidder in its proposal and, if accepted by the State, will become part of the contract. Any specifically defined deviations must not be in conflict with the basic nature of the Request for Proposal, mandatory requirements, or applicable state or federal laws or statutes. "Deviation", for the purposes of this RFP, means any proposed changes or alterations to either the contractual language or deliverables within the scope of this RFP. The State discourages deviations and reserves the right to reject proposed deviations.

T. GOVERNING LAW

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The contract shall be governed in all respects by the laws and statutes of the State of Nebraska. Any legal proceedings against the State of Nebraska regarding this Request for Proposal or any resultant contract shall be brought in the State of Nebraska administrative or judicial forums as defined by State law. The Contractor must be in compliance with all Nebraska statutory and regulatory law.

U. ATTORNEY'S FEES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

In the event of any litigation, appeal, or other legal action to enforce any provision of the contract, the Contractor agrees to pay all expenses of such action, as permitted by law, including attorney's fees and costs, if the State is the prevailing party.

V. ADVERTISING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor agrees not to refer to the contract award in advertising in such a manner as to state or imply that the company or its services are endorsed or preferred by the State. News releases pertaining to the project shall not be issued without prior written approval from the State.

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W. STATE PROPERTY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall be responsible for the proper care and custody of any State-owned property which is furnished for the Contractor's use during the performance of the contract. The Contractor shall reimburse the State for any loss or damage of such property; normal wear and tear is expected

X. SITE RULES AND REGULATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall use its best efforts to ensure that its employees, agents, and Subcontractors comply with site rules and regulations while on State premises. If the Contractor must perform on-site work outside of the daily operational hours set forth by the State, it must make arrangements with the State to ensure access to the facility and the equipment has been arranged. No additional payment will be made by the State on the basis of lack of access, unless the State fails to provide access as agreed to between the State and the Contractor.

Y. NOTIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

During the bid process, all communication between the State and a bidder shall be between the bidder's representative clearly noted in its proposal and the buyer noted in Section II.A. Procuring Office and Contact Person, of this RFP. After the award of the contract, all notices under the contract shall be deemed duly given upon delivery to the staff designated as the point of contact for this Request for Proposal, in person, or upon delivery by U.S. Mail, facsimile, or e-mail. Each bidder should provide in its proposal the name, title, and complete address of its designee to receive notices.

1. Except as otherwise expressly specified herein, all notices, requests, or other communications shall be in writing and shall be deemed to have been given if delivered personally or mailed, by U.S. Mail, postage prepaid, return receipt requested, to the parties at their respective addresses set forth above, or at such other addresses as may be specified in writing by either of the parties. All notices, requests, or communications shall be deemed effective upon personal delivery or three (3) calendar days following deposit in the mail.

2. Whenever the Contractor encounters any difficulty which is delaying or threatens to delay its timely performance under the contract, the Contractor shall immediately give notice thereof in writing to the State reciting all relevant information with respect thereto. Such notice shall not in any way constitute a basis for an extension of the delivery schedule or be construed as a waiver by the State of any of its rights or remedies to which it is entitled by law or equity or pursuant to the provisions of the contract. Failure to give such notice, however, may be grounds for denial of any request for an extension of the delivery schedule because of such delay.

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Either party may change its address for notification purposes by giving notice of the change, and setting forth the new address and an effective date.

For the duration of the contract, all communication between Contractor and the State regarding the contract shall take place between the Contractor and individuals specified by the State in writing. Communication about the contract between Contractor and individuals not designated as points of contact by the State is strictly forbidden.

Z. EARLY TERMINATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The contract may be terminated as follows:

1. The State and the Contractor, by mutual written agreement, may terminate the contract at any time.

2. The State, in its sole discretion, may terminate the contract for any reason upon thirty (30) calendar day's written notice to the Contractor. Such termination shall not relieve the Contractor of warranty or other service obligations incurred under the terms of the contract including turnover requirements as described in Section IV.W – Termination of DBPM Contract. In the event of termination the Contractor shall be entitled to payment, determined on a pro rata basis, for services satisfactorily performed or provided.

3. The State will provide the Contractor with a timely written Notice of Intent to Terminate (Notice) that states the nature and basis of the penalty or sanction and pre-termination hearing rights.

4. The Contractor may, at the discretion of the State, be allowed to correct the deficiencies within the thirty (30) calendar day notice period, unless other provisions in this Section demand otherwise, prior to the issuance of a Notice of Termination.

5. In accordance with 42 CFR §438.710, the State will conduct a pre-termination hearing upon the request of the DBPM as outlined in the Notice to provide DBPM the opportunity to contest the nature and basis of the sanction.

   a. The request must be submitted in writing to the State prior to the determined date of termination stated in the Notice.

   b. The DBPM must receive a written notice of the outcome of the pre-termination hearing, if applicable, indicating decision reversal or affirmation.

6. The State will notify Medicaid members enrolled in the DBPM in writing, consistent with 42 CFR §438.710 and §438.722, of the affirming termination decision and of their options for receiving Medicaid services and to disenroll immediately.

7. The State may terminate the contract immediately for the following reasons:

   a. if directed to do so by statute;
   b. Contractor has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business;
   c. a trustee or receiver of the Contractor or of any substantial part of the Contractor's assets has been appointed by a court;
   d. fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by its Contractor, its employees, officers, directors, or shareholders;
   e. an involuntary proceeding has been commenced by any party against the Contractor under any one of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for at least sixty (60) calendar days; or (ii) the Contractor has consented, either expressly or by operation of law, to the entry of an order for relief; or (iii) the Contractor has been decreed or adjudged a debtor;
   f. a voluntary petition has been filed by the Contractor under any of the chapters of Title 11 of the United States Code;

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g. Contractor intentionally discloses confidential information;
h. Contractor has or announces it will discontinue support of the deliverable;
i. second or subsequent documented "vendor performance report" form deemed acceptable by the State Purchasing Bureau; or
j. Contractor engaged in collusion or actions which could have provided Contractor an unfair advantage in obtaining this contract.

AA. FUNDING OUT CLAUSE OR LOSS OF APPROPRIATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State may terminate the contract, in whole or in part, in the event funding is no longer available. The State's obligation to pay amounts due for fiscal years following the current fiscal year is contingent upon legislative appropriation of funds for the contract. Should said funds not be appropriated, the State may terminate the contract with respect to those payments for the fiscal years for which such funds are not appropriated. The State will give the Contractor written notice thirty (30) calendar days prior to the effective date of any termination, and advise the Contractor of the location (address and room number) of any related equipment. All obligations of the State to make payments after the termination date will cease and all interest of the State in any related equipment will terminate. The Contractor shall be entitled to receive just and equitable compensation for any authorized work which has been satisfactorily completed as of the termination date. In no event shall the Contractor be paid for a loss of anticipated profit.

BB. BREACH BY CONTRACTOR

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State may terminate the contract, in whole or in part, if the Contractor fails to perform its obligations under the contract in a timely and proper manner. The State may, by providing a written notice of default to the Contractor, allow the Contractor to cure a failure or breach of contract within a period of thirty (30) calendar days (or longer at State's discretion considering the gravity and nature of the default). Said notice shall be delivered by Certified Mail, Return Receipt Requested, or in person with proof of delivery. Allowing the Contractor time to cure a failure or breach of contract does not waive the State's right to immediately terminate the contract for the same or different contract breach which may occur at a different time. In case of default of the Contractor, the State may contract the service from other sources and hold the Contractor responsible for any excess cost occasioned thereby.

Pursuant to 42 CFR §438.708 the State may provide benefits to members through other options included in the Medicaid State Plan if the State, at its sole discretion, determines that the Contractor has failed to carry out the substantive terms of the contract, or meet applicable requirements in Sections 1932, 1903(m) or 1905(t) of the Social Security Act.

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CC. ASSURANCES BEFORE BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If any document or deliverable required pursuant to the contract does not fulfill the requirements of the Request for Proposal/resulting contract, upon written notice from the State, the Contractor shall deliver assurances in the form of additional Contractor resources at no additional cost to the project in order to complete the deliverable, and to ensure that other project schedules will not be adversely affected.

DD. ADMINISTRATION – CONTRACT TERMINATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

1. Contractor must provide confirmation that upon contract termination all deliverables prepared in accordance with this agreement shall become the property of the State of Nebraska; subject to the ownership provision (section E) contained herein, and is provided to the State of Nebraska at no additional cost to the State.

2. Contractor must provide confirmation that in the event of contract termination, all records that are the property of the State will be returned to the State within thirty (30) calendar days. Notwithstanding the above, Contractor may retain one copy of any information as required to comply with applicable work product documentation standards or as are automatically retained in the course of Contractor's routine back up procedures.

EE. PENALTY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State has the option to invoke penalties as described in Section IV – Project Description.

FF. PERFORMANCE BOND

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor will be required to supply a bond executed by a corporation authorized to contract surety in the State of Nebraska, payable to the State of Nebraska, which shall be valid for the life of the contract to include any renewal and/or extension periods. The amount of the bond must be $10,000,000.00. The bond will guarantee that the Contractor will faithfully perform all requirements, terms and conditions of the contract. Failure to comply shall be

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grounds for forfeiture of the bond as liquidated damages. Amount of forfeiture will be determined by the agency based on loss to the State. The bond will be returned when the service has been satisfactorily completed as solely determined by the State, after termination or expiration of the contract.

The Contractor must obtain and maintain a performance bond, rated a minimum of A by A.M. Best Company, of a standard commercial scope from a surety company or companies holding a certificate of authority to transact surety business in the state. The Contractor must not leverage the bond as collateral for debt or create other creditors using the bond as security. The Contractor must be in breach of this contract if it fails to maintain or renew the performance bond as required by this contract.

1. The Contractor must obtain a performance bond in an amount equal to $10,000,000.00. The bond will guarantee that the selected contractor will faithfully perform all requirements, terms and conditions of the contract. Failure to comply must be grounds for forfeiture of the bond as liquidated damages. Amount of forfeiture will be determined by the agency based on loss to the State. The bond will be returned when the service has been satisfactorily completed as solely determined by the State, after termination or expiration of the contract.

2. The Contractor agrees that if it is declared to be in default of any term of this contract, MLTC may elect to, in addition to any other remedies it may have under this contract, obtain payment under the performance bond for the following:

   a. Making funds available through a consensus proceeding in the appropriate court for payment to subcontracted providers and non-contracted health care providers for reimbursement due to nonpayment of claims by Contractor, in the event of a breach of Contractor's obligation under this contract;
   b. Reimbursing MLTC for any payments made by MLTC on behalf of the Contractor;
   c. Reimbursing MLTC for any extraordinary administrative expenses incurred by a breach of Contractor's obligations under this contract, including, expenses incurred after termination of this contract by MLTC;
   d. Making any payments or expenditures deemed necessary to MLTC, in its sole discretion, incurred by MLTC in the direct operation of the contract pursuant to the terms of this contract and to reimburse MLTC for any extraordinary administrative expenses incurred in connection with the direct operation of the Contractor; and
   e. The Contractor must reimburse MLTC for expenses exceeding the performance bond amount.

GG. FORCE MAJEURE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Neither party shall be liable for any costs or damages resulting from its inability to perform any of its obligations under the contract due to a natural disaster, or other similar event outside the control and not the fault of the affected party ("Force Majeure Event"). A Force Majeure Event shall not constitute a breach of the contract. The party so affected shall immediately give notice to the other party of the Force Majeure Event. The State may grant relief from performance of the contract if the Contractor is prevented from performance by a Force Majeure Event. The burden of proof for the need for such relief shall rest upon the Contractor. To obtain release based on a Force Majeure Event, the Contractor shall file a written request for such relief with the State Purchasing Bureau. Labor disputes with the impacted party's own employees will not be considered a Force Majeure Event and will not suspend performance requirements under the contract.

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HH. PAYMENT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

State will render payment to Contractor when the terms and conditions of the contract and specifications have been satisfactorily completed on the part of the Contractor as solely determined by the State. Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §§ 81-2401 through 81-2408). The State may require the Contractor to accept payment by electronic means such as ACH deposit. In no event shall the State be responsible or liable to pay for any services provided by the Contractor prior to the Effective Date, and the Contractor hereby waives any claim or cause of action for any such services.

II. RIGHT TO AUDIT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Contractor shall establish and maintain a reasonable accounting system that enables the State to readily audit contract. The State and its authorized representatives shall have the right to audit, to examine, and to make copies of or extracts from all financial and related records (in whatever form they may be kept, whether written, electronic, or other) relating to or pertaining to this contract kept by or under the control of the Contractor, including, but not limited to those kept by the Contractor, its employees, agents, assigns, successors, and Subcontractors. Such records shall include, but not be limited to, accounting records, written policies and procedures; all paid vouchers including those for out-of-pocket expenses; other reimbursement supported by invoices; ledgers; cancelled checks; deposit slips; bank statements; journals; original estimates; estimating work sheets; contract amendments and change order files; back charge logs and supporting documentation; insurance documents; payroll documents; timesheets; memoranda; and correspondence.

Contractor shall, at all times during the term of this contract and for a period of five (5) years after the completion of this contract, maintain such records, together with such supporting or underlying documents and materials. The Contractor shall at any time requested by the State, whether during or after completion of this contract and at Contractor's own expense make such records available for inspection and audit (including copies and extracts of records as required) by the State. Such records shall be made available to the State during normal business hours at the Contractor's office or place of business. In the event that no such location is available, then the financial records, together with the supporting or underlying documents and records, shall be made available for audit at a time and location that is convenient for the State. Contractor shall ensure the State has these rights with Contractor's assigns, successors, and Subcontractors, and the obligations of these rights shall be explicitly included in any subcontracts or agreements formed between the Contractor and any Subcontractors to the extent that those Subcontracts or agreements relate to fulfillment of the Contractor's obligations to the State.

Costs of any audits conducted under the authority of this right to audit and not addressed elsewhere will be borne by the State unless certain exemption criteria are met. If the audit identifies overpricing or overcharges (of any nature) by the Contractor to the State in excess of one-half of one percent (.5%) of the total contract billings, the Contractor shall reimburse the State for the total costs of the audit. If the audit discovers substantive findings related to fraud, misrepresentation, or non-performance, the Contractor shall reimburse the State for total costs of audit. Any adjustments and/or payments that must be made as a result of any such audit or inspection of the Contractor's invoices and/or records shall be made within a reasonable amount of time (not to exceed 90 days) from presentation of the State's findings to Contractor.

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JJ. TAXES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State is not required to pay taxes of any kind and assumes no such liability as a result of this solicitation. Any property tax payable on the Contractor's equipment which may be installed in a state-owned facility is the responsibility of the Contractor.

KK. INSPECTION AND APPROVAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Final inspection and approval of all work required under the contract shall be performed by the designated State officials. The State and/or its authorized representatives shall have the right to enter any premises where the Contractor or Subcontractor duties under the contract are being performed, and to inspect, monitor or otherwise evaluate the work being performed. All inspections and evaluations shall be at reasonable times and in a manner that will not unreasonably delay work.

LL. CHANGES IN SCOPE/CHANGE ORDERS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State may, upon the written agreement of Contractor, make changes to the contract within the general scope of the RFP. The State may, at any time work is in progress, by written agreement, make alterations in the terms of work as shown in the specifications, require the Contractor to make corrections, decrease the quantity of work, or make such other changes as the State may find necessary or desirable. The Contractor shall not claim forfeiture of contract by reasons of such changes by the State.

Corrections of any deliverable, service or performance of work required pursuant to the contract shall not be deemed a modification. Changes or additions to the contract beyond the scope of the RFP are not permitted; however, the contract must meet all applicable federal legal requirements and regulations, including Medicaid laws, rules and regulations, and any future amendments to the contract that are required to bring Nebraska in compliance with federal Medicaid law must be deemed part of the scope of the requested bid. Changes or additions to the contract beyond the scope of the RFP are not permitted except as noted herein.

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MM. SEVERABILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If any term or condition of the contract is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and conditions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the contract did not contain the particular provision held to be invalid.

NN. CONFIDENTIALITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

All materials and information provided by the State or acquired by the Contractor on behalf of the State shall be regarded as confidential information. All materials and information provided by the State or acquired by the Contractor on behalf of the State shall be handled in accordance with federal and state law, and ethical standards. The Contractor must ensure the confidentiality of such materials or information. Should said confidentiality be breached by a Contractor; Contractor shall notify the State immediately of said breach and take immediate corrective action.

It is incumbent upon the Contractor to inform its officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a (i)(1), which is made applicable to Contractors by 5 U.S.C. 552a (m)(1), provides that any officer or employee of a Contractor, who by virtue of his/her employment or official position has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

OO. PROPRIETARY INFORMATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Data contained in the proposal and all documentation provided therein, become the property of the State of Nebraska and the data becomes public information upon opening the proposal. If the bidder wishes to have any information withheld from the public, such information must fall within the definition of proprietary information contained within Nebraska's public record statutes. **All proprietary information the bidder wishes the State to withhold must be submitted in a sealed package, which is separate from the remainder of the proposal, and provide supporting documents showing why such documents should be marked proprietary.** The separate package must be clearly marked PROPRIETARY on the outside of the package. **Bidders may not mark their entire Request for Proposal as proprietary.** Failure of the bidder to follow the instructions for submitting proprietary and copyrighted information may result in the information being viewed by other bidders and the public. Proprietary information is defined as trade secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. § 84-712.05(3)). In accordance with Attorney General Opinions 92068 and 97033, bidders submitting information as proprietary may be required to prove specific, named competitor(s) who would be advantaged by release of the information and the specific advantage the competitor(s) would receive. Although every effort will be made to withhold information that is properly submitted as proprietary and meets the State's definition of proprietary

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Information, the State is under no obligation to maintain the confidentiality of proprietary information and accepts no liability for the release of such information.

PP. CERTIFICATION OF INDEPENDENT PRICE DETERMINATION/COLLUSIVE BIDDING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

By submission of this proposal, the bidder certifies that it is the party making the foregoing proposal and that the proposal is not made in the interest of, or on behalf of, any undisclosed person, partnership, company, association, organization, or corporation; that the proposal is genuine and not collusive or sham; that the bidder has not directly or indirectly induced or solicited any other bidder to put in a false or sham proposal, and has not directly or indirectly colluded, conspired, connived, or agreed with any bidder or anyone else to put in a sham proposal, or that anyone shall refrain from bidding; that the bidder has not in any manner, directly or indirectly, sought by agreement, communication, or conference with anyone to fix the proposal price of the bidder or any other bidder, or to fix any overhead, profit, or cost element of the proposal price, or of that of any other bidder, or to secure any advantage against the public body awarding the contract of anyone interested in the proposed contract; that all statements contained in the proposal are true; and further that the bidder has not, directly or indirectly, submitted the proposal price or any breakdown thereof, or the contents thereof, or divulged information or data relative thereto, or paid, and will not pay, any fee to any corporation, partnership, company association, organization, proposal depository, or to any member or agent thereof to effectuate a collusive or sham proposal.

QQ. STATEMENT OF NON-COLLUSION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The proposal shall be arrived at by the bidder independently and be submitted without collusion with, and without any direct or indirect agreement, understanding or planned common course of action with, any person; firm; corporation; bidder; Contractor of materials, supplies, equipment or services described in this RFP. Bidder shall not collude with, or attempt to collude with, any state officials, employees or agents; or evaluators or any person involved in this RFP. The bidder shall not take any action in the restraint of free competition or designed to limit independent bidding or to create an unfair advantage.

Should it be determined that collusion occurred, the State reserves the right to reject a bid or terminate the contract and impose further administrative sanctions.

RR. PRICES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Price information is provided under Section IV.P – DBPM Reimbursement.

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SS. ETHICS IN PUBLIC CONTRACTING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

No bidder shall pay or offer to pay, either directly or indirectly, any fee, commission compensation, gift, gratuity, or anything of value to any State officer, legislator, employee or evaluator based on the understanding that the receiving person's vote, actions, or judgment will be influenced thereby. No bidder shall give any item of value to any employee of the State Purchasing Bureau or any evaluator.

Bidders shall be prohibited from utilizing the services of lobbyists, attorneys, political activists, or consultants to secure the contract. It is the intent of this provision to assure that the prohibition of state contact during the procurement process is not subverted through the use of lobbyists, attorneys, political activists, or consultants. It is the intent of the State that the process of evaluation of proposals and award of the contract be completed without external influence. It is not the intent of this section to prohibit bidders from seeking professional advice, for example consulting legal counsel, regarding terms and conditions of this Request for Proposal or the format or content of their proposal.

If the bidder is found to be in non-compliance with this section of the Request for Proposal, they may forfeit the contract if awarded to them or be disqualified from the selection process.

In compliance with the Byrd Anti-Lobbying Amendment, contractors who apply or bid must file the required certification that each tier will not use federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any federal contract, grant or any other award covered by 31 U.S.C. §1352. Each tier must also disclose any lobbying with nonfederal funds that takes place in connection with obtaining any federal award. Such disclosures are forwarded from tier-to-tier up to the recipient (45 CFR §3).

TT. INDEMNIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

1. GENERAL
The Contractor agrees to defend, indemnify, hold, and save harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses ("the claims"), sustained or asserted against the State, arising out of, resulting from, or attributable to the willful misconduct, negligence, error, or omission of the Contractor, its employees, Subcontractors, consultants, representatives, and agents, except to the extent such Contractor liability is attenuated by any action of the State which directly and proximately contributed to the claims.

2. INTELLECTUAL PROPERTY
The Contractor agrees it will, at its sole cost and expense, defend, indemnify, and hold harmless the indemnified parties from and against any and all claims, to the extent such claims arise out of, result from, or are attributable to, the actual or alleged infringement or misappropriation of any patent, copyright, trade secret, trademark, or confidential information of any third party by the Contractor or its employees, Subcontractors, consultants, representatives, and agents; provided, however, the State gives the Contractor prompt notice in writing of the claim. The Contractor may not settle any infringement claim that will affect the State's use of the Licensed Software without the State's prior written consent, which consent may be withheld for any reason.

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If a judgment or settlement is obtained or reasonably anticipated against the State's use of any intellectual property for which the Contractor has indemnified the State, the Contractor shall, at the Contractor's sole cost and expense, promptly modify the item or items which were determined to be infringing, acquire a license or licenses on the State's behalf to provide the necessary rights to the State to eliminate the infringement, or provide the State with a non-infringing substitute that provides the State the same functionality. At the State's election, the actual or anticipated judgment may be treated as a breach of warranty by the Contractor, and the State may receive the remedies provided under this RFP.

3. **PERSONNEL**
The Contractor shall, at its expense, indemnify and hold harmless the indemnified parties from and against any claim with respect to withholding taxes, worker's compensation, employee benefits, or any other claim, demand, liability, damage, or loss of any nature relating to any of the personnel provided by the Contractor.

4. **SELF-INSURANCE**
The State of Nebraska is self-insured for any loss and purchases excess insurance coverage pursuant to Neb. Rev. Stat. § 81-8,239.01 (Reissue 2008). If there is a presumed loss under the provisions of this agreement, Contractor may file a claim with the Office of Risk Management pursuant to Neb. Rev. Stat. §§ 81-8,829 – 81-8,306 for review by the State Claims Board. The State retains all rights and immunities under the State Miscellaneous (Section 81-8,294), Tort (Section 81-8,209), and Contract Claim Acts (Section 81-8,302), as outlined in Neb. Rev. Stat. § 81-8,209 *et seq.* and under any other provisions of law and accepts liability under this agreement to the extent provided by law.

UU. NEBRASKA TECHNOLOGY ACCESS STANDARDS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Contractor shall review the Nebraska Technology Access Standards, found at http://nitc.nebraska.gov/standards/2-201.html and ensure that products and/or services provided under the contract are in compliance or will comply with the applicable standards to the greatest degree possible. In the event such standards change during the Contractor's performance, the State may create an amendment to the contract to request the contract comply with the changed standard at a cost mutually acceptable to the parties.

VV. ANTITRUST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor hereby assigns to the State any and all claims for overcharges as to goods and/or services provided in connection with this contract resulting from antitrust violations which arise under antitrust laws of the United States and the antitrust laws of the State.

Section III Terms and Conditions [Page 21 of 23]

WW. DISASTER RECOVERY/BACK UP PLAN

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall have a disaster recovery and back-up plan, of which a copy should be provided to the State, which includes, but is not limited to equipment, personnel, facilities, and transportation, in order to continue services as specified under the specifications in the contract in the event of a disaster.

XX. TIME IS OF THE ESSENCE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Time is of the essence in this contract. The acceptance of late performance with or without objection or reservation by the State shall not waive any rights of the State nor constitute a waiver of the requirement of timely performance of any obligations on the part of the Contractor remaining to be performed.

YY. RECYCLING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Preference will be given to items which are manufactured or produced from recycled material or which can be readily reused or recycled after their normal use as per Neb. Rev. Stat. § 81-15,159.

ZZ. DRUG POLICY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Contractor certifies it maintains a drug free work place environment to ensure worker safety and workplace integrity. Contractor agrees to provide a copy of its drug free workplace policy at any time upon request by the State.

Section III Terms and Conditions [Page 22 of 23]

AAA. EMPLOYEE WORK ELIGIBILITY STATUS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of employees physically performing services within the State of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of an employee.

If the Contractor is an individual or sole proprietorship, the following applies:

1. The Contractor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at http://das.nebraska.gov/materiel/purchasing.html

   The completed United States Attestation Form should be submitted with the Request for Proposal response.

2. If the Contractor indicates on such attestation form that he or she is a qualified alien, the Contractor agrees to provide the US Citizenship and Immigration Services documentation required to verify the Contractor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.

3. The Contractor understands and agrees that lawful presence in the United States is required and the Contractor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. § 4-108.

BBB. CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND INELIGIBILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor, by signature to this RFP, certifies that the Contractor is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency from participating in transactions (debarred). The Contractor also agrees to include the above requirements in any and all Subcontracts into which it enters. The Contractor shall immediately notify the Department if, during the term of this contract, Contractor becomes debarred. The Department may immediately terminate this contract by providing Contractor written notice if Contractor becomes debarred during the term of this contract.

Contractor, by signature to this RFP, certifies that Contractor has not had a contract with the State of Nebraska terminated early by the State of Nebraska. If Contractor has had a contract terminated early by the State of Nebraska, Contractor must provide the contract number, along with an explanation of why the contract was terminated early. Prior early termination may be cause for rejecting the proposal.

Section III Terms and Conditions [Page 23 of 23]

CCC. OFFICE OF PUBLIC COUNSEL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If it provides, under the terms of this contract and on behalf of the State of Nebraska, health and human services to individuals; service delivery; service coordination; or case management, Contractor shall submit to the jurisdiction of the Office of Public Counsel, pursuant to Neb. Rev. Stat. §§ 81-8,240 et seq. This section must survive the termination of this contract and shall not apply if Contractor is a long-term care facility subject to the Long-Term Care Ombudsman Act, Neb. Rev. Stat. §§ 81-2237 et seq.

DDD. LONG-TERM CARE OMBUDSMAN

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If it is a long-term care facility subject to the Long-Term Care Ombudsman Act, Neb. Rev. Stat. §§ 81-2237 et seq., Contractor shall comply with the Act. This section shall survive the termination of this contract.

III. TERMS AND CONDITIONS

By signing the "Request for Proposal for Contractual Services" form, the bidder guarantees compliance with the provisions stated in this Request for Proposal, agrees to the Terms and Conditions unless otherwise agreed to, and certifies bidder maintains a drug free work place environment.

Bidders are expected to closely read the Terms and Conditions and provide a binding signature of intent to comply with the Terms and Conditions; provided, however, a bidder may indicate any exceptions to the Terms and Conditions by (1) clearly identifying the term or condition by subsection, and (2) including an explanation for the bidder's inability to comply with such term or condition which includes a statement recommending terms and conditions the bidder would find acceptable. Rejection in whole or in part of the Terms and Conditions may be cause for rejection of a bidder's proposal. **Bidders must include completed Section III with their proposal response.**

The State of Nebraska is soliciting bids in response to the RFP. The State of Nebraska will not consider proposals that propose the substitution of the bidder's contract, agreements, or terms for those of the State of Nebraska's. Any License, Service Agreement, Customer Agreement, User Agreement, Bidder Terms and Conditions, Document, or Clause purported or offered to be included as a part of this RFP must be submitted as individual clauses, as either a counter-offer or additional language, and each clause must be acknowledged and accepted in writing by the State. If the Bidder's clause is later found to be in conflict with the RFP or resulting contract the Bidder's clause shall be subordinate to the RFP or resulting contract.

A. GENERAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
Ch			

The contract resulting from this Request for Proposal shall incorporate the following documents:

1. Amendment to Contract Award with the most recent dated amendment having the highest priority;
2. Contract Award and any attached Addenda;
3. The Request for Proposal form and the Contractor's Proposal, signed in ink;
4. Amendments to RFP and any Questions and Answers; and
5. The original RFP document and any Addenda.

These documents constitute the entirety of the contract.

Unless otherwise specifically stated in a contract amendment, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference with number one (1) receiving preference over all other documents and with each lower numbered document having preference over any higher numbered document: 1) Amendment to Contract Award with the most recent dated amendment having the highest priority, 2) Contract Award and any attached Addenda, 3) the signed Request for Proposal form and the Contractor's Proposal, 4) Amendments to RFP and any Questions and Answers, 5) the original RFP document and any Addenda.

Any ambiguity in any provision of this contract which shall be discovered after its execution shall be resolved in accordance with the rules of contract interpretation as established in the State of Nebraska.

Once proposals are opened they become the property of the State of Nebraska and will not be returned.

B. AWARD

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

All purchases, leases, or contracts which are based on competitive proposals will be awarded according to the provisions in the Request for Proposal. The State reserves the right to reject any or all proposals, in whole or in part, or to award to multiple bidders in whole or in part, and at its discretion, may withdraw or amend the Request for Proposal at any time. The State reserves the right to waive any deviations or errors that are not material, do not invalidate the legitimacy of the proposal, and do not improve the bidder's competitive position. All awards will be made in a manner deemed in the best interest of the State. The Request for Proposal does not commit the State to award a contract. If, in the opinion of the State, revisions or amendments will require substantive changes in proposals, the due date may be extended.

By submitting a proposal in response to this Request for Proposal, the bidder grants to the State the right to contact or arrange a visit in person with any or all of the bidder's clients.

Once intent to award decision has been determined, it will be posted to the Internet at:
http://das.nebraska.gov/materiel/purchasing.html

Protest procedure is available on the Internet at:
http://das.nebraska.gov/materiel/purchase_bureau/docs/vendors/protest/ProtestGrievanceProcedureForVendors.pdf

Any protests must be filed by a vendor within ten (10) business days after the intent to award decision is posted to the Internet.

C. COMPLIANCE WITH CIVIL RIGHTS LAWS AND EQUAL OPPORTUNITY EMPLOYMENT / NONDISCRIMINATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall comply with all applicable local, state, and federal statutes and regulations regarding civil rights laws and equal opportunity employment. The Nebraska Fair Employment Practice Act prohibits Contractors of the State of Nebraska, and their Subcontractors, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions, compensation, or privileges of employment because of race, color, religion, sex, disability, marital status, or national origin (Neb. Rev. Stat. §§ 48-1101 to 48-1125). The Contractor guarantees compliance with the Nebraska Fair Employment Practice Act, and breach of this provision shall be regarded as a material breach of contract. The Contractor shall insert a similar provision in all Subcontracts for services to be covered by any contract resulting from this Request for Proposal.

D. PERMITS, REGULATIONS, LAWS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall procure and pay for all permits, licenses, and approvals necessary for the execution of the contract. The Contractor shall comply with all applicable local, state, and federal laws, ordinances, rules, orders, and regulations.

E. OWNERSHIP OF INFORMATION AND DATA

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State of Nebraska shall have the unlimited right to publish, duplicate, use, and disclose all non-proprietary information and data developed or derived by the Contractor pursuant to this contract.

The Contractor must guarantee that it has the full legal right to the materials, supplies, equipment, and other rights or titles (e.g. rights to licenses transfer or assign deliverables) necessary to execute this contract. The contract price shall, without exception, include compensation for all royalties and costs arising from patents, trademarks, and copyrights that are in any way involved in the contract. It shall be the responsibility of the Contractor to pay for all royalties and costs, and the State must be held harmless from any such claims.

F. INSURANCE REQUIREMENTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall not commence work under this contract until all the insurance required hereunder has been obtained and such insurance has been approved by the State. The Contractor shall maintain all required insurance for the life of this contract and shall ensure that the State Purchasing Bureau has the most current certificate of insurance throughout the life of this contract. If Contractor will be utilizing any Subcontractors, the Contractor is responsible for obtaining the certificate(s) of insurance required herein under from any and all Subcontractor(s). The Contractor is also responsible for ensuring Subcontractor(s) maintain the insurance required until completion of the contract requirements. The Contractor shall not allow any Subcontractor to commence work on any Subcontract until all similar insurance required of the Subcontractor has been obtained and approved by the Contractor. Approval of the insurance by the State shall not limit, relieve, or decrease the liability of the Contractor hereunder.

If by the terms of any insurance a mandatory deductible is required, or if the Contractor elects to increase the mandatory deductible amount, the Contractor shall be responsible for payment of the amount of the deductible in the event of a paid claim.

Insurance coverages shall function independent of all other clauses in the contract, and in no instance shall the limits of recovery from the insurance be reduced below the limits required by this section.

1. WORKERS' COMPENSATION INSURANCE

The Contractor shall take out and maintain during the life of this contract the statutory Workers' Compensation and Employer's Liability Insurance for all of the contactors' employees to be engaged in work

on the project under this contract and, in case any such work is sublet, the Contractor shall require the Subcontractor similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the Subcontractor's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work is to be performed, including Occupational Disease. This policy shall include a waiver of subrogation in favor of the State. The amounts of such insurance shall not be less than the limits stated hereinafter.

2. **COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE**

The Contractor shall take out and maintain during the life of this contract such Commercial General Liability Insurance and Commercial Automobile Liability Insurance as shall protect Contractor and any Subcontractor performing work covered by this contract from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this contract, whether such operation be by the Contractor or by any Subcontractor or by anyone directly or indirectly employed by either of them, and the amounts of such insurance shall not be less than limits stated hereinafter.

The Commercial General Liability Insurance shall be written on an occurrence basis, and provide Premises/Operations, Products/Completed Operations, Independent Contractors, Personal Injury, and Contractual Liability coverage. The policy shall include the State, and others as required by the contract documents, as Additional Insured(s). This policy shall be primary, and any insurance or self-insurance carried by the State shall be considered excess and non-contributory. The Commercial Automobile Liability Insurance shall be written to cover all Owned, Non-owned, and Hired vehicles.

3. **INSURANCE COVERAGE AMOUNTS REQUIRED**

COMMERCIAL GENERAL LIABILITY	
General Aggregate	$4,000,000
Products/Completed Operations Aggregate	$4,000,000
Personal/Advertising Injury	$1,000,000 per occurrence
Bodily Injury/Property Damage	$1,000,000 per occurrence
Medical Payments	$10,000 any one person
Damage to Rented Premises	$300,000 each occurrence
Contractual	Included
Independent Contractors	Included
Abuse & Molestation	Included
If higher limits are required, the Umbrella/Excess Liability limits are allowed to satisfy the higher limit.	
WORKER'S COMPENSATION	
Employers Liability Limits	$500K/$500K/$500K
Statutory Limits- All States	Statutory - State of Nebraska
USL&H Endorsement	Statutory
Voluntary Compensation	Statutory
COMMERCIAL AUTOMOBILE LIABILITY	
Bodily Injury/Property Damage	$1,000,000 combined single limit
Include All Owned, Hired & Non-Owned Automobile liability	Included
UMBRELLA/EXCESS LIABILITY	
Over Primary Insurance	$5,000,000
PROFESSIONAL LIABILITY	
Errors and Omissions	$7,000,000
COMMERCIAL CRIME	
Crime/Employee Dishonesty Including 3rd Party Fidelity	$7,000,000
CYBER LIABILITY	
Breach of Privacy, Security Breach, Denial of Service, Remediation, Fines and Penalties	$15,000,000
SUBROGATION WAIVER	
"Workers' Compensation policy shall include a waiver of subrogation in favor of the State of Nebraska."	
LIABILITY WAIVER	
"Commercial General Liability & Commercial Automobile Liability policies shall be primary and any insurance or self-insurance carried by the State shall be considered excess and non-contributory."	

4. **EVIDENCE OF COVERAGE**

The Contractor should furnish the State, with their proposal response, a certificate of insurance coverage complying with the above requirements to the attention of the Buyer at 402-471-2089 (fax)

Administrative Services
State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, NE 68508

These certificates or the cover sheet must reference the RFP number, and the certificates must include the name of the company, policy numbers, effective dates, dates of expiration, and amounts and types of coverage afforded. If the State is damaged by the failure of the Contractor to maintain such insurance, then the Contractor shall be responsible for all reasonable costs properly attributable thereto.

Notice of cancellation of any required insurance policy must be submitted to Administrative Services State Purchasing Bureau when issued and a new coverage binder must be submitted immediately to ensure no break in coverage.

G. COOPERATION WITH OTHER CONTRACTORS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State may already have in place or choose to award supplemental contracts for work related to this Request for Proposal, or any portion thereof.

1. The State reserves the right to award the contract jointly between two or more potential Contractors, if such an arrangement is in the best interest of the State.
2. The Contractor must agree to cooperate with such other Contractors, and shall not commit or permit any act which may interfere with the performance of work by any other Contractor.

H. INDEPENDENT CONTRACTOR

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

It is agreed that nothing contained herein is intended or should be construed in any manner as creating or establishing the relationship of partners between the parties hereto. The Contractor represents that it has, or will secure at its own expense, all personnel required to perform the services under the contract. The Contractor's employees and other persons engaged in work or services required by the contractor under the contract shall have no contractual relationship with the State; they shall not be considered employees of the State.

All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination against the Contractor, its officers, or its agents) shall in no way be the responsibility of the State. The Contractor will hold the State harmless from any and all such claims. Such personnel or other persons shall not require nor be entitled to any compensation, rights, or benefits from the State including without limit, tenure rights, medical and hospital care, sick and vacation leave, severance pay, or retirement benefits.

I. CONTRACTOR RESPONSIBILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor is solely responsible for fulfilling the contract, with responsibility for all services offered and products to be delivered as stated in the Request for Proposal, the Contractor's proposal, and the resulting contract. The Contractor shall be the sole point of contact regarding all contractual matters.

If the Contractor intends to utilize any Subcontractor's services, the Subcontractor's level of effort, tasks, and time allocation must be clearly defined in the Contractor's proposal. The Contractor shall agree that it will not utilize any Subcontractors not specifically included in its proposal in the performance of the contract without the prior written authorization of the State. Following execution of the contract, the Contractor shall proceed diligently with all services and shall perform such services with qualified personnel in accordance with the contract.

J. CONTRACTOR PERSONNEL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor warrants that all persons assigned to the project shall be employees of the Contractor or specified Subcontractors, and shall be fully qualified to perform the work required herein. Personnel employed by the Contractor to fulfill the terms of the contract shall remain under the sole direction and control of the Contractor. The Contractor shall include a similar provision in any contract with any Subcontractor selected to perform work on the project.

Personnel commitments made in the Contractor's proposal shall not be changed without the prior written approval of the State. Replacement of key personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications.

The State reserves the right to require the Contractor to reassign or remove from the project any Contractor or Subcontractor employee.

In respect to its employees, the Contractor agrees to be responsible for the following:

1. any and all employment taxes and/or other payroll withholding;
2. any and all vehicles used by the Contractor's employees, including all insurance required by state law;
3. damages incurred by Contractor's employees within the scope of their duties under the contract;
4. maintaining workers' compensation and health insurance and submitting any reports on such insurance to the extent required by governing State law; and
5. determining the hours to be worked and the duties to be performed by the Contractor's employees.

K. CONTRACT CONFLICTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Contractor shall insure that contracts or agreements with sub-contractors and agents, and the performance of services in relation to this contract by sub-contractors and agents, does not conflict with this contract.

L. STATE OF NEBRASKA PERSONNEL RECRUITMENT PROHIBITION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall not recruit or employ any State employee or agent who has worked on the Request for Proposal or project, or who had any influence on decisions affecting the Request for Proposal or project, for a period of two years after the date of award.

M. CONFLICT OF INTEREST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

By submitting a proposal, bidder certifies that there does not now exist any relationship between the bidder and any person or entity which is or gives the appearance of a conflict of interest related to this Request for Proposal or project.

The bidder certifies that it shall not take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its services hereunder or which creates an actual or appearance of conflict of interest.

The bidder certifies that it will not employ any individual known by bidder to have a conflict of interest.

N. PROPOSAL PREPARATION COSTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State shall not incur any liability for any costs incurred by bidders in replying to this Request for Proposal, in the demonstrations and/or oral presentations, or in any other activity related to bidding on this Request for Proposal.

O. ERRORS AND OMISSIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The bidder shall not take advantage of any errors and/or omissions in this Request for Proposal or resulting contract. The bidder must promptly notify the State of any errors and/or omissions that are discovered.

P. BEGINNING OF WORK

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The bidder shall not commence any billable work until a valid contract has been fully executed by the State and the successful Contractor. The Contractor will be notified in writing when work may begin.

Q. ASSIGNMENT BY THE STATE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State shall have the right to assign or transfer the contract or any of its interests herein to any agency, board, commission, or political subdivision of the State of Nebraska. There shall be no charge to the State for any assignment hereunder.

R. ASSIGNMENT BY THE CONTRACTOR

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor may not assign, voluntarily or involuntarily, the contract or any of its rights or obligations hereunder (including without limitation rights and duties of performance) to any third party, without the prior written consent of the State, which will not be unreasonably withheld.

S. DEVIATIONS FROM THE REQUEST FOR PROPOSAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The requirements contained in the Request for Proposal become a part of the terms and conditions of the contract resulting from this Request for Proposal. Any deviations from the Request for Proposal must be clearly defined by the bidder in its proposal and, if accepted by the State, will become part of the contract. Any specifically defined deviations must not be in conflict with the basic nature of the Request for Proposal, mandatory requirements, or applicable state or federal laws or statutes. "Deviation", for the purposes of this RFP, means any proposed changes or alterations to either the contractual language or deliverables within the scope of this RFP. The State discourages deviations and reserves the right to reject proposed deviations.

T. GOVERNING LAW

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The contract shall be governed in all respects by the laws and statutes of the State of Nebraska. Any legal proceedings against the State of Nebraska regarding this Request for Proposal or any resultant contract shall be brought in the State of Nebraska administrative or judicial forums as defined by State law. The Contractor must be in compliance with all Nebraska statutory and regulatory law.

U. ATTORNEY'S FEES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

In the event of any litigation, appeal, or other legal action to enforce any provision of the contract, the Contractor agrees to pay all expenses of such action, as permitted by law, including attorney's fees and costs, if the State is the prevailing party.

V. ADVERTISING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor agrees not to refer to the contract award in advertising in such a manner as to state or imply that the company or its services are endorsed or preferred by the State. News releases pertaining to the project shall not be issued without prior written approval from the State.

W. STATE PROPERTY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall be responsible for the proper care and custody of any State-owned property which is furnished for the Contractor's use during the performance of the contract. The Contractor shall reimburse the State for any loss or damage of such property; normal wear and tear is expected.

X. SITE RULES AND REGULATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall use its best efforts to ensure that its employees, agents, and Subcontractors comply with site rules and regulations while on State premises. If the Contractor must perform on-site work outside of the daily operational hours set forth by the State, it must make arrangements with the State to ensure access to the facility and the equipment has been arranged. No additional payment will be made by the State on the basis of lack of access, unless the State fails to provide access as agreed to between the State and the Contractor.

Y. NOTIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

During the bid process, all communication between the State and a bidder shall be between the bidder's representative clearly noted in its proposal and the buyer noted in Section II.A. Procuring Office and Contact Person, of this RFP. After the award of the contract, all notices under the contract shall be deemed duly given upon delivery to the staff designated as the point of contact for this Request for Proposal, in person, or upon delivery by U.S. Mail, facsimile, or e-mail. Each bidder should provide in its proposal the name, title, and complete address of its designee to receive notices.

1. Except as otherwise expressly specified herein, all notices, requests, or other communications shall be in writing and shall be deemed to have been given if delivered personally or mailed, by U.S. Mail, postage prepaid, return receipt requested, to the parties at their respective addresses set forth above, or at such other addresses as may be specified in writing by either of the parties. All notices, requests, or communications shall be deemed effective upon personal delivery or three (3) calendar days following deposit in the mail.

2. Whenever the Contractor encounters any difficulty which is delaying or threatens to delay its timely performance under the contract, the Contractor shall immediately give notice thereof in writing to the State reciting all relevant information with respect thereto. Such notice shall not in any way constitute a basis for an extension of the delivery schedule or be construed as a waiver by the State of any of its rights or remedies to which it is entitled by law or equity or pursuant to the provisions of the contract. Failure to give such notice, however, may be grounds for denial of any request for an extension of the delivery schedule because of such delay.

Either party may change its address for notification purposes by giving notice of the change, and setting forth the new address and an effective date.

For the duration of the contract, all communication between Contractor and the State regarding the contract shall take place between the Contractor and individuals specified by the State in writing. Communication about the contract between Contractor and individuals not designated as points of contact by the State is strictly forbidden.

Z. EARLY TERMINATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The contract may be terminated as follows:

1. The State and the Contractor, by mutual written agreement, may terminate the contract at any time.

2. The State, in its sole discretion, may terminate the contract for any reason upon thirty (30) calendar day's written notice to the Contractor. Such termination shall not relieve the Contractor of warranty or other service obligations incurred under the terms of the contract including turnover requirements as described in Section IV.W – Termination of DBPM Contract. In the event of termination the Contractor shall be entitled to payment, determined on a pro rata basis, for services satisfactorily performed or provided.

3. The State will provide the Contractor with a timely written Notice of Intent to Terminate (Notice) that states the nature and basis of the penalty or sanction and pre-termination hearing rights.

4. The Contractor may, at the discretion of the State, be allowed to correct the deficiencies within the thirty (30) calendar day notice period, unless other provisions in this Section demand otherwise, prior to the issuance of a Notice of Termination.

5. In accordance with 42 CFR §438.710, the State will conduct a pre-termination hearing upon the request of the DBPM as outlined in the Notice to provide DBPM the opportunity to contest the nature and basis of the sanction.

   a. The request must be submitted in writing to the State prior to the determined date of termination stated in the Notice.

   b. The DBPM must receive a written notice of the outcome of the pre-termination hearing, if applicable, indicating decision reversal or affirmation.

6. The State will notify Medicaid members enrolled in the DBPM in writing, consistent with 42 CFR §438.710 and §438.722, of the affirming termination decision and of their options for receiving Medicaid services and to disenroll immediately.

7. The State may terminate the contract immediately for the following reasons:

   a. if directed to do so by statute;
   b. Contractor has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business;
   c. a trustee or receiver of the Contractor or of any substantial part of the Contractor's assets has been appointed by a court;
   d. fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by its Contractor, its employees, officers, directors, or shareholders;
   e. an involuntary proceeding has been commenced by any party against the Contractor under any one of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for at least sixty (60) calendar days; or (ii) the Contractor has consented, either expressly or by operation of law, to the entry of an order for relief; or (iii) the Contractor has been decreed or adjudged a debtor;
   f. a voluntary petition has been filed by the Contractor under any of the chapters of Title 11 of the United States Code;

g. Contractor intentionally discloses confidential information;
h. Contractor has or announces it will discontinue support of the deliverable;
i. second or subsequent documented "vendor performance report" form deemed acceptable by the State Purchasing Bureau; or
j. Contractor engaged in collusion or actions which could have provided Contractor an unfair advantage in obtaining this contract.

AA. FUNDING OUT CLAUSE OR LOSS OF APPROPRIATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State may terminate the contract, in whole or in part, in the event funding is no longer available. The State's obligation to pay amounts due for fiscal years following the current fiscal year is contingent upon legislative appropriation of funds for the contract. Should said funds not be appropriated, the State may terminate the contract with respect to those payments for the fiscal years for which such funds are not appropriated. The State will give the Contractor written notice thirty (30) calendar days prior to the effective date of any termination, and advise the Contractor of the location (address and room number) of any related equipment. All obligations of the State to make payments after the termination date will cease and all interest of the State in any related equipment will terminate. The Contractor shall be entitled to receive just and equitable compensation for any authorized work which has been satisfactorily completed as of the termination date. In no event shall the Contractor be paid for a loss of anticipated profit.

BB. BREACH BY CONTRACTOR

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State may terminate the contract, in whole or in part, if the Contractor fails to perform its obligations under the contract in a timely and proper manner. The State may, by providing a written notice of default to the Contractor, allow the Contractor to cure a failure or breach of contract within a period of thirty (30) calendar days (or longer at State's discretion considering the gravity and nature of the default). Said notice shall be delivered by Certified Mail, Return Receipt Requested, or in person with proof of delivery. Allowing the Contractor time to cure a failure or breach of contract does not waive the State's right to immediately terminate the contract for the same or different contract breach which may occur at a different time. In case of default of the Contractor, the State may contract the service from other sources and hold the Contractor responsible for any excess cost occasioned thereby.

Pursuant to 42 CFR §438.708 the State may provide benefits to members through other options included in the Medicaid State Plan if the State, at its sole discretion, determines that the Contractor has failed to carry out the substantive terms of the contract, or meet applicable requirements in Sections 1932, 1903(m) or 1905(t) of the Social Security Act.

CC. ASSURANCES BEFORE BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If any document or deliverable required pursuant to the contract does not fulfill the requirements of the Request for Proposal/resulting contract, upon written notice from the State, the Contractor shall deliver assurances in the form of additional Contractor resources at no additional cost to the project in order to complete the deliverable, and to ensure that other project schedules will not be adversely affected.

DD. ADMINISTRATION – CONTRACT TERMINATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

1. Contractor must provide confirmation that upon contract termination all deliverables prepared in accordance with this agreement shall become the property of the State of Nebraska; subject to the ownership provision (section E) contained herein, and is provided to the State of Nebraska at no additional cost to the State.

2. Contractor must provide confirmation that in the event of contract termination, all records that are the property of the State will be returned to the State within thirty (30) calendar days. Notwithstanding the above, Contractor may retain one copy of any information as required to comply with applicable work product documentation standards or as are automatically retained in the course of Contractor's routine back up procedures.

EE. PENALTY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State has the option to invoke penalties as described in Section IV – Project Description.

FF. PERFORMANCE BOND

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor will be required to supply a bond executed by a corporation authorized to contract surety in the State of Nebraska, payable to the State of Nebraska, which shall be valid for the life of the contract to include any renewal and/or extension periods. The amount of the bond must be $10,000,000.00. The bond will guarantee that the Contractor will faithfully perform all requirements, terms and conditions of the contract. Failure to comply shall be

grounds for forfeiture of the bond as liquidated damages. Amount of forfeiture will be determined by the agency based on loss to the State. The bond will be returned when the service has been satisfactorily completed as solely determined by the State, after termination or expiration of the contract.

The Contractor must obtain and maintain a performance bond, rated a minimum of A by A.M. Best Company, of a standard commercial scope from a surety company or companies holding a certificate of authority to transact surety business in the state. The Contractor must not leverage the bond as collateral for debt or create other creditors using the bond as security. The Contractor must be in breach of this contract if it fails to maintain or renew the performance bond as required by this contract.

1. The Contractor must obtain a performance bond in an amount equal to $10,000,000.00. The bond will guarantee that the selected contractor will faithfully perform all requirements, terms and conditions of the contract. Failure to comply must be grounds for forfeiture of the bond as liquidated damages. Amount of forfeiture will be determined by the agency based on loss to the State. The bond will be returned when the service has been satisfactorily completed as solely determined by the State, after termination or expiration of the contract.

2. The Contractor agrees that if it is declared to be in default of any term of this contract, MLTC may elect to, in addition to any other remedies it may have under this contract, obtain payment under the performance bond for the following:

   a. Making funds available through a consensus proceeding in the appropriate court for payment to subcontracted providers and non-contracted health care providers for reimbursement due to nonpayment of claims by Contractor, in the event of a breach of Contractor's obligation under this contract;
   b. Reimbursing MLTC for any payments made by MLTC on behalf of the Contractor;
   c. Reimbursing MLTC for any extraordinary administrative expenses incurred by a breach of Contractor's obligations under this contract, including, expenses incurred after termination of this contract by MLTC;
   d. Making any payments or expenditures deemed necessary to MLTC, in its sole discretion, incurred by MLTC in the direct operation of the contract pursuant to the terms of this contract and to reimburse MLTC for any extraordinary administrative expenses incurred in connection with the direct operation of the Contractor; and
   e. The Contractor must reimburse MLTC for expenses exceeding the performance bond amount.

GG. FORCE MAJEURE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Neither party shall be liable for any costs or damages resulting from its inability to perform any of its obligations under the contract due to a natural disaster, or other similar event outside the control and not the fault of the affected party ("Force Majeure Event"). A Force Majeure Event shall not constitute a breach of the contract. The party so affected shall immediately give notice to the other party of the Force Majeure Event. The State may grant relief from performance of the contract if the Contractor is prevented from performance by a Force Majeure Event. The burden of proof for the need for such relief shall rest upon the Contractor. To obtain release based on a Force Majeure Event, the Contractor shall file a written request for such relief with the State Purchasing Bureau. Labor disputes with the impacted party's own employees will not be considered a Force Majeure Event and will not suspend performance requirements under the contract.

HH. PAYMENT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

State will render payment to Contractor when the terms and conditions of the contract and specifications have been satisfactorily completed on the part of the Contractor as solely determined by the State. Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §§ 81-2401 through 81-2408). The State may require the Contractor to accept payment by electronic means such as ACH deposit. In no event shall the State be responsible or liable to pay for any services provided by the Contractor prior to the Effective Date, and the Contractor hereby waives any claim or cause of action for any such services.

II. RIGHT TO AUDIT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Contractor shall establish and maintain a reasonable accounting system that enables the State to readily audit contract. The State and its authorized representatives shall have the right to audit, to examine, and to make copies of or extracts from all financial and related records (in whatever form they may be kept, whether written, electronic, or other) relating to or pertaining to this contract kept by or under the control of the Contractor, including, but not limited to those kept by the Contractor, its employees, agents, assigns, successors, and Subcontractors. Such records shall include, but not be limited to, accounting records, written policies and procedures; all paid vouchers including those for out-of-pocket expenses; other reimbursement supported by invoices; ledgers; cancelled checks; deposit slips; bank statements; journals; original estimates; estimating work sheets; contract amendments and change order files; back charge logs and supporting documentation; insurance documents; payroll documents; timesheets; memoranda; and correspondence.

Contractor shall, at all times during the term of this contract and for a period of five (5) years after the completion of this contract, maintain such records, together with such supporting or underlying documents and materials. The Contractor shall at any time requested by the State, whether during or after completion of this contract and at Contractor's own expense make such records available for inspection and audit (including copies and extracts of records as required) by the State. Such records shall be made available to the State during normal business hours at the Contractor's office or place of business. In the event that no such location is available, then the financial records, together with the supporting or underlying documents and records, shall be made available for audit at a time and location that is convenient for the State. Contractor shall ensure the State has these rights with Contractor's assigns, successors, and Subcontractors, and the obligations of these rights shall be explicitly included in any subcontracts or agreements formed between the Contractor and any Subcontractors to the extent that those Subcontracts or agreements relate to fulfillment of the Contractor's obligations to the State.

Costs of any audits conducted under the authority of this right to audit and not addressed elsewhere will be borne by the State unless certain exemption criteria are met. If the audit identifies overpricing or overcharges (of any nature) by the Contractor to the State in excess of one-half of one percent (.5%) of the total contract billings, the Contractor shall reimburse the State for the total costs of the audit. If the audit discovers substantive findings related to fraud, misrepresentation, or non-performance, the Contractor shall reimburse the State for total costs of audit. Any adjustments and/or payments that must be made as a result of any such audit or inspection of the Contractor's invoices and/or records shall be made within a reasonable amount of time (not to exceed 90 days) from presentation of the State's findings to Contractor.

JJ. TAXES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State is not required to pay taxes of any kind and assumes no such liability as a result of this solicitation. Any property tax payable on the Contractor's equipment which may be installed in a state-owned facility is the responsibility of the Contractor.

KK. INSPECTION AND APPROVAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Final inspection and approval of all work required under the contract shall be performed by the designated State officials. The State and/or its authorized representatives shall have the right to enter any premises where the Contractor or Subcontractor duties under the contract are being performed, and to inspect, monitor or otherwise evaluate the work being performed. All inspections and evaluations shall be at reasonable times and in a manner that will not unreasonably delay work.

LL. CHANGES IN SCOPE/CHANGE ORDERS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State may, upon the written agreement of Contractor, make changes to the contract within the general scope of the RFP. The State may, at any time work is in progress, by written agreement, make alterations in the terms of work as shown in the specifications, require the Contractor to make corrections, decrease the quantity of work, or make such other changes as the State may find necessary or desirable. The Contractor shall not claim forfeiture of contract by reasons of such changes by the State.

Corrections of any deliverable, service or performance of work required pursuant to the contract shall not be deemed a modification. Changes or additions to the contract beyond the scope of the RFP are not permitted; however, the contract must meet all applicable federal legal requirements and regulations, including Medicaid laws, rules and regulations, and any future amendments to the contract that are required to bring Nebraska in compliance with federal Medicaid law must be deemed part of the scope of the requested bid. Changes or additions to the contract beyond the scope of the RFP are not permitted except as noted herein.

MM. SEVERABILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If any term or condition of the contract is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and conditions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the contract did not contain the particular provision held to be invalid.

NN. CONFIDENTIALITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

All materials and information provided by the State or acquired by the Contractor on behalf of the State shall be regarded as confidential information. All materials and information provided by the State or acquired by the Contractor on behalf of the State shall be handled in accordance with federal and state law, and ethical standards. The Contractor must ensure the confidentiality of such materials or information. Should said confidentiality be breached by a Contractor; Contractor shall notify the State immediately of said breach and take immediate corrective action.

It is incumbent upon the Contractor to inform its officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a (i)(1), which is made applicable to Contractors by 5 U.S.C. 552a (m)(1), provides that any officer or employee of a Contractor, who by virtue of his/her employment or official position has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

OO. PROPRIETARY INFORMATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Data contained in the proposal and all documentation provided therein, become the property of the State of Nebraska and the data becomes public information upon opening the proposal. If the bidder wishes to have any information withheld from the public, such information must fall within the definition of proprietary information contained within Nebraska's public record statutes. **All proprietary information the bidder wishes the State to withhold must be submitted in a sealed package, which is separate from the remainder of the proposal, and provide supporting documents showing why such documents should be marked proprietary**. The separate package must be clearly marked PROPRIETARY on the outside of the package. **Bidders may not mark their entire Request for Proposal as proprietary**. Failure of the bidder to follow the instructions for submitting proprietary and copyrighted information may result in the information being viewed by other bidders and the public. Proprietary information is defined as trade secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. § 84-712.05(3)). In accordance with Attorney General Opinions 92068 and 97033, bidders submitting information as proprietary may be required to prove specific, named competitor(s) who would be advantaged by release of the information and the specific advantage the competitor(s) would receive. Although every effort will be made to withhold information that is properly submitted as proprietary and meets the State's definition of proprietary

information, the State is under no obligation to maintain the confidentiality of proprietary information and accepts no liability for the release of such information.

PP. CERTIFICATION OF INDEPENDENT PRICE DETERMINATION/COLLUSIVE BIDDING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

By submission of this proposal, the bidder certifies that it is the party making the foregoing proposal and that the proposal is not made in the interest of, or on behalf of, any undisclosed person, partnership, company, association, organization, or corporation; that the proposal is genuine and not collusive or sham; that the bidder has not directly or indirectly induced or solicited any other bidder to put in a false or sham proposal, and has not directly or indirectly colluded, conspired, connived, or agreed with any bidder or anyone else to put in a sham proposal, or that anyone shall refrain from bidding; that the bidder has not in any manner, directly or indirectly, sought by agreement, communication, or conference with anyone to fix the proposal price of the bidder or any other bidder, or to fix any overhead, profit, or cost element of the proposal price, or of that of any other bidder, or to secure any advantage against the public body awarding the contract of anyone interested in the proposed contract; that all statements contained in the proposal are true; and further that the bidder has not, directly or indirectly, submitted the proposal price or any breakdown thereof, or the contents thereof, or divulged information or data relative thereto, or paid, and will not pay, any fee to any corporation, partnership, company association, organization, proposal depository, or to any member or agent thereof to effectuate a collusive or sham proposal.

QQ. STATEMENT OF NON-COLLUSION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The proposal shall be arrived at by the bidder independently and be submitted without collusion with, and without any direct or indirect agreement, understanding or planned common course of action with, any person; firm; corporation; bidder; Contractor of materials, supplies, equipment or services described in this RFP. Bidder shall not collude with, or attempt to collude with, any state officials, employees or agents; or evaluators or any person involved in this RFP. The bidder shall not take any action in the restraint of free competition or designed to limit independent bidding or to create an unfair advantage.

Should it be determined that collusion occurred, the State reserves the right to reject a bid or terminate the contract and impose further administrative sanctions.

RR. PRICES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Price information is provided under Section IV.P – DBPM Reimbursement.

SS. ETHICS IN PUBLIC CONTRACTING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

No bidder shall pay or offer to pay, either directly or indirectly, any fee, commission compensation, gift, gratuity, or anything of value to any State officer, legislator, employee or evaluator based on the understanding that the receiving person's vote, actions, or judgment will be influenced thereby. No bidder shall give any item of value to any employee of the State Purchasing Bureau or any evaluator.

Bidders shall be prohibited from utilizing the services of lobbyists, attorneys, political activists, or consultants to secure the contract. It is the intent of this provision to assure that the prohibition of state contact during the procurement process is not subverted through the use of lobbyists, attorneys, political activists, or consultants. It is the intent of the State that the process of evaluation of proposals and award of the contract be completed without external influence. It is not the intent of this section to prohibit bidders from seeking professional advice, for example consulting legal counsel, regarding terms and conditions of this Request for Proposal or the format or content of their proposal.

If the bidder is found to be in non-compliance with this section of the Request for Proposal, they may forfeit the contract if awarded to them or be disqualified from the selection process.

In compliance with the Byrd Anti-Lobbying Amendment, contractors who apply or bid must file the required certification that each tier will not use federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any federal contract, grant or any other award covered by 31 U.S.C. §1352. Each tier must also disclose any lobbying with nonfederal funds that takes place in connection with obtaining any federal award. Such disclosures are forwarded from tier-to-tier up to the recipient (45 CFR §3).

TT. INDEMNIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

1. **GENERAL**
The Contractor agrees to defend, indemnify, hold, and save harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses ("the claims"), sustained or asserted against the State, arising out of, resulting from, or attributable to the willful misconduct, negligence, error, or omission of the Contractor, its employees, Subcontractors, consultants, representatives, and agents, except to the extent such Contractor liability is attenuated by any action of the State which directly and proximately contributed to the claims.

2. **INTELLECTUAL PROPERTY**
The Contractor agrees it will, at its sole cost and expense, defend, indemnify, and hold harmless the indemnified parties from and against any and all claims, to the extent such claims arise out of, result from, or are attributable to, the actual or alleged infringement or misappropriation of any patent, copyright, trade secret, trademark, or confidential information of any third party by the Contractor or its employees, Subcontractors, consultants, representatives, and agents; provided, however, the State gives the Contractor prompt notice in writing of the claim. The Contractor may not settle any infringement claim that will affect the State's use of the Licensed Software without the State's prior written consent, which consent may be withheld for any reason.

If a judgment or settlement is obtained or reasonably anticipated against the State's use of any intellectual property for which the Contractor has indemnified the State, the Contractor shall, at the Contractor's sole cost and expense, promptly modify the item or items which were determined to be infringing, acquire a license or licenses on the State's behalf to provide the necessary rights to the State to eliminate the infringement, or provide the State with a non-infringing substitute that provides the State the same functionality. At the State's election, the actual or anticipated judgment may be treated as a breach of warranty by the Contractor, and the State may receive the remedies provided under this RFP.

3. PERSONNEL

The Contractor shall, at its expense, indemnify and hold harmless the indemnified parties from and against any claim with respect to withholding taxes, worker's compensation, employee benefits, or any other claim, demand, liability, damage, or loss of any nature relating to any of the personnel provided by the Contractor.

4. SELF-INSURANCE

The State of Nebraska is self-insured for any loss and purchases excess insurance coverage pursuant to Neb. Rev. Stat. § 81-8,239.01 (Reissue 2008). If there is a presumed loss under the provisions of this agreement, Contractor may file a claim with the Office of Risk Management pursuant to Neb. Rev. Stat. §§ 81-8,829 – 81-8,306 for review by the State Claims Board. The State retains all rights and immunities under the State Miscellaneous (Section 81-8,294), Tort (Section 81-8,209), and Contract Claim Acts (Section 81-8,302), as outlined in Neb. Rev. Stat. § 81-8,209 *et seq.* and under any other provisions of law and accepts liability under this agreement to the extent provided by law.

UU. NEBRASKA TECHNOLOGY ACCESS STANDARDS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Contractor shall review the Nebraska Technology Access Standards, found at http://nitc.nebraska.gov/standards/2-201.html and ensure that products and/or services provided under the contract are in compliance or will comply with the applicable standards to the greatest degree possible. In the event such standards change during the Contractor's performance, the State may create an amendment to the contract to request the contract comply with the changed standard at a cost mutually acceptable to the parties.

VV. ANTITRUST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor hereby assigns to the State any and all claims for overcharges as to goods and/or services provided in connection with this contract resulting from antitrust violations which arise under antitrust laws of the United States and the antitrust laws of the State.

WW. DISASTER RECOVERY/BACK UP PLAN

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall have a disaster recovery and back-up plan, of which a copy should be provided to the State, which includes, but is not limited to equipment, personnel, facilities, and transportation, in order to continue services as specified under the specifications in the contract in the event of a disaster.

XX. TIME IS OF THE ESSENCE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Time is of the essence in this contract. The acceptance of late performance with or without objection or reservation by the State shall not waive any rights of the State nor constitute a waiver of the requirement of timely performance of any obligations on the part of the Contractor remaining to be performed.

YY. RECYCLING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Preference will be given to items which are manufactured or produced from recycled material or which can be readily reused or recycled after their normal use as per Neb. Rev. Stat. § 81-15,159.

ZZ. DRUG POLICY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Contractor certifies it maintains a drug free work place environment to ensure worker safety and workplace integrity. Contractor agrees to provide a copy of its drug free workplace policy at any time upon request by the State.

AAA. EMPLOYEE WORK ELIGIBILITY STATUS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of employees physically performing services within the State of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of an employee.

If the Contractor is an individual or sole proprietorship, the following applies:

1. The Contractor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at http://das.nebraska.gov/materiel/purchasing.html

   The completed United States Attestation Form should be submitted with the Request for Proposal response.

2. If the Contractor indicates on such attestation form that he or she is a qualified alien, the Contractor agrees to provide the US Citizenship and Immigration Services documentation required to verify the Contractor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.

3. The Contractor understands and agrees that lawful presence in the United States is required and the Contractor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. § 4-108.

BBB. CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND INELIGIBILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor, by signature to this RFP, certifies that the Contractor is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency from participating in transactions (debarred). The Contractor also agrees to include the above requirements in any and all Subcontracts into which it enters. The Contractor shall immediately notify the Department if, during the term of this contract, Contractor becomes debarred. The Department may immediately terminate this contract by providing Contractor written notice if Contractor becomes debarred during the term of this contract.

Contractor, by signature to this RFP, certifies that Contractor has not had a contract with the State of Nebraska terminated early by the State of Nebraska. If Contractor has had a contract terminated early by the State of Nebraska, Contractor must provide the contract number, along with an explanation of why the contract was terminated early. Prior early termination may be cause for rejecting the proposal.

CCC. OFFICE OF PUBLIC COUNSEL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If it provides, under the terms of this contract and on behalf of the State of Nebraska, health and human services to individuals; service delivery; service coordination; or case management, Contractor shall submit to the jurisdiction of the Office of Public Counsel, pursuant to Neb. Rev. Stat. §§ 81-8,240 et seq. This section must survive the termination of this contract and shall not apply if Contractor is a long-term care facility subject to the Long-Term Care Ombudsman Act, Neb. Rev. Stat. §§ 81-2237 et seq.

DDD. LONG-TERM CARE OMBUDSMAN

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If it is a long-term care facility subject to the Long-Term Care Ombudsman Act, Neb. Rev. Stat. §§ 81-2237 et seq., Contractor shall comply with the Act. This section shall survive the termination of this contract.

Acknowledgment of Addenda

MCNA acknowledges Addenda 1 through 5 to RFP 5427 Z1, and we understand and agree that they will become part of the proposal. Please see **Attachment Addenda-1** for a copy of all addenda.

Part 1 - Corporate Overview
A. Bidder Identification

Part 1 – Corporate Overview

A. Bidder Identification and Information

The bidder must provide the full company or corporate name, address of the company's headquarters, entity organization (corporation, partnership, proprietorship), state in which the bidder is incorporated or otherwise organized to do business, year in which the bidder first organized to do business and whether the name and form of organization has changed since first organized.

MCNA Insurance Company, the bidder, received its Certificate of Authority as a Texas accident and health insurance company on May 4, 2011. The Nebraska Department of Insurance authorized MCNA Insurance Company to transact the business of sickness and accident insurance in the State on October 1, 2015, with an effective date of May 1, 2016. Our core business is delivering the **highest quality dental care** to traditionally underserved populations enrolled in Medicaid, CHIP, and Medicare programs. MCNA Insurance Company is a wholly owned subsidiary of MCNA Health Care Holdings, LLC, a Florida limited liability company ("MCNA Holdings") and has no partners.

MCNA Holdings is also the parent company of Managed Care of North America, Inc., d/b/a MCNA Dental Plans. MCNA Insurance Company has contracted with MCNA Dental Plans to provide dental administrative services for its national Medicaid and CHIP operations. [redacted]

MCNA Dental Plans has operated as a dental insurance administrator since January 30, 1992. [redacted]

MCNA Insurance Company, the bidder, is headquartered at:

4400 Northwest Loop 410, Suite 250
San Antonio, Texas 78229

MCNA Dental Plan's administrative offices and the headquarters of our parent corporation are located at:

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

For the purposes of this response to the RFP, MCNA Insurance Company, its parent, and affiliates shall be referred to collectively as MCNA. MCNA Insurance Company is a Texas corporation and has not changed its name or form of organization since it was first organized.

[redacted]

[redacted]

B. Financial Statements

The bidder must provide financial statements applicable to the firm. If publicly held, the bidder must provide a copy of the corporation's most recent audited financial reports and statements, and the name, address, and telephone number of the fiscally responsible representative of the bidder's financial or banking organization.

If the bidder is not a publicly held corporation, either the reports and statements required of a publicly held corporation, or a description of the organization, including size, longevity, client base, areas of specialization and expertise, and any other pertinent information, must be submitted in such a manner that proposal evaluators may reasonably formulate a determination about the stability and financial strength of the organization. Additionally, a non-publicly held firm must provide a banking reference.

The bidder must disclose any and all judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization, or state that no such condition is known to exist.

The State may elect to use a third-party to conduct credit checks as part of the corporate overview evaluation.

Corporate Overview

MCNA's core business is delivering the **highest quality dental care** to traditionally underserved populations enrolled in Medicaid, CHIP, and Medicare programs. The MCNA Organization was founded in Florida and is headquartered in Fort Lauderdale, with regional headquarters in San Antonio, Texas, and New Orleans, Louisiana. We manage dental benefits on a full-risk basis for **nearly 3,500,000 children and adults** throughout the nation.

We serve some of the most vulnerable members of society, with the mission of improving overall health through the provision of quality dental care. We also offer commercial dental plans for private employers, individuals, and families. Our commitment to ensuring our members have access to care in urban and rural areas through our statewide provider networks has allowed us to become the premier dental plan throughout the nation. We approach our work of developing and implementing dental service programs with dedication and commitment to excellence.

The ultimate parent of MCNA is MCNA Holdings. MCNA Holdings is also the parent company of MCNA Dental Plans, a Florida corporation licensed as a pre-paid limited health services organization. MCNA Dental Plans has operated as a dental insurance administrator since January 30, 1992.

Finally, MCNA Holdings is the parent company of MCNA Systems, which licenses its DentalTrac™ management information system and technology infrastructure to MCNA Dental Plans. MCNA Dental Plans uses the DentalTrac™ software to provide its third-party administrative services to the bidder.

Mission and Goal

Our proposal combines the financial strength of MCNA Insurance Company and the unparalleled dental managed care experience of its affiliate, MCNA Dental Plans, to deliver to the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care (MLTC) a turnkey solution and seamless transition for the new contract term. MCNA was founded by Jeffrey P. Feingold, DDS, MSD, a Florida-licensed Periodontist and Diplomate of the American Board of Periodontology. With a staff of over 550, MCNA has the infrastructure and experience to deliver **best-in-class** dental benefits management to our clients.

MCNA's mission is to deliver value to our clients and participating dentists by providing access, quality, and service excellence that improves the oral health outcomes of our members. Our goal is to promote high quality and cost effective oral health by increasing access to dental care for the public while closely monitoring treatment frequencies and methodologies to ensure their appropriateness and efficacy.

Dr. Feingold has made finding ways to reach out and treat children and adults in underserved areas a priority throughout his career. Through his leadership, MCNA has maintained a focus on delivering quality pediatric and adult dental care, with an emphasis on serving those enrolled in Medicaid and CHIP programs.

Financial Strength and Stability

MCNA (including MCNA's parent organization, affiliates, and subsidiaries) is not a publicly traded (stock-exchange-listed) corporation. Accordingly, there have been no publicly available financial filings with the United States Securities and Exchange Commission (SEC). There have been no SEC investigations involving MCNA or any of its affiliated companies, nor are there any other current or pending investigations, civil or criminal, involving MCNA. No conditions, such as judgments, pending or expected litigation, or other real or potential financial reversals which might materially affect our viability or stability are known to exist. We are pleased to provide the State of Nebraska with assurances of our financial solvency and strong fiscal track record. We submit herewith evidence of our financial capacity.

MCNA has timely met all quarterly and annual regulatory reporting requirements of both Texas and Louisiana Departments of Insurance as well as those specifically required by the state agencies overseeing our program contracts, the Texas Health and Human Services Commission (HHSC) and the Louisiana Department of Health (LDH). We are especially proud to **meet and exceed** all State-mandated capital requirements, including premium writing ratio and risk based capital (RBC) percentages. Relationships with our banking and reinsurance financial partners remain strong as clearly evidenced by their ongoing willingness to support our operations.

Efficient and effective contract performance has put us on a solid financial footing and positioned us to provide our high-caliber services to MLTC for the DBPM program. This is the business space where we excel. MCNA forges strong relationships with our members and providers, and works diligently with regulatory agencies. As noted, we are in **full compliance** with our financial solvency requirements as determined by the Texas Department of Insurance and we will continue to comply with any additional

requirements that are mandated under Nebraska law as a result of being awarded a contract by MLTC. Most importantly, we will deliver quality access to dental care for MLTC enrollees.

To demonstrate our financial sufficiency, MCNA is providing the following financial information:

- Audited, GAAP-basis 2015 and 2014 financial statements with footnote disclosures for both the Offeror and the Consolidated Parent Company **(Attachment B-1)**
- Unaudited, GAAP-basis quarterly and year-to-date financial statements for both the Offeror and the Consolidated Parent Company **(Attachment B-3)**
- Non-Publically Held Firm Banking Reference from Bank of America **(Attachment B-4)**
- An active Certificate of Insurance coverage that meets or exceeds all RFP coverage requirements **(Attachment B-7)**

With respect to the audited financial statements presented herewith, there have been:

- No changes in audit firms during the last three years.
- No "going concern" statements issued by our auditor during the last three years.
- No qualified opinions issued by our auditor in the last three years.
- No significant delays (of two months or more) in completing the previous audits.

MCNA (including its parent organization, affiliates and subsidiaries) has never filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, nor undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. MCNA guarantees that it will comply with federal solvency standards for MCOs/PAHPs/PIHPs as set forth in 42 CFR 438.116.

Key MCNA (including affiliates) non-financial metrics to report with this submission are:

- MCNA has been in business for approximately 25 years.

- Office locations are currently in Fort Lauderdale, Florida, San Antonio, Texas, and New Orleans, Louisiana.
- Staff exceeding 550 individuals.

The Company currently contracts with the States of Florida, Texas, Louisiana, Iowa, and Idaho, for Medicaid and CHIP programs, as well as several HMO Plans, providing comprehensive dental managed care services for nearly 3,500,000 members.

Our Commitment to Quality Dental Care

In 2014, MCNA became the first dental plan in the nation to receive full Dental Plan Accreditation and Claims Processing Accreditation from URAC. Following our successful accreditations, our Chief Dental Officer, Dr. Ronald Ruth, was invited to serve on the URAC Advisory Board to assist with developing and maintaining dental plan accreditation standards.

We have been certified by the **National Committee for Quality Assurance (NCQA)** in Credentialing and Re-credentialing since 2011. We were recertified in 2013 and 2015, with our current recertification effective through 2017.

Since 2012, MCNA has received multiple **Service Organization Control (SOC) 2 reports confirming that we meet the standards of the American Institute of Certified Public Accountants (AICPA)**. Most recently, MCNA received a SOC 2 Type 2 report, which is a more thorough and advanced version of the SOC 2 report. This certifies that the suitability of the design and operating effectiveness of our systems, security processes, and controls provide both MCNA, and more importantly our clients, an independent, third party assurance that we are taking the appropriate steps to protect our systems and our clients' data. For a copy of our SOC 2 Type 2 Report, please see **Attachment B-8**.

MCNA is also a member of the **Dental Quality Alliance (DQA)**, a national organization established by the **American Dental Association** to advance performance measurement as a means to improve oral health, patient care, and safety through a consensus-building process.

C. Change of Ownership

If any change in ownership or control of the company is anticipated during the twelve (12) months following the proposal due date, the bidder must describe the circumstances of such change and indicate when the change will likely occur. Any change of ownership to an awarded vendor(s) will require notification to the State.

Neither the sole shareholder, MCNA Health Care Holdings, LLC nor the officers or directors of MCNA anticipate a change of ownership of MCNA or any other affiliate in the MCNA holding company system in the next twelve (12) months.

mcnadental

D. Office Location

The bidder's office location responsible for performance pursuant to an award of a contract with the State of Nebraska must be identified.

Our plan leadership, underwriting, primary call center operations for members and providers, outreach management, clinical oversight, and provider services management are located at:

MCNA Insurance Company
4400 Northwest Loop 410, Suite 250
San Antonio, Texas 78229

MCNA's executive management, financial and third-party administration, [redacted] are located at:

Managed Care of North America, Inc.
200 West Cypress Creek Road, Suite 500
Fort Lauderdale, Florida 33309

MCNA's Nebraska based office will be located in Lincoln. Since 2009, MCNA has operated a regionally based claims payment team located in the state of Nebraska. Our Nebraska Dental Director, **Dr. Scott Wieting**, a long standing Nebraska-licensed General Dentist, and most recent past President of the Nebraska Dental Association, currently resides in York, Nebraska. MCNA's Nebraska Executive Director, **Dr. Holly Portwood**, a pediatric dentist and adjunct faculty member at the University of Nebraska Medical Center College of Dentistry, currently resides in Hastings, Nebraska.

E. Relationships with the State

The bidder shall describe any dealings with the State over the previous five (5) years. If the organization, its predecessor, or any party named in the bidder's proposal response has contracted with the State, the bidder shall identify the contract number(s) and/or any other information available to identify such contract(s). If no such contracts exist, so declare.

MCNA has not been engaged by the State of Nebraska prior to the date of this response to the RFP. MCNA declares that no such contracts exist.

F. Bidder's Employee Relations to State

If any party named in the bidder's proposal response is or was an employee of the State within the past twelve (12) months, identify the individual(s) by name, State agency with whom employed, job title or position held with the State, and separation date. If no such relationship exists or has existed, so declare.

If any employee of any agency of the State of Nebraska is employed by the bidder or is a Subcontractor to the bidder, as of the due date for proposal submission, identify all such persons by name, position held with the bidder, and position held with the State (including job title and agency). Describe the responsibilities of such persons within the proposing organization. If, after review of this information by the State, it is determined that a conflict of interest exists or may exist, the bidder may be disqualified from further consideration in this proposal. If no such relationship exists, so declare.

No party named in MCNA's proposal response is or was an employee of the State within the past twelve (12) months. MCNA declares that no such relationship exists or has existed.

No employee of any agency of the State of Nebraska is employed by MCNA or is a Subcontractor to MCNA, as of the due date for proposal submission. MCNA declares that no such relationship exists.

G. Contract Performance

If the bidder or any proposed Subcontractor has had a contract terminated for default during the past five (5) years, all such instances must be described as required below. Termination for default is defined as a notice to stop performance delivery due to the bidder's non-performance or poor performance, and the issue was either not litigated due to inaction on the part of the bidder or litigated and such litigation determined the bidder to be in default.

It is mandatory that the bidder submit full details of all termination for default experienced during the past five (5) years, including the other party's name, address, and telephone number. The response to this section must present the bidder's position on the matter. The State will evaluate the facts and will score the bidder's proposal accordingly. If no such termination for default has been experienced by the bidder in the past five (5) years, so declare.

If at any time during the past five (5) years, the bidder has had a contract terminated for convenience, non-performance, non-allocation of funds, or any other reason, describe fully all circumstances surrounding such termination, including the name and address of the other contracting party.

The bidder, MCNA Insurance Company, declares that it has not experienced a termination for default in the past five (5) years, nor has MCNA Insurance Company had a contract terminated for convenience, non-performance, non-allocation of funds, or any other reason.

Bidder's affiliate and Third Party Administrator, MCNA Dental Plans, has not had any contracts terminated due to default, non-performance, or non-allocation of funds. [redacted]

H. Summary of Bidder's Corporate Experience

The bidder shall provide a summary matrix listing the bidder's previous projects similar to this Request for Proposal in size, scope, and complexity. The State will use no more than three (3) narrative project descriptions submitted by the bidder during its evaluation of the proposal.

The bidder must address the following:

i. Provide narrative descriptions to highlight the similarities between the bidder's experience and this Request for Proposal. These descriptions must include:

a. The time period of the project;
b. The scheduled and actual completion dates;
c. The Contractor's responsibilities;
d. For reference purposes, a customer name (including the name of a contact person, a current telephone number, a facsimile number, and e-mail address); and
e. Each project description shall identify whether the work was performed as the prime Contractor or as a Subcontractor. If a bidder performed as the prime Contractor, the description must provide the originally scheduled completion date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget.

ii. Contractor and Subcontractor(s) experience must be listed separately. Narrative descriptions submitted for Subcontractors must be specifically identified as Subcontractor projects.

iii. If the work was performed as a Subcontractor, the narrative description shall identify the same information as requested for the Contractors above. In addition, Subcontractors shall identify what share of contract costs, project responsibilities, and time period were performed as a Subcontractor.

An Experienced Partner

MCNA has provided dental managed care services for individuals and state programs for over 20 years. The following lists our **active full-risk contracts with state Medicaid and CHIP agencies:**

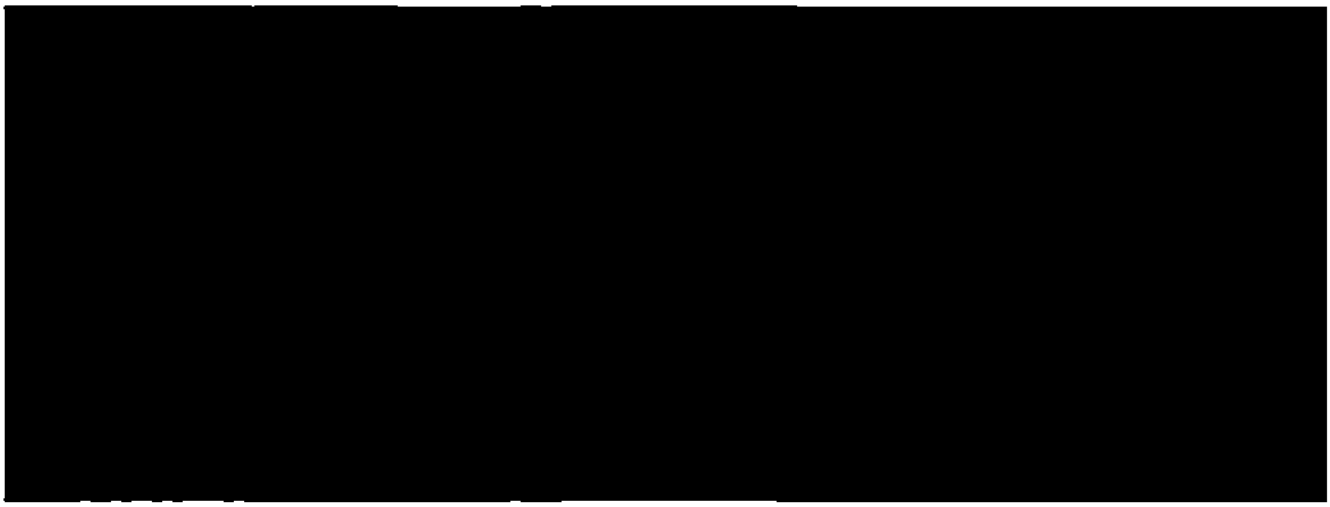
- **Florida** – MCNA has been providing dental managed care services for Florida's CHIP Program, **since January 1, 2005**. We currently serve approximately 70,000 enrollees. In early 2016, MCNA was awarded its fourth consecutive contract by the Florida Healthy Kids Corporation (FHKC) to continue managing this program. MCNA scored first in FHKC's most recent dental HEDIS results.

- **Texas** – MCNA has been providing dental managed care services for the Texas Health and Human Services Commission Medicaid and CHIP dental programs **since March 1, 2012**. We currently serve approximately 1,500,000 enrollees.
- **Louisiana** – MCNA was **ranked first** in the Louisiana procurement to serve as the **sole dental benefits program manager** with a go-live date of July 1, 2014. We currently serve the State's 1,400,000 Medicaid and CHIP members under a contract with the Louisiana Department of Health.
- **Iowa** – MCNA was awarded a contract by the Iowa Medicaid Enterprise to serve adult members enrolled in the State's Dental Wellness Plan. We commenced operations on August 1, 2016, and have a current enrollment of approximately 10,000 members.
- **Idaho** – MCNA was recently **ranked first** in the Idaho Smiles procurement and awarded the **sole contract** by the Idaho Department of Health and Welfare to provide dental managed care services to the State's 280,000 Medicaid and CHIP enrollees with a go-live date of February 1, 2017.

We maintain a commercial plan in the State of Florida, and we serve Medicaid, ACA, and long term care members under various subcontracts with Medicaid managed care plans in Florida, Indiana, and West Virginia.

From 2009 to 2014, MCNA served Florida's Medicaid enrollees under a direct contract with the Florida Agency for Health Care Administration. The program began as a demonstration project in Miami-Dade County and was so successful that the Legislature expanded it on a statewide basis in 2012. Throughout the life of the contract, MCNA's enrollment for both programs peaked at over 600,000 members.

Additionally, MCNA was subcontracted by Centene Corporation's Florida affiliate, Sunshine Health, to provide all dental benefits administration services for its Florida Medicaid and Long Term Care members from 2008 through 2014. Over the life of the contract, enrollment increased from 100,000 to approximately 400,000 members.



The following client listing details our past five years of experience in terms of the programs and populations served.

Texas Medicaid and CHIP

Contract Term: March 2012 - Present

Contract Type: Medicaid and CHIP

Contact Information: Cindy Fortress
HHSC Health Plan Manager

4900 N. Lamar Blvd.
Austin, TX 78751

MCNA manages a full spectrum of dental care, including diagnostic, preventive, restorative, endodontic, periodontic, orthodontic, and oral and maxillofacial surgery services to approximately 1.5 million children statewide in the Texas Medicaid and CHIP programs on a full-risk basis.

This contract began on March 1, 2012, for an initial term of three (3) years and has up to five (5) additional one (1) year extensions. Our contract has been renewed through March 1, 2019 and includes 1 additional one-year renewal option.

Louisiana Medicaid and CHIP

Contract Term: July 2014 - Present

Contract Type: Medicaid and CHIP

Contact Information: Cordelia Clay
Program Manager

628 North 4th Street
Baton Rouge, LA 70821

MCNA was ranked #1 in the procurement and awarded the Dental Benefit Program Management (DBPM) contract for Louisiana Medicaid and CHIP as the sole vendor. Under the program, MCNA manages on a full-risk basis dental benefits for approximately 1.4 million children and adults.

This contract began on July 1, 2014, for an initial term of three (3) years and has up to two (2) additional one (1) year extensions.

Idaho Medicaid and CHIP

Contract Term: Begins on February 1, 2017

Contract Type: Medicaid and CHIP

Contact Information: Arianne Quignon
Purchasing Officer

450 W State Street
Boise, ID 83720

MCNA was recently ranked #1 in the Idaho procurement and awarded a contract by the Idaho Department of Health and Welfare to manage the dental benefits of the State's Medicaid and CHIP programs as the sole vendor on a full-risk basis. We will manage the full spectrum of dental care, including diagnostic, preventive, restorative, endodontic, periodontic, orthodontic, and oral and maxillofacial surgery services to approximately 280,000 children and adults.

This contract will begin on February 1, 2017, for an initial term of three (3) years, with options to renew upon mutual agreement for a total of seven (7) full years of service delivery.

Florida Healthy Kids Corporation

Contract Term: January 2005 - Present

Contract Type: CHIP

Contact Information: Rebecca Matthews
Chief Executive Officer

661 East Jefferson Street, Suite 200
Tallahassee, FL 32301

MCNA Dental Plans is a full-risk contractor with the Florida Healthy Kids Corporation under a capitation arrangement. We currently serve approximately 70,000 Florida CHIP children statewide. We provide comprehensive dental benefits, including diagnostic, preventive, restorative, endodontic, periodontic, orthodontic, and oral and maxillofacial surgery services. Our initial contract began January 1, 2005, and has been continuously renewed through multiple procurements.

Iowa Dental Wellness Plan

Contract Term: August 2016 - Present

Contract Type: Medicaid

Contact Information: Sabrina Johnson
Dental Policy Specialist

100 Army Post Rd
Des Moines, IA 50315

MCNA is a full-risk contractor to the Iowa Medicaid Enterprise for its Dental Wellness Plan. We currently serve approximately 10,000 Iowa Medicaid expansion adults statewide. We provide comprehensive dental benefits, including diagnostic, preventive, restorative, endodontic, periodontic, orthodontic, and oral and maxillofacial surgery services. Our initial contract began August 1, 2016.

CareSource

Contract Term: January 2015 - Present

Contract Type: Affordable Care Act

Contact Information: Steve Smitherman
Executive Director

135 N Pennsylvania St, Suite 1300
Indianapolis, IN 46204

MCNA Dental Plans currently provides a robust provider network including provider network management and oversight for approximately 35,000 Just4Me™ members in Indiana and West Virginia, and beginning on January 1, 2017, for West Virginia Medicaid members.

Community Care Plan

Contract Term: July 2014 - Present

Contract Type: Medicaid

Contact Information: Lupe Rivero
VP of Government and Member Programs

1643 Harrison Parkway, Suite H200
Sunrise, FL 33323

MCNA Dental Plans provides the full spectrum of dental benefits management for 46,000 Community Care Plan Medicaid members in Broward County, Florida.

Coventry Health Care

Contract Term: January 2013 - Present

Contract Type: Medicaid and Long Term Care

Contact Information: Heidi Garwood
Chief Executive Officer

1340 Concord Terrace
Sunrise, FL 33323

MCNA Dental Plans provides the full spectrum of dental benefits management for 67,000 Coventry Health Care Medicaid members and 5,000 Long Term Care members in Florida.

Florida Agency for Health Care Administration

Contract Term:	June 2009 - August 2014
Contract Type:	Medicaid
Contact Information:	Pamela Hull *AHC Administrator* 2727 Mahan Drive Tallahassee, FL 32308

MCNA Dental Plans provided the full spectrum of dental benefits management for approximately 600,000 Medicaid children in Florida through various programs. This contract expired due to legislation that changed the program design.

Sunshine Health

Contract Term:	July 2006 - December 2014
Contract Type:	Medicaid
Contact Information:	Chris Paterson *Chief Executive Officer* 1301 International Parkway, 4th Floor Sunrise, FL 33323

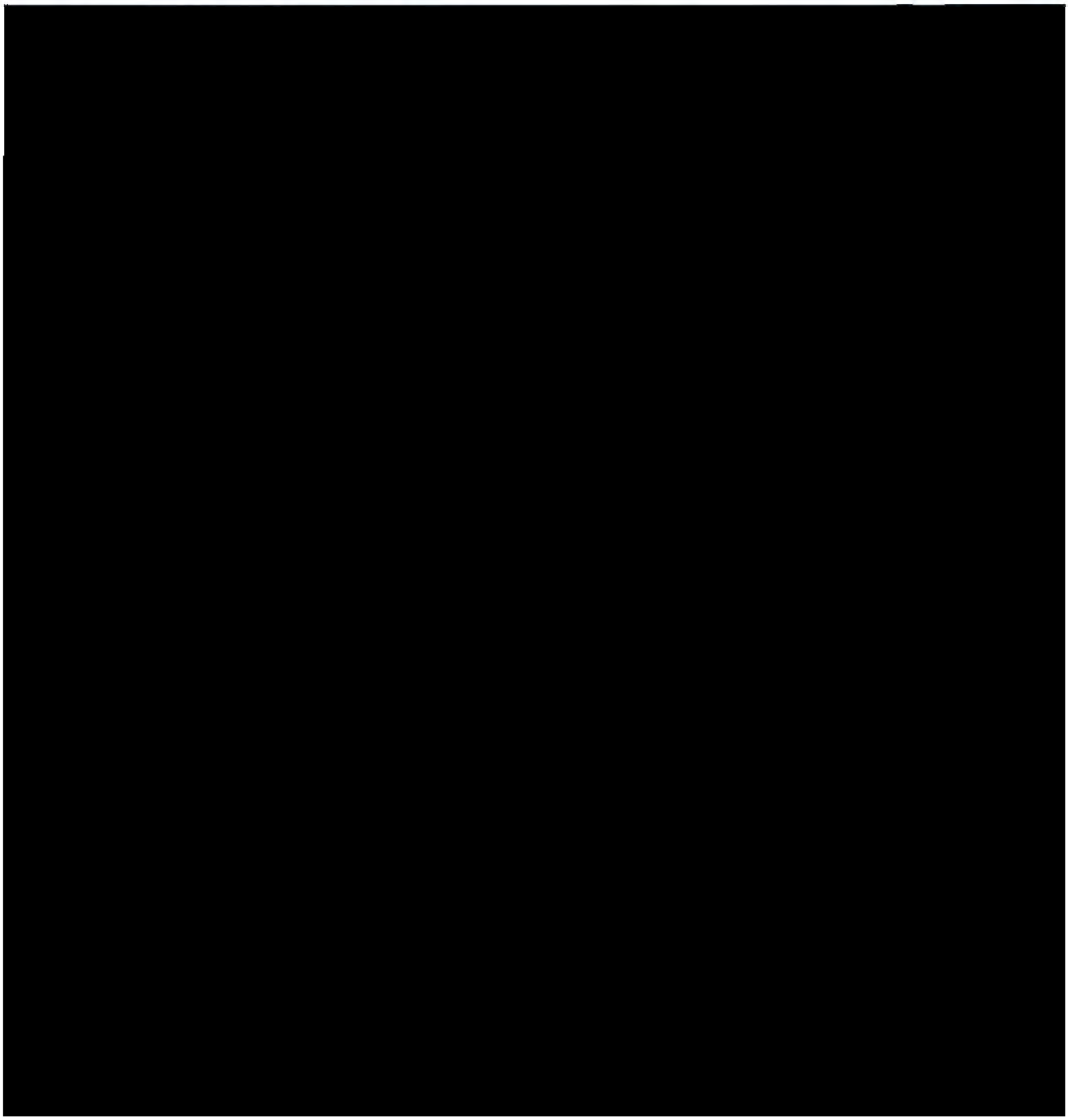
sunshine health

MCNA Dental Plans provided the full spectrum of dental benefits management for approximately 400,000 Sunshine Health members in Florida. The initial contract was with Access Health Solutions from July 2006 through April 2008, at which time Centene Corporation purchased the plan and renamed it Sunshine Health.

Summary Matrix Listing

MCNA is pleased to provide four of our most recent projects similar to the Nebraska DBPM program in terms of size, scope, and complexity. We currently hold the most full-risk Medicaid and CHIP dental managed care contracts with state agencies.

[redacted]



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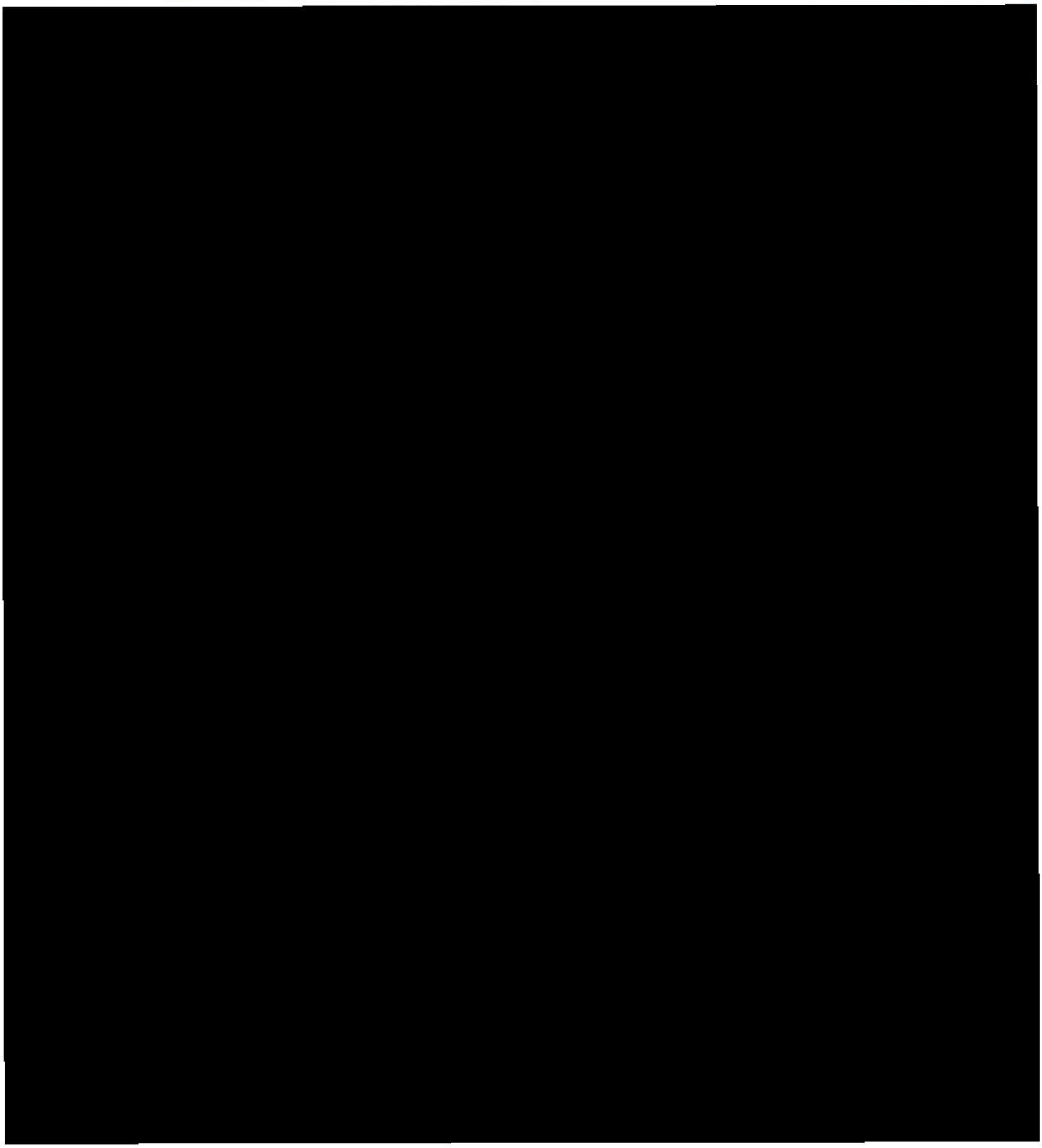


I. Summary of Bidder's Proposed Personnel/Management Approach

The bidder must present a detailed description of its proposed approach to the management of the project.

The bidder must identify the specific professionals who will work on the State's project if their company is awarded the contract resulting from this Request for Proposal. The names and titles of the team proposed for assignment to the State project shall be identified in full, with a description of the team leadership, interface and support functions, and reporting relationships. The primary work assigned to each person should also be identified.

The bidder shall provide resumes for all personnel proposed by the bidder to work on the project. The State will consider the resumes as a key indicator of the bidder's understanding of the skill mixes required to carry out the requirements of the Request for Proposal in addition to assessing the experience of specific individuals.

Resumes must not be longer than three (3) pages. Resumes shall include, at a minimum, academic background and degrees, professional certifications, understanding of the process, and at least three (3) references (name, address, and telephone number) who can attest to the competence and skill level of the individual. Any changes in proposed personnel shall only be implemented after written approval from the State.

Proposed Personnel/Management Approach

MCNA's proposed personnel and management approach 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 Nebraska Department of Health and Human Services, Division of Medicaid and Long Term Care (MLTC), a turnkey solution for a seamless transition.

MCNA was founded by Jeffrey P. Feingold, DDS, MSD, a Florida-licensed Periodontist and Diplomate of the American Board of Periodontology. With over 550 employees, MCNA has the infrastructure and experience to deliver **best-in-class** dental benefits management to our clients.

Our mission is to deliver value to our clients and participating dentists by providing access, quality, and service excellence that improves the oral health outcomes of our members. Our goal is to promote high quality and cost effective oral health by increasing access to dental care for the public while closely monitoring treatment frequencies and methodologies to ensure their appropriateness and efficacy.

Dr. Feingold has made finding ways to reach out and treat children and adults in underserved areas a priority throughout his career. Through his leadership, MCNA has maintained a focus on delivering

quality pediatric and adult dental care, with an emphasis on serving those enrolled in Medicaid and CHIP programs.

Under the guidance and leadership of Dr. Feingold, MCNA's personnel and management approach for Nebraska includes the following components:

- A locally based operation supplemented by experienced, veteran MCNA team members
- Staffing strategies
  - Forecasting
  - Recruiting
  - Training
  - Retention
- Contract oversight

MCNA understands a well-defined staffing plan is critical to successfully meeting the operational requirements of this contract. As such, our Talent Acquisition team will be deployed to Nebraska to fill the required local positions and will work with MLTC to obtain the necessary approvals for all candidates being considered for key staff roles. Our Nebraska team will receive leadership, administrative, and operational support from our corporate and regional offices in Florida and Texas throughout the contract term.

The table below represents the MCNA team who will provide ongoing leadership and support to Nebraska:

Name and Title	Primary Location
Jeffrey P. Feingold, DDS, MSD *Founder and Chief Executive Officer*	**Florida**
Glen S. Feingold *Executive Vice President and Chief Operating Officer*	**Florida**
Philip H. Hunke, DDS, MSD *Plan President*	**Texas**
Scott Wieting, DDS *Nebraska Dental Director*	**Nebraska**
Holly Portwood, DDS *Nebraska Executive Director*	**Nebraska**
Gary Lehn, DDS *Nebraska Associate Dental Director*	**Nebraska**
Carlos A. Lacasa *Senior Vice President and General Counsel*	**Florida**
Edward A. Strongin, CPA *Chief Financial Officer*	**Florida**
Daniel Salama, BSE *Chief Information Officer*	**Florida**
Mayre Thompson, MHA *Chief Compliance and Privacy Officer*	**Florida**
Shannon Boggs-Turner, JD *Vice President of Operations*	**Texas**
DeDe Davis *Vice President of Dental Management and Quality Improvement*	**Florida**
Martha Bailey *Associate Vice President of Administration and Operations*	**Texas**

Oteasa Townsend-Hardy, BHSA, RN *Director of Quality Improvement and Risk Management*	**Florida**
Meghan Henkel, LPN *Director of Utilization Management and Case Management*	**Florida**
Carol Raspa *Director of Claims Management*	**Florida**
Diana Davis *Director of Grievances and Appeals*	**Florida**
René Canales *Director of Network Development*	**Texas**
Aldwin Gomez *Director of Call Center Operations*	**Florida**
Sophia Wallen *Director of Credentialing*	**Florida**
Cynthia Johnson *Grievance System Manager*	**Nebraska**
Sherri O'Brien *Provider Services Manager and Member Services Manager*	**Nebraska**
Vonnie Schaeffer *Claims Administrator*	**Nebraska**
Jeanette Logan, MBA *Senior Manager of Client Services*	**Texas**

Nebraska is a priority to our organization, and as such, our most valuable resources will be dedicated to the success of this contract. MCNA plans to be fully staffed prior to the Operational Readiness Review.

All persons employed by MCNA to provide services under this contract will be vetted to ensure they are legally authorized to do so under Nebraska law. We will ensure that a single individual will not hold more than two (2) positions, with the exception of the Executive Director and Dental Director, which will hold no more than one (1) position.

The following is an overview of the Key Personnel roles and responsibilities and MCNA's qualified candidates for these roles. Resumes for all Key Personnel candidates are attached to this RFP as **Attachment I-1**, and set forth the experience and qualifications of each team member.

Key Personnel

- **Dental Director: Dr. Scott Wieting, DDS**
  - Dr. Wieting will be responsible for the oversight and management of MCNA's Clinical Reviewers for the State of Nebraska. He is responsible for the implementation of policies and procedures, and monitoring the dental care delivery system. Dr. Wieting lives in Nebraska and report directly to MCNA's Plan President, Dr. Philip Hunke.

- **Executive Director: Dr. Holly Portwood, DDS**
  - Dr. Portwood will oversee the Administrative functions for the Nebraska plan. Dr. Portwood is a board-certified pediatric dentist who lives in Nebraska and reports directly to MCNA's Plan President, Dr. Philip Hunke.

- **Operations Manager: Shannon Boggs-Turner, JD**
  - MCNA's Vice President of Operations, Shannon Boggs-Turner is responsible for managing the day-to-day operations of all MCNA departments, staff, and functions to ensure that performance measures and requirements are met. Shannon will be the primary point of contact with MLTC for all operational issues. She is based in our Texas office and reports directly to MCNA's Plan President, Dr. Philip Hunke.

- **Finance Manager: Edward Strongin, CPA**
  - MCNA's Chief Financial Officer, Edward Strongin, CPA is responsible for oversight of all MCNA financial-related activity including all audit activities, accounting systems, financial reporting and budgeting. Edward is based in our corporate office in Florida and reports to MCNA's Board of Directors with a dotted line to our CEO, Dr. Jeffrey Feingold.

- **Grievance System Manager: Cynthia Johnson**
  - Cynthia Johnson is responsible for managing/adjudicating member grievances, appeals, and requests for fair hearing and provider grievances and appeals for the State of Nebraska. She will ensure issues are resolved within the mandatory guidelines as established by state and federal regulatory agencies, accrediting organizations standards, and in accordance with MCNA's Grievance and Appeals Department policies and procedures. Cynthia lives in Nebraska and reports to MCNA's Provider and Member Services Manager, Sherri O'Brien.

- **Business Continuity Planning and Emergency Coordinator/Information Management and Systems Director: Daniel Salama, BSE**
  - MCNA's Chief Information Officer, Daniel Salama, will serve as MCNA's Business Continuity Planning and Emergency Coordinator and is responsible for the development, maintenance, and implementation of MCNA's business continuity and disaster recovery strategies and solutions, including risk assessments, business impact analyses, strategy selection, and documentation of business continuity and disaster recovery procedures. In the role of Information Management and Systems Director, Daniel is responsible for the technological direction of MCNA as it relates to the contract with MLTC. Daniel is based in our corporate office in Florida. He reports to MCNA's Board of Directors with a

dotted line to our CEO, Dr. Jeffrey Feingold.

- **Provider Services Manager and Member Services Manager: Sherri O'Brien**
  - In the role of Provider Services Manager, Sherri will be the primary manager of MCNA's Provider Relations Department and is responsible for the development and implementation of the policies, procedures, processes and staff activities. As the Member Services Manager, she is responsible for coordinating communications between MCNA and Nebraska Medicaid members and ensuring there are sufficient member services representatives, including sufficient culturally and linguistically appropriate services, to enable members to receive prompt resolution of their problems or questions and appropriate education about participation in the Medicaid managed care program. Sherri lives in Nebraska and reports to MCNA's Vice President of Operations (Operations Manager), Shannon Boggs-Turner.

- **Claims Administrator: Vonnie Schaefer**
  - MCNA's Claims Manager, Vonnie Schaefer, will serve in the role of Claims Administrator. She is responsible for developing, implementing, and administering a comprehensive Nebraska Medicaid Managed Care claims processing system capable of paying claims in accordance with State and Federal requirements and the terms of the contract. Vonnie lives in Nebraska and reports to MCNA's Vice President of Operations (Operations Manager), Shannon Boggs-Turner.

- **Encounter Data Quality Coordinator: Jeanette Logan, MBA**
  - MCNA's Manager of Business Services, Jeanette Logan, will serve as the Encounter Data Quality Coordinator for Nebraska. Jeanette is responsible for organizing and coordinating services and communication between MCNA administration and MLTC for the purpose of identifying, monitoring, and resolving encounter data validation and management issues. Jeanette is based in our Texas regional office and reports to Daniel Salama, MCNA's Chief Information Officer.

MCNA is currently recruiting for the following key positions. Resumes for all candidates under consideration for key positions will be provided to MLTC for review and approval.

- **Program Integrity Officer**
  - The Program Integrity officer coordinates and oversees new and ongoing audits, surveys, and reviews, and assures monitoring of, responses to, reporting and program integrity with, Medicaid legislation, regulatory and policy requirements binding upon MCNA. The position provides equal policy direction and recommendations concerning Medicaid requirements that affect business practices and operations. This position is based in Nebraska and reports to MCNA's Executive Director, Dr. Holly Portwood.

- **Contract Compliance Coordinator**
  - The Contract Compliance Coordinator is responsible for planning, directing, and coordinating activities to ensure MCNA's compliance with the contract. This position is

based in Nebraska and reports to MCNA's Executive Director, Dr. Holly Portwood.

- **Performance and Quality Improvement Coordinator**
  - The Performance and Quality Improvement Coordinator is responsible for managing clinical improvement initiatives for MCNA members in Nebraska, ensuring regulatory compliance and promoting improved health care outcomes. This position is based in Nebraska and reports to MCNA's Vice President of Operations (Operations Manager), Shannon Boggs-Turner.

- **Tribal Network Liaison**
  - The Tribal Network Liaison is responsible for planning and working with Provider Services staff to expand and enhance dental services for American Indian members in the State of Nebraska. The Tribal Network Liaison assists and educates all members about MCNA's complaints and appeals process, serves as a member's personal dental plan representative by providing a consistent point of contact, and maintaining an ongoing relationship to enhance customer service and build loyalty through one-to-one interactions and community outreach. This position is based in Nebraska and reports to MCNA's Performance and Quality Improvement Coordinator, currently being recruited.

Staffing Plan

MCNA understands a successful program in Nebraska will require additional clinical and support staff to ensure operations are efficient and effective. Meeting contractual performance goals and providing world-class customer-service to our members, providers, and MLTC partners is very important to MCNA. We know that having the right amount of resources allocated to Nebraska will significantly impact response times and customer satisfaction.

MCNA forecasts staffing needs based on a variety of factors. The following table represents the factors considered to meet contractual requirements for Nebraska and our departmental forecasts for additional staff.

Recruiting to Meet Staff Requirements

MCNA's recruiting and training plan is a well-established process. Our experience with prior implementations has taught us that the first step to selecting the right candidates is to pinpoint the skills, abilities and behaviors required for each position. MCNA's Talent Acquisition team within our Human Resources Department works with hiring managers to gain in-depth insight into the requirements of the role. The recruitment process then takes place via the most appropriate channel for the particular position; this can include attending job fairs or postings on Internet-based job search tools such as Monster, CareerBuilder, or LinkedIn. We know that involving our hiring managers from the beginning helps streamline the hiring process. All required competencies and responsibilities are defined and candidates are then identified based on their experience, education, skill sets, and potential for growth within the company.

Training for Comprehensive Understanding

Once the candidate is selected and passes all required background checks, MCNA's Human Resources Department works with the department head to schedule the newly hired employee for orientation and training. MCNA's comprehensive training program sets a solid foundation for success for our staff. All employees receive MCNA New Hire Orientation and Common Core training prior to receiving role specific training. Our Human Resources Department conducts New Hire Orientation.

Module NE01 contains all of the required training elements outlined in the RFP.

Strategies for Long-Term Retention

We know that investing in our employees is a benefit to our members, providers, the local community, our employees, and MCNA. For this reason, we foster opportunities for growth and leadership for each individual that we employ.

MCNA believes in creating career paths for our existing staff and look within to determine if talent is readily available. This philosophy helps with employee retention, which is a critical component of our staffing strategy to manage employee turnover and attract quality employees to our organization.

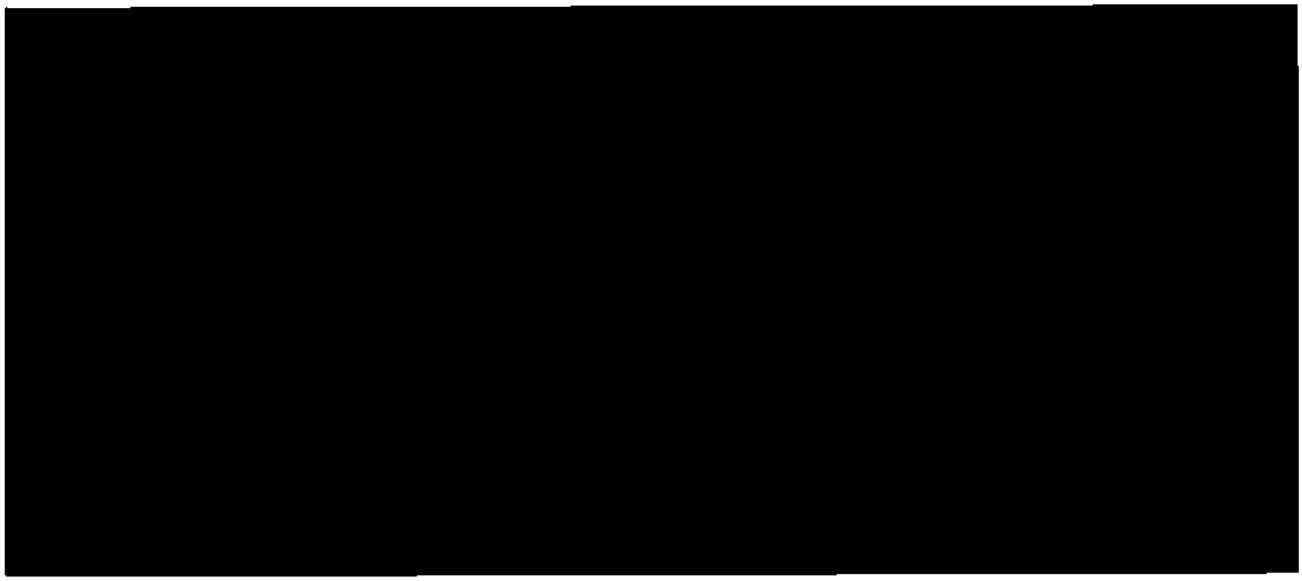
Career Path Development

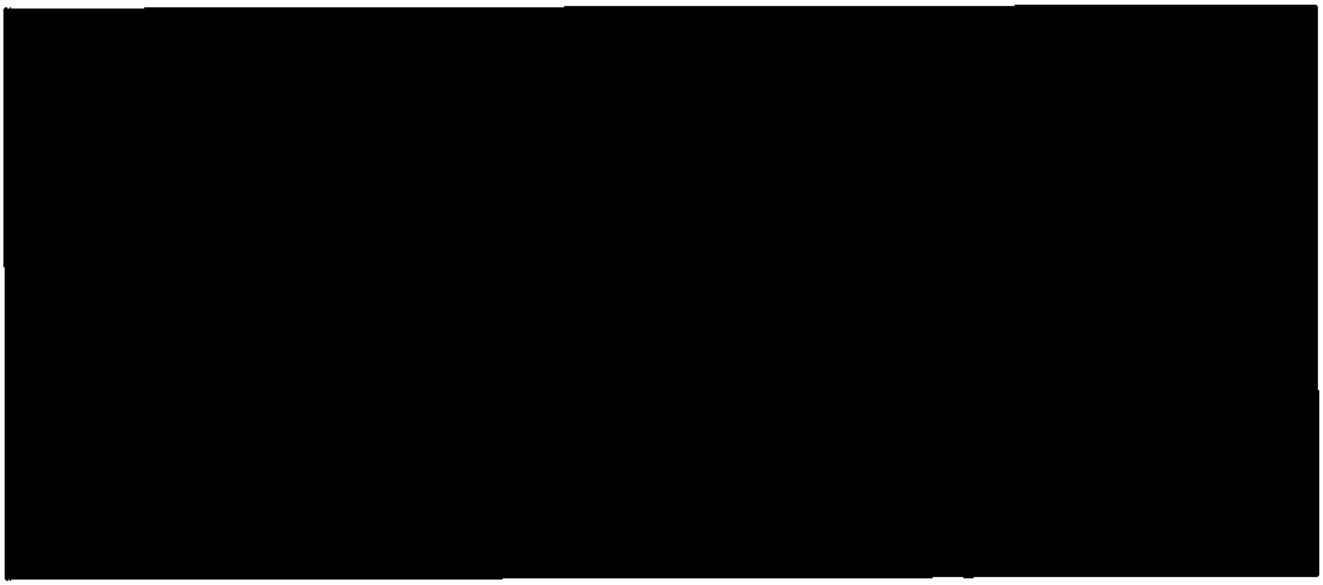
Our Leadership and Development (L&D) program focuses on developing the leadership potential of our employees in a student-centered style that caters to their echelon and imbues them with the tools for success. The MCNA L&D program is paired with operational leader-led mentorship to develop our employees' talent. The result is a large pool of internal talent ready to meet the challenges offered through promotions and growth needs.

Team Building and Community Involvement

MCNA recognizes that high turnover can be very disruptive and expensive. Recruiting and training new employees takes time and an unfilled position means productivity may suffer. Our strategy to retain good workers helps to offset employee replacement costs and reduces the indirect costs associated with attrition such as decreased productivity due to low morale. MCNA knows that happy employees are productive employees. We strive to create a positive work environment in order to strengthen our employees' commitment to MCNA.

MCNA's retention program focuses on the relationship between management and their staff. MCNA believes competitive pay, benefits, employee recognition and employee assistance programs are all necessary to maintain employee satisfaction. Our Human Resources department utilizes feedback received from exit interviews and focus groups to improve employee relations and reduce turnover. We utilize teambuilding activities and community involvement projects to build morale and give our employees a sense of pride in what they do.





MCNA works hard to retain stellar employees in order to ensure a reliable knowledge base to administer our processes, procedures, and plan requirements. We seek maximum positive impact to quality and productivity, staff morale, and employee satisfaction from our retention efforts. We know that staff continuity also builds stronger relationships with our State partners, and fosters a better understanding of their needs in order to meet the unique requirements of each contract. For these reasons, MCNA is committed to maintaining the same proposed key personnel throughout the contract term.

MCNA has a successful track record of retaining key personnel. Employees who have been with MCNA for more than 5 years will fill many of the roles required for this contract. Our retention efforts ensure MCNA will retain new staff hired to fill key staffing roles of this contract.

MCNA recognizes that circumstances may arise that will impede the ability of key staff members to perform their job duties. We believe in succession planning and work diligently to cross-train staff and conduct ongoing staff development training to prepare for circumstances that would require substitution or replacement of key personnel. MCNA will have alternate staff ready to step into key personnel roles immediately and seamlessly. All substitutes and replacements of key personnel will have qualifications at least equal to those of the key personnel for whom the replacement is requested. MCNA acknowledges that key staff may not be substituted or removed from working under this Contract without the prior written approval of MLTC.

Contract Oversight

MCNA's Board of Directors is an outstanding group of professionals from the fields of dentistry, finance, law, business, and public service, who provide governance and leadership to MCNA. The Board of Directors acts as advisors and counselors to executive management and ultimately monitors contract performance. They help to identify emerging issues and ensure that MCNA's program management is both effective and accountable.

Meet our esteemed Board of Directors who will provide oversight of the Nebraska Medicaid and CHIP contract:

- **Dr. Jeffrey P. Feingold, Chairman** – Dr. Feingold is a Diplomate of the American Board of Periodontology and founder, Chairman of the Board, and Chief Executive Officer of MCNA.
- **Albert Hawkins, Vice Chairman** – Mr. Hawkins served as the Senior White House Aide to President George W. Bush and is a former Executive Commissioner of the Texas Health and Human Services Commission, overseeing the state's Medicaid and CHIP programs.
- **Governor Rick Perry** – Governor Perry is the longest serving governor of the State of Texas, holding the office for 14 years, and oversaw the restructuring of the Texas Medicaid Program to successfully control costs and utilize innovative market-based solutions to improve quality.
- **Gary Clarke, Esq** – Mr. Clarke is a former State of Florida Medicaid Director and has a wealth of experience in providing public policy leadership to Health Maintenance Organizations, hospitals, and practice management companies.
- **Barbara Feingold** – Mrs. Feingold has served as a member of the Florida State Board of Education and is an outspoken advocate and philanthropist supporting early intervention and community involvement in support of education for children.
- **Glen Feingold** – Mr. Feingold is MCNA's Chief Operating Officer and provides the oversight and key leadership for all operational aspects of the company that drive continual high levels of service and quality for our members and state clients.
- **Jack Greenman, CPA** – Mr. Greenman is a senior health care financial executive with over 30 years of experience and has served as Chief Financial Officer for several large health care organizations.

- **Carlos Lacasa, Esq.** – Mr. Lacasa is a corporate and health care attorney with over 25 years of experience, former member of the Florida House of Representatives, and former Chairman of Citizen's Property Insurance Corporation in Florida.
- **Samuel Hammer, CPA** – Mr. Hammer is a Certified Chartered Global Management Accountant with over 30 years of health care experience and is the Managing Principle for Hammer Herzog and Associates.

J. Subcontractors

If the bidder intends to Subcontract any part of its performance hereunder, the bidder must provide:

i. **name, address, and telephone number of the Subcontractor(s);**
ii. **specific tasks for each Subcontractor(s);**
iii. **percentage of performance hours intended for each Subcontract; and**
iv. **total percentage of Subcontractor(s) performance hours.**

MCNA Insurance Company (MCNA) will comply with the requirements of the MLTC RFP by underwriting the cost of the dental benefits, ensuring all Provider Relations and Outreach responsibilities are fulfilled, providing a robust team of general and specialty dentists to provide clinical review services, managing a robust network of general dentists and specialists, and overseeing our affiliated subcontractor who will provide additional administrative services.

[redacted]

Part 2 – Technical Approach

Understanding of the Project Requirements

MCNA's response to this RFP is based on over 20 years of experience. We are currently contracted to serve **nearly 3,500,000 children and adults** in Texas, Louisiana, Florida, and Iowa. Additionally, MCNA was recently awarded the sole contract to provide dental managed care services to all of the enrollees of Idaho's Medicaid and CHIP programs on a full-risk basis with a go-live date of February 1, 2017, making MCNA the largest underwriter of direct, full-risk Medicaid and CHIP dental managed care contracts with state agencies in the United States.

We have gained a deep understanding of how to support children, adolescents, and adults, including individuals with disabilities or special health care needs who require comprehensive dental care. MCNA will provide choice to our members, and their families who support them, by ensuring a robust network of primary care dentists, paraprofessionals, and dental specialists. Our model focuses on the delivery of dental services in a manner that is easy to navigate, fully integrated, and tailor-made for Nebraska.

We assist our members by incorporating evidence-based practices, engaging providers and stakeholders to solicit feedback, and continuously gathering and analyzing data to support our quality improvement initiatives. MCNA is dedicated to improving the oral health of our members.

MCNA is poised to offer innovative integrated care programs and services that will maximize the long-term viability, success, and value of the Nebraska Medicaid dental program. Our community-based model pairs local expertise and relationships with national resources and best practices. These solutions are the product of our years of experience in establishing commercial and state-sponsored dental programs. We successfully execute complex benefit programs for Medicaid participants. There are multiple components to a seamless implementation and successful operation, and we will detail those throughout this proposal. Here is a summary of key focus areas:

1. **Development and adherence to a detailed implementation plan.**
   Our plan will include our task list, staff responsibilities, timelines, and processes that we will use to ensure services begin on the contract effective date. If awarded a contract, we are committed to implement the program in the time frames described in the plan. **MCNA has successfully passed every readiness review and met every operational start date for the programs we have launched in Texas, Florida, Louisiana, Iowa, and Kentucky.**

2. **Creation of a robust provider network.**
   As a company founded by dentists, MCNA focuses on provider inclusion. We have a strong track record of developing broad-based provider networks that are tailored to the needs of the communities we serve. In preparation for submission of this RFP response, MCNA has spent considerable time with the provider community in Nebraska, including the Nebraska Dental Association. We have familiarized ourselves extensively with the challenges of participation in the Medicaid program and have taken into account an abundance of provider feedback. MCNA will introduce a robust technological platform and customer service approach to ensure that

providers' concerns about timeliness of authorizations, responsiveness, and other obstacles to participation are resolved. We are already in the process of building this network in Nebraska. **MCNA reimburses providers on a fee-for-service basis.** We process claims in a timely manner and make payments on a weekly basis via EFT or paper check based on the preference of the provider.

3. **Enhance provider support and service.**
   MCNA not only contracts with providers, we partner with them. Our comprehensive Provider Manual sets forth the policies and procedures that providers need to serve our Nebraska members. In addition to the Provider Manual, MCNA utilizes provider bulletins, fax blasts, email, our YouTube channel, social media, and our provider newsletter, "Dental Details," to ensure that Nebraska's dental community is kept abreast of program requirements and industry trends.

   MCNA provides a dedicated Provider Hotline team skilled in assisting dentists and their office staff with any needs that may arise. We will employ Nebraska based Provider Relations Representatives who will travel throughout the state providing education, training, and resolution of issues through face-to-face meetings with providers. MCNA's free online Provider Portal enables providers to submit prior authorization requests and claims, verify eligibility, manage patient rosters, schedule appointments, and serves as an additional method of communication between the provider and MCNA.

4. **Improve oral health outcomes of our members.**
   We drive improvements in quality and oral health outcomes in many ways. MCNA implements meaningful Performance Improvement Projects (PIPs) to achieve our primary goal of increasing the utilization of preventive care services and improving the oral health outcomes and whole-person care of our members. We utilize a variety of industry standard metrics to continually measure the number of members who see the dentist and receive exams, sealants, fluoride, and prophylaxis services. MCNA utilizes multiple channels to outreach to members who are in need of care. Our main goal for children is to drive adherence to the periodicity schedule. We outreach to members through our dedicated outbound call team known as Care Connections. MCNA Member Advocate Outreach Specialists will be deployed across Nebraska to engage members in their communities through participation in health fairs and community events.

5. **Provide dental services in a highly coordinated manner.**
   We are pleased that Nebraska has chosen to keep the dental program separate and carved-out from medical plan services. This enables the dental insurer to be responsive to the needs and expectations of MLTC rather than the health plan they would serve as a subcontractor. This separation ultimately allows us to better integrate dental services into our members' care and assure that our approach is tailored to meet the needs of individuals with special health care needs, disabilities, language barriers, or other challenges. We leverage specialized clinicians, clinical practices, and guidelines that address the unique physical, behavioral health, and social support needs of each of our members. This level of care coordination cannot be replicated in a situation where the dental plan is a subordinate to the medical plan and does not have the independence needed to address issues in care delivery. MCNA believes in holistic care. In full recognition of the nexus between physical health and oral health, we developed a

comprehensive case management program for members with special health care needs, focused on maintaining the connection between each member's health plan case manager and our team of skilled professionals. Our Case Management team outreaches to physicians and other providers who serve our members to ensure coordination of care. This high-touch approach is particularly useful in assisting members with cranio-facial anomalies that often require surgery and medical care in addition to complex dental services.

6. **Decrease healthcare costs through the reduction of unnecessary, inappropriate, and duplicative services.**
   MCNA ensures our members receive the right care, in the right setting, at the right time. Our utilization management program uses evidence-based guidelines to ensure services are medically necessary and provided in the amount, duration, and scope required for each patient. All clinical decisions, both approvals and denials, are made by licensed dentists. Our sophisticated, proprietary management information system, DentalTrac™, includes edits to identify duplicative services and ensure that benefit plan requirements are followed.

7. **Identify and eliminate waste, fraud, and abuse.**
   Fraud, waste, and abuse represents an unnecessary and avoidable cost to state Medicaid programs. We provide high-quality care while continually monitoring data analytics to identify potential waste, fraud, and abuse. The DentalTrac™ system is designed to proactively screen claims through a complex hierarchy of rules to avoid overpayments. Additionally, MCNA's Special Investigations Unit utilizes claims data to generate provider profiling reports to identify potential overutilization. Licensed dentists then conduct dental record reviews to validate any findings. This approach has enabled us to save our clients over $7 million dollars over the past three years and create a deterrent to future acts of fraud, waste, and abuse.

8. **Enhance member satisfaction and health literacy through the use of leading edge technology.**
   Members can reach MCNA via a dedicated toll-free Member Hotline from 7:00 am to 7:00 pm CST, Monday through Friday. Our call center is staffed with individuals who speak a variety of languages including English, Spanish, Haitian Creole, French Creole, Vietnamese, and French. Any languages not spoken by our call center staff are easily available through the use of our translation vendor, LanguageLine.

   MCNA's website enables members to access resources 24 hours a day, 7 days a week. Members are able to send secure email messages to MCNA, download oral health and hygiene information, and select a dentist. We also have an interactive section of the website called "MCNA Kids Zone," which contains games and videos geared toward improving the oral health literacy of our members. MCNA utilizes social media tools such as Facebook, Twitter, and YouTube to connect with members and educate them about the importance of proper oral hygiene and the need to seek timely dental care.

We have a proven track record of successfully implementing programs in other states that are similar in scope to the Nebraska Medicaid Dental Benefit Program. We look forward to sharing a more in-depth look at our capabilities and solutions throughout this proposal.

Response to Attachment 11 – Proposal Statements and Questions

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

Regulatory Actions and Sanctions

In the last five years, MCNA Insurance Company (the bidder) and its affiliate subcontractor, Managed Care of North America, Inc., have received the following regulatory actions, sanctions, or letters of deficiency issued by the Texas Health and Human Services Commission (HHSC), Louisiana Department of Health (LDH), and the Florida Agency for Health Care Administration (AHCA).

None of the assessments levied have involved quality of care, failure to pay claims in a timely manner, provider relations, network adequacy, credentialing, prior authorizations, or other such performance related issues that could compromise our ability to administer high quality dental services for our members. The regulatory actions are described as follows:

Managed Care of North America, Inc. – Florida Line of Business
Regulatory Agency: Agency for Health Care Administration (AHCA)

Notice Date	Summary	Amount
8/22/2012	Assessment for late submission of claims aging reports. The reports were each filed late by one day.	$400
12/31/2012	Assessment for inaccurate and untimely encounter data. Notice also included a CAP, but upon reconsideration, AHCA released MCNA from the CAP.	$5,000
2/7/2013	Assessment for filing of CHCUP reports seven days late.	$2,800
3/3/2013	Assessment for filing our 2013 CHCUP Corrective Action Plan for the Statewide Medicaid program five days late.	$1,000
4/18/2013	Assessment for filing our 2012 Audited Annual Financial reports for the Miami-Dade Medicaid program and the Statewide Medicaid program two days late.	$800
2/7/2014	Assessment for failure to meet required 60% screening rate.	$10,000

MCNA Insurance Company – Texas Line of Business Regulatory Agency: Texas Health and Human Services Commission (HHSC)		
Notice Date	**Summary**	**Amount**
12/17/2012	Assessment for submitting a FREW Quarterly Monitoring report with an incorrect naming convention.	$1,250
7/1/2013	Assessment for a data processing issue involving the CDT codes "FQHC" versus "D1999."	$500
8/1/2014	Assessment for non-compliance issues in SFY 2013 as follows: (1) $300 for not resolving 98% of CHIP and Medicaid Provider appeals within 30 days, (2) $25 for not resolving 98% of CHIP Member Complaints within 30 days, and (3) $3,400 for the inaccurate submission of the Medicaid and CHIP TPR Reports for Q4 2013. In the same notice, we were found to be non-compliant with our Medicaid and CHIP Third Party Liability Reports for Q3 2013 and the Q4 2013 Medicaid Out-of-Network Report. However, HHSC did not assess a fine for this non-compliance issue.	$3,725
9/25/2014	Assessment for discrepancies in submitted Medicaid and CHIP Claims Lag and Summary reports.	$5,200
1/16/2015	Assessment for submitting encounters with the wrong Federal Tax ID number, and due to the inbound complaint email inbox hosted by Google Business email service experiencing a brief interruption.	$5,500
3/12/2015	Assessment for the inaccurate submission of an Annual FSR report due to a discrepancy with the incentive expenses on the report.	$9,000
4/8/2015	MCNA was placed on a CAP for inadequate collaborative efforts with respect to identification of children of migrant farmworkers for two of eleven HHSC Regions. The CAP was removed December 2015 after compliance was met.	No Penalty
5/20/2015	HHSC provided notice to MCNA for not accurately reporting the number of health fairs attended in the FREW Quarterly Monitoring Report. HHSC did not assess a fine for non-compliance.	No Penalty
2/24/2016	Assessment for the CHIP Encounter Reconciliation Report not being within a 2% variance.	$250
7/5/2016	Assessment for submitting the Medicaid and CHIP Third Party Liability reports on incorrect templates and naming convention.	$1,000
8/24/2016	Assessment for our Medicaid and CHIP Encounter Reconciliation Report not being within a 2% variance.	$2,000

MCNA Insurance Company – Louisiana Line of Business Regulatory Agency: Louisiana Department of Health (LDH)		
Notice Date	**Summary**	**Amount**
7/13/2016	MCNA was assessed 1% of our monthly premium for the month of May 2016 for not meeting two CMS 416 performance goals in FFY 2015. On July 22, 2016, LDH revised these goals by lowering the target from 5% to 2%, a more reasonable target.	$128,095.42

MCNA submits **hundreds of reports** to Texas, Louisiana, Florida, and Iowa regulatory agencies each year related to our dental contracts. We work diligently to anticipate issues that could delay timely reporting before they happen. When a reporting related issue does occur, we correct it as quickly and effectively as possible, and we use the "lessons learned" to improve our internal controls and reporting procedures to reduce the incidence of reporting errors, and to ensure that all required reports are submitted on a timely basis.

2	**Describe the DBPM's anticipated process to utilize the eligibility and enrollment files from MLTC or its designee to manage membership. Include the process for resolving discrepancies between these files and internal membership records.**

Processing MLTC Eligibility and Enrollment Files

MCNA's 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 exchange of transaction files** with over 75 trading partners. The module exchanges encounter data, enrollment updates, eligibility inquiries, and payment acknowledgements. DentalTrac™ will receive, process, and update enrollment data on a daily basis utilizing the ASC X12N 834 Benefit Enrollment and Maintenance transaction files received from MLTC.

*In 2015, the MCNA EDI module processed **over 85 million enrollment transactions** for almost 3 million members with an average turnaround time of 19.7 hours from the time the transaction file was received.*

We currently process enrollment files daily and have the ability to process on any frequency desired by MLTC. Once the eligibility file has been received, any discrepancies between the new file and current Member records are flagged prior to loading. MCNA will notify MLTC in writing within ten (10) calendar days of receipt of the enrollment file if any inconsistencies are identified in the data. Once eligibility information is processed and available in DentalTrac™, all Member records are automatically updated and available to our Member Hotline and to providers to verify member eligibility via our toll-free hotline, automated Interactive Voice Response (IVR) system, and online Provider Portal.

We believe that having a dedicated resource for this key contract component is critical to the effective management of the enrollment process. MCNA's **Enrollment Manager** is responsible for ensuring that enrollment files received are processed within 24 hours from the time of receipt. All files are reviewed to identify potential enrollment and disenrollment issues, ensuring each member's eligibility status is accurate. MCNA understands that all enrollments are effective at 12:01 a.m. on the 1st calendar day of the month of assignment. Should we become aware of any changes in demographic information for members, we will notify MLTC within five (5) business days of identification, including changes in mailing address, residential address, email address, telephone number and insurance coverage.

All data received from MLTC 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 on at least a weekly basis. 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. MCNA will reconcile the monthly ASC X12N 820 capitation payment transaction file from MLTC against our records and will notify MLTC of any discrepancies within three (3) months of file receipt.

3	**Describe the approach the DBPM will take to ensure compliance with all relevant provisions of Part 438 of Chapter 42 of the CFR, Title 471, 477, and 482 NAC.**

MCNA's Corporate Culture of Compliance

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 promotes an organizational culture that encourages ethical conduct and a commitment to compliance with the law. MCNA's Chief Compliance and Privacy Officer, Mayre Thompson, is responsible for the implementation and oversight of MCNA's Compliance Program, Compliance Committee, HIPAA privacy requirements, and related activities. Ms. Thompson also oversees the organization's special investigations unit (SIU), which is dedicated to detecting waste, fraud, and abuse. MCNA's Chief Compliance and Privacy Officer is an executive leader of the company who reports to the Chief Executive Officer and MCNA's Board of Directors.

Spotlight: Chief Compliance and Privacy Officer

Mayre Thompson, 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. Thompson 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 creates and maintains corporate policies and procedures that govern the manner in which we conduct our business. These policies and procedures are specific to each business area within the company. Compliance with Part 438 of Chapter 42 of the CFR; HIPAA; and HITECH requirements are integrated into all applicable policies and procedures and into our employee training. MCNA also educates our staff regarding anti-discrimination requirements and cultural competency standards. The requirements of Title 471, 477, and 482 of the Nebraska Administrative Code will be added to all

applicable policies and procedures, training materials, and other documents as needed to ensure that MCNA fully complies with the requirements of this RFP and meets the expectations of MLTC.

All MCNA employees receive compliance training within 30 days of initial hiring, upon adoption of updates to the Compliance Program, and annually as a condition of employment. Thirty days before an employee's anniversary, our Human Resources Department begins the process of reminding all employees 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 curriculum for compliance training:

- Chief Compliance and Privacy Officer roles and responsibilities
- Overview of Compliance Department
- Overview of MCNA's Compliance Program
- HIPAA and HITECH Acts
- 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
- Employee role and responsibilities

On a continuous basis, our Human Resources Department ensures new hire and annual trainings are completed within required timeframes through the Learning Management and Workforce Management features of DentalTrac™. If the employee has not completed scheduled training within the required timeframe, the Human Resources Director notifies the employee's supervisor of his or her non-compliance, and the employee may be removed from his or her duties until 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. Members of the Board of Directors receive compliance training annually. Additionally, all employees and members of the Board of Directors are required to complete confidentiality and conflict of interest attestations annually.

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, and 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. Routine HIPAA assessments are also performed throughout MCNA. These audits focus on ensuring information is properly maintained by employees in the

workplace. The results of these audits are reviewed by MCNA's Compliance Committee and reported to the Board of Directors on a quarterly basis.

MCNA will comply with any applicable Federal and State laws that pertain to member rights and ensure that its staff and affiliated providers also do this when furnishing services to members.

MCNA's Compliance Department keeps the company abreast of changes to all State and Federal requirements, including HIPAA and HITECH requirements, and promotes awareness through ongoing training, memorandums, postcard reminders, and newsletter articles in the MCNA employee newsletter, *The Biz Buzz*.

MCNA maintains a Compliance Hotline for employees, members, and providers to report violations of Federal and State regulations regarding discrimination, privacy, and disability. MCNA employees found to have violated any HIPAA, ADA, or anti-discrimination requirements will be disciplined in accordance with MCNA's disciplinary policies, up to and including termination of employment.

We also enforce the provisions of our participating provider agreements through administrative sanctions, the use of corrective action plans, additional training, and if necessary, termination of the provider's contract.

For a copy of MCNA's Compliance Program, please see **Attachment 3-1**. 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 mission and goals.

MCNA's employees understand that adherence to the Compliance Program, HIPAA, and HITECH is necessary in order for the company to remain successful. Please see the following examples of our Compliance training materials.

At MCNA, we know that good oral health is essential for a person to succeed in school and in the workforce. We are committed to providing our members with the most current and relevant information necessary to empower them to take advantage of the high quality dental care available to them under the Nebraska Medicaid Dental Plan.

"Constant Compliance" Section from an MCNA Biz Buzz Employee Newsletter

BiZ BUZZ

2016 ISSUE #2

CONSTANT COMPLIANCE

One of the ways that employees can ensure MCNA remains compliant with HIPAA laws is by properly maintaining PHI and disposing of it properly when necessary to protect it from unauthorized access.

Any paper copies of medical files, claims, or other information that is needed for employees to perform their duties should be locked in a desk or file cabinet when not in use. When the information is no longer needed, it should be deposited in one of the gray shredding bins located throughout MCNA's offices. **Under no circumstances may this material be placed in the regular trash receptacle.**

Follow these additional guidelines every day to maintain the confidentiality of member PHI you may have access to as a part of your position at MCNA:

- Do not discuss any member's medical concerns in public areas like elevators and the break room.
- Lock your computers every time you leave your workstations.
- Do not share your computer or system passwords with a co-worker.
- Pick up all faxes and copies from the copy station in a timely manner.

If you regularly interact with members as a part of your job responsibilities, it is important that you verify member identity when speaking with an individual. Unless you have verified that you are speaking with the member or authorized representative, you may not discuss or disclose any PHI.

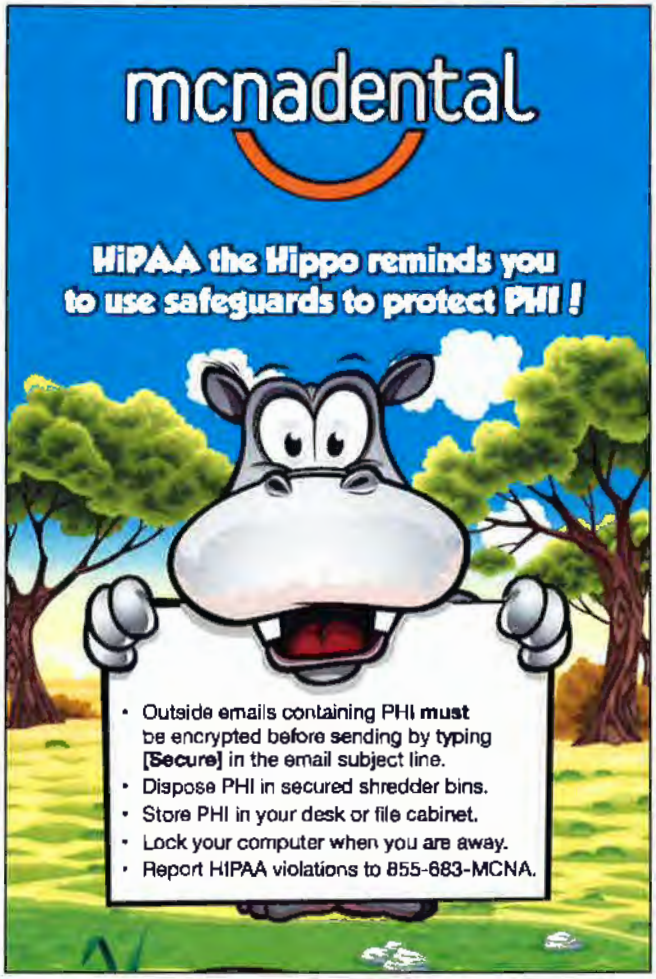
All MCNA employees are required to report, in good faith, any suspected HIPAA violations. This reporting may be done verbally or in writing and the employee may remain anonymous. There are four ways to make a report:

1. Tell your department supervisor
2. Call the Compliance Hotline at 1-855-683-6262
3. Send an email to compliance_reporting@mcna.net
4. Contact Mayre Thompson, MCNA Chief Compliance and Privacy Officer

Compliance issues are everybody's responsibility! Any employee who reports a suspected violation in good faith may not be retaliated against, and all reports are kept confidential. You will get support, if you report!

Mayre Thompson
Chief Compliance/Privacy Officer

Sample Employee Reminder Postcards



4	Include a copy of the COA from the Department of Insurance.

Licensed Nebraska Insurance Company

[redacted]

The Nebraska Department of Insurance authorized MCNA Insurance Company to transact the business of sickness and accident insurance in the State on October 1, 2015, with an effective date of May 1, 2016. MCNA shall do all acts necessary to maintain our Certificate of Authority in good standing at all times, including during the term of any contract entered into by MCNA pursuant to this RFP.

MCNA is pleased to provide a copy of our Nebraska Certificate of Authority on the following page, and an image of MCNA's license details located on the Nebraska Department of Insurance website.

Certificate of Authority

STATE OF NEBRASKA
DEPARTMENT OF INSURANCE

CERTIFICATE OF AUTHORITY

MCNA INSURANCE COMPANY

DOMICILED IN THE STATE OF TEXAS

IS HEREBY AUTHORIZED AND LICENSED TO TRANSACT THE BUSINESS OF INSURANCE IN THE STATE OF NEBRASKA AS DESCRIBED BY THE FOLLOWING SUB-SECTION(S) OF SECTION 44-201 OF THE STATUTES OF NEBRASKA:

04 Sickness and Accident Insurance

156902	May 1, 2016	April 30, 2017
NEBRASKA IDENTIFICATION NUMBER	DATE ISSUED	DATE EXPIRES

SIGNED AT LINCOLN, NEBRASKA

GREAT SEAL OF THE STATE OF NEBRASKA
MARCH 1, 1867

Bruce R. Ramge
DIRECTOR OF INSURANCE

License Details from the Nebraska Department of Insurance Website

Company Search Look-up

NAIC Consumer Information Source (https://eapps.naic.org/cis/)

CLOSE

COMPANY DEMOGRAPHICS

Company Name:	MCNA INSURANCE COMPANY			**FEIN:**	52-2459969
State of Incorporation:	TEXAS	**Incorporation Date:**	05/04/2011	**Issue Date:**	10/01/2015
Company #:	156902	**NAIC #:**	14063		
NAIC Group #:	4730	**NAIC Group Name:**	MCNA Grp		
Domicile Type :	Foreign	**Company Type:**	Life and Health		
Status:	Active				
Effective Date:	05/01/2016				

Please select by clicking the appropriate link for additional information:

Company Address	Line of Business	Company Contacts	Company Name Change History	Company Merger History

5	**Describe the DBPM's proposed approach for collaboration with other entities and programs, as required in Section IV.C.**

MCNA routinely coordinates with a wide variety of other entities and programs that serve our members. In Nebraska, this collaboration will include the member's Heritage Health MCO, as well as other state agencies and social service programs such as:

- Nebraska Office of Oral Health and Dentistry programs (including the Oral Health Access for Young Children program)
- Together For Kids and Families – Medical/Dental Home Work Group
- Division of Behavioral Health funded programs
- Division of Children and Family Services funded programs that support the safety, permanency, and well-being of children in the care and custody of the State
- Division of Developmental Disabilities programs that involve rehabilitative and habilitative services for persons with developmental disabilities
- The Nebraska Department of Education Early Development Network
- Community agencies including but not limited to the Area Agencies on Aging and League of Human Dignity Waiver Offices
- The Office of Probation
- Other MLTC programs, initiatives, and contractors related to dental care and health care coordination

MCNA will collaborate with these entities and programs to identify and respond to the dental and health needs of our members as expeditiously as possible. We will also work with these entities and programs, as well as with our network providers, regarding planning initiatives and system transformation.

Our highly trained and experienced team is recognized for the specialized assistance they provide to our most vulnerable members.

Any member identified with special health care needs or a chronic dental condition is referred to our Case Management department for the coordination of their care, and any members who are behind in their preventive care (EPSDT compliance for child members) are flagged for outreach. Our Case Management Coordinators also receive referrals for members with special health care needs from participating dental providers, other state agencies, and from special requests made by parents or guardians. We collaborate with the member's health plan case managers ensuring holistic and coordinated care.

Our team also coordinates care with and payment for Medicaid services that continue to be provided through the fee-for-service program (carved-out services), other state agencies or programs, or through the member's Heritage Health MCO. For example, in the Louisiana Medicaid and CHIP program MCNA coordinates with the Louisiana Department of Health (LDH) claims administrator or the member's medical plan to ensure coverage for certain services which are carved-out.

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 State staff and providers. Our Member Services Representatives, Case Management Coordinators, and Member Advocate and Outreach Specialists (MAOS) are trained to provide members with 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 fee-for-service Medicaid to determine who is responsible for the coverage of carved-out service benefits.

We are committed to providing superior service to the Nebraska Medicaid program and its state partners.

Please see the following excerpt from our current Texas Medicaid and CHIP Provider Manual regarding Coordination of Non-Capitated Services. A similar provision will be included in our Nebraska Provider Manual.

Excerpt from MCNA's Texas Medicaid and CHIP Provider Manual

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)
- Health and Human Services Commission's Medical Transportation

Either the member's medical plan or HHSC's claims administrator will pay for treatment and 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
- Treatment of craniofacial anomalies

CHIP Services Not Covered by MCNA

Some services are paid by CHIP medical plans instead of MCNA. These services include treatment and 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
- Treatment craniofacial anomalies

6	**Describe if any of the DBPM's Medicaid DBPMs are accredited by NCQA and, if not currently accredited in Nebraska, how it will attain accreditation for its Nebraska DBPM. Please describe any unsuccessful accreditation attempts in other states.**

Our Commitment to Quality Dental Care

In 2014, MCNA became the first dental plan in the nation to receive full Dental Plan Accreditation and Claims Processing Accreditation from URAC for all of our Medicaid and CHIP lines of business. Following our successful accreditations, our Chief Dental Officer, Dr. Ronald Ruth, was invited to serve on the URAC Advisory Board to assist with developing and maintaining dental plan accreditation standards.

MCNA has been certified by the **National Committee for Quality Assurance (NCQA)** in Credentialing and Re-credentialing since 2011. We were recertified in 2013 and 2015, with our current recertification effective through 2017.

Since 2012, MCNA has received multiple **Service Organization Control (SOC) 2 reports confirming that we meet the standards of the American Institute of Certified Public Accountants (AICPA)**. Most recently, MCNA received a SOC 2 Type 2 report, which is a more thorough and advanced version of the SOC 2 report. This certifies that the suitability of the design and operating effectiveness of our systems, security processes, and controls provide both MCNA, and more importantly our clients, an independent, third party assurance that we are taking the appropriate steps to protect our systems and our clients' data.

Our URAC accreditations and NCQA certification apply to Nebraska, and we commit to maintaining our accreditations and certification throughout the life of the contract. **MCNA has never had an unsuccessful accreditation attempt in any state.**

We are pleased to provide copies in **Attachment 6-1** of our award certificates of full accreditation for compliance with URAC's Dental Plan Accreditation Program:

- MCNA Insurance Company Certificate Number: DPL003879-3666
- Managed Care of North America, Inc. Certificate Number: DPL003880-3648

MCNA is including a copy of our award certificate of full accreditation for URAC's claims processing program in **Attachment 6-2.**

MCNA is also providing a copy of our current award certification for Credentialing and Recredentialing from NCQA as **Attachment 6-3**. No deficiencies requiring correction were noted during the survey process.

7	**If applicable, describe any restriction of coverage for counseling or referral services the DBPM is required to provide because of moral or religious obligation. Describe how the DBPM will provide members with access to those services.**

MCNA has no restrictions of coverage for counseling or referral services because of moral or religious obligation.

8	**Describe the organization's number of employees, lines of business, and office locations. Submit an organizational chart showing the structure and lines of responsibility and authority in the company. Include the organization's parent organization, affiliates, and subsidiaries that will support this contract.**

Organizational Structure and Client Base

MCNA Insurance Company, the bidder, received its Certificate of Authority as a Texas accident and health insurance company on May 4, 2011. The Nebraska Department of Insurance authorized MCNA Insurance Company to transact the business of sickness and accident insurance in the State on October 1, 2015, with an effective date of May 1, 2016. MCNA Insurance Company is a wholly owned subsidiary of MCNA Health Care Holdings, LLC ("MCNA Holdings"). The MCNA Organization was founded in Florida and is headquartered in Fort Lauderdale, with regional headquarters in San Antonio, Texas, and New Orleans, Louisiana. We manage dental benefits on a full-risk basis for **nearly 3,500,000 children and adults** throughout the nation.

MCNA Holdings is also the parent company of MCNA Dental Plans, a Florida corporation licensed as a pre-paid limited health services organization. MCNA Dental Plans has operated as a dental insurance administrator since January 30, 1992. MCNA Dental Plans will provide third-party administrative services to the bidder, MCNA Insurance Company. The combination of the resources and underwriting capacity of MCNA Insurance Company, and the administrative expertise of MCNA Dental Plans, has been the hallmark of our successful approach in Texas, Louisiana, Iowa, and Idaho.

With a staff of over **550**, the MCNA Organization has the infrastructure and experience to deliver **best-in-class** dental benefits management to our clients.

MCNA has developed into one of the nation's leading dental benefit managers for state Medicaid and CHIP programs. We hold the most full-risk dental managed care contracts with state agencies for the provision of Medicaid and CHIP dental benefits. MCNA is currently contracted with the Texas Health and Human Services Commission, the Louisiana Department of Health, the Idaho Department of Health and Welfare, the Iowa Medicaid Enterprise, the Florida Healthy Kids Corporation, and various health plans to provide dental benefits management. For a more detailed description of MCNA's client base, please see our response to Section B (Financial Statements) in Part 1 of this RFP.

Screening for Excluded or Disbarred Entities

MCNA recognizes that we are prohibited from employing or contracting with any individual who has been debarred, suspended, or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under regulations issued under Executive Order 12549 or under guidelines implementing Executive Order 12549 [42 CFR §438.610(a) and (b), 42 CFR §1001.190.1901(b) and 42 CFR §1003.102(a)(2)]. Our Fraud and Abuse Program provides written policies and procedures that outline MCNA's commitment to comply with all state and federal requirements and to use established protocols to identify debarred individuals or excluded

providers. The Credentialing and Human Resources departments are responsible for ensuring that MCNA does not hire, or enter into contracts with individuals or entities that are listed as debarred, suspended, excluded or otherwise ineligible for participation in state and federal health care programs including both Medicaid and Medicare. Upon initial employment and contracting, and monthly thereafter, the following websites are monitored to ensure that prospective employees, providers, subcontractors, and other individuals affiliated with MCNA are not listed:

- The Office of the Inspector General's (OIG) List of Excluded Individuals and Entities database
- Federal System for Award Management (SAM) sanctions and debarment reports
- Nebraska Medicaid Excluded Providers list and Nebraska Board of Dentistry
- Healthcare Integrity and Protection Data Bank (HIPDB)

If MCNA discovers that any owner, employee, network provider, subcontractor, or subcontractor's employee has been excluded, suspended, or debarred from any state or federal healthcare program or any program listed in Executive Order 12549, the Chief Compliance and Privacy Officer will report such information to MLTC within three (3) business days. **MCNA will immediately initiate efforts to sever the relationship with the debarred or excluded individual or entity.**

Background Checks to Discover Potential Issues

MCNA conducts criminal background checks for all candidates, employees, and subcontractors upon hire, transfer and promotion to identify any potential issues that could affect our business and our relationships with State partners. Any background check that reveals unfavorable information is reviewed by MCNA's Director of Human Resources and General Counsel. The decision to offer or maintain employment is based on the nature and severity of the offense. Upon request, MCNA will provide MLTC with satisfactory criminal background checks or an attestation stating that satisfactory background checks have been completed for all MCNA employees and subcontractor staff.

MCNA's staffing strategy was developed based on our experience with administering dental plan benefits to states with similar populations to the Nebraska Medicaid program. We consider a variety of needs and requirements across all departments to build staffing models that will support all contractual goals by analyzing factors such as anticipated provider and member enrollment, claims and preauthorization histories, and call volume. Our workforce management team continuously monitors service levels and adjusts staffing allocations to ensure we have the right amount of resources in each functional area to meet contract requirements, but most importantly provide stellar customer service to our members, providers, and state partners.

MCNA's Cultural Competency plan ensures employees and subcontractors will comply with MLTC's policy to provide culturally competent services. MCNA is confident we will meet or exceed expectations and acknowledges that any deficiencies may result in additional monitoring and regulatory action by MLTC including, but not limited to, the need to hire additional resources or incur monetary penalties. MCNA will be responsible for all costs associated with on-site audits or other oversight activities conducted by MLTC in Florida and Texas. MCNA has provided a proposed staffing plan for all required positions and job descriptions for key staff in RFP Questions 10 and 11. MCNA will submit a thorough and comprehensive Human Resources and Staffing Plan to MLTC within 45 days of the contract start

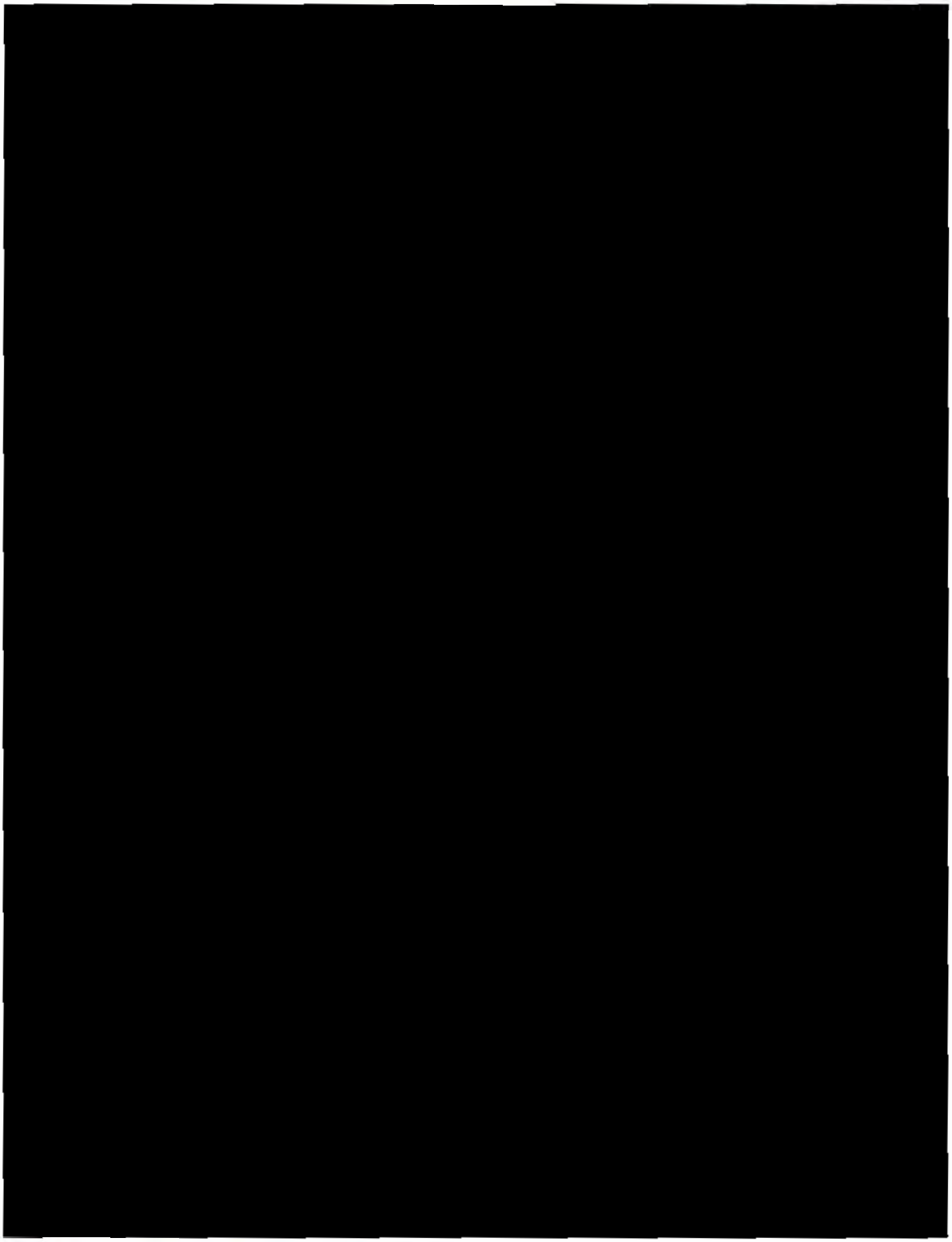
date for review and approval. The plan will include detailed information related to recruiting, hiring, training, supervising and terminating key staff and additional personnel required to meet the terms of this contract. MCNA will demonstrate the experience and Medicaid expertise of all staff and subcontractor staff assigned to work on this contract. MCNA will remove or reassign employees deemed unacceptable by the MLTC and will hold MLTC harmless for actions taken as a result of all requests.

MCNA is proud to present our Board of Directors who will oversee contract compliance:

- **Dr. Jeffrey P. Feingold, Chairman** – Dr. Feingold is a Diplomate of the American Board of Periodontology and founder, Chairman of the Board, and Chief Executive Officer of MCNA.
- **Albert Hawkins, Vice Chairman** – Mr. Hawkins served as the Senior White House Aide to President George W. Bush and is a former Executive Commissioner of the Texas Health and Human Services Commission, overseeing the state's Medicaid and CHIP programs.
- **Governor Rick Perry** – Governor Perry is the longest serving governor of the State of Texas, holding the office for 14 years, and oversaw the restructuring of the Texas Medicaid Program to successfully control costs and utilize innovative market-based solutions to improve quality.
- **Gary Clarke, Esq** – Mr. Clarke is a former State of Florida Medicaid Director and has a wealth of experience in providing public policy leadership to Health Maintenance Organizations, hospitals, and practice management companies.
- **Barbara Feingold** – Mrs. Feingold has served as a member of the Florida State Board of Education and is an outspoken advocate and philanthropist supporting early intervention and community involvement in support of education for children.
- **Glen Feingold** – Mr. Feingold is MCNA's Chief Operating Officer and provides the oversight and key leadership for all operational aspects of the company that drive continual high levels of service and quality for our members and state clients.
- **Jack Greenman, CPA** – Mr. Greenman is a senior health care financial executive with over 30 years of experience and has served as Chief Financial Officer for several large health care organizations.
- **Carlos Lacasa, Esq** – Mr. Lacasa is a corporate and health care attorney with over 25 years of experience, former member of the Florida House of Representatives, and former Chairman of Citizen's Property Insurance Corporation in Florida.
- **Samuel Hammer, CPA** – Mr. Hammer is a Certified Chartered Global Management Accountant with over 30 years of health care experience and is the Managing Principle for Hammer Herzog and Associates.

In the event there are any changes to our Board members, MCNA will provide written notification to MLTC within ten (10) business days. Please see the following organizational chart showing the structure and lines of responsibility and authority for our Nebraska Medicaid program.

9	Provide an organizational chart for this contract, including but not limited to key staff and additional required staff. Label this "Nebraska Organizational Chart"



10	**In table format, indicate the proposed number of FTEs for each key staff and additional required staff for discrete time periods (no longer than 3 month intervals) from contract award through 6 months after the start date of operations and whether or not positions are located in Nebraska. Label this table "Proposed FTEs by Time Period."**

Proposed FTEs by Time Period

Function	Location	Pre-Contract Award	Post-Contract Award[1]	Readiness Phase[2]	Start-Up Phase[3]	Ongoing Operations
Dental Director*	NE	1	1	1	1	1
Executive Director*	NE	1	1	1	1	1
Operations Manager*	TX	1	1	1	1	1
Finance Manager*	FL	1	1	1	1	1
Program Integrity Officer* Contract Compliance Coordinator*	NE	Recruiting	1	1	1	1
Grievance System Manager*	NE	1	1	1	1	1
Business Continuity Planning and Emergency Coordinator*	FL	1	1	1	1	1
Performance and Quality Improvement Coordinator*	NE	Recruiting	1	1	1	1
Provider Services Manager* Member Services Manager*	NE	1	1	1	1	1
Claims Administrator*	NE	1	1	1	1	1
Information Management and Systems Director*	FL	1	1	1	1	1
Encounter Data Quality Coordinator*	FL	1	1	1	1	1
Tribal Network Liaison*	NE	Recruiting	1	1	1	1
Member and Provider Services Hotline Representatives and Quality Assurance Analysts	TX, FL	No additional FTEs[4]	No additional FTEs[4]	No additional FTEs[4]	No additional FTEs[4]	No additional FTEs[4]
Provider Relations Representatives	NE, TX	2	3	TBD[5]	TBD[5]	TBD[5]

Member Advocate Outreach Specialists	NE	Recruiting	2	TBD[5]	TBD[5]	TBD[5]
Claims Examiners	NE, FL	1	2	2	2	2
Clinical Reviewers	NE	1	2	2	2	2
Grievances and Appeals	NE, FL	1	2	2	2	2
Reporting Analysts	NE, FL	1	1	1	1	1
Business Analysts	NE, FL	1	1	1	1	1
EDI Specialists	FL	1	1	1	1	1
SIU/FWA Investigators	NE	Recruiting	2	2	2	2
Quality Improvement Coordinators	NE	Recruiting	1	1	1	1

Notes:

- * Denotes a key staff position
- [1] Post-Contract Award: 1/3/17 through 3/31/17
- [2] Readiness Phase: 4/1/17 through 6/30/17
- [3] Start-Up Phase: 7/1/17 through 9/30/17
- [4] Our Call Centers are staffed with over 200 highly skilled Member and Provider Services Representatives. For the purposes of this RFP, **MCNA does not project the need for additional FTEs to support the Nebraska program.**
- [5] MCNA will reassess staffing requirements for Provider Relations Representatives and Member Advocate Outreach Specialists based on actual enrollment numbers and geographic distribution.

11 Provide job descriptions (including education and experience qualifications) of employees in key staff positions.

MCNA has maintained a presence in the State of Nebraska since 2009. Five of our long-term team members reside in the state and will serve in key staff positions for our Nebraska operation. We have also recruited several prominent Nebraska dentists to hold key leadership roles. Our Dental Director, Dr. Scott Wieting, is Past President of the Nebraska Dental Association. Dr. Holly Portwood is a board-certified pediatric dentist and adjunct faculty member at the University of Nebraska Medical Center College of Dentistry, and she will serve as MCNA's Executive Director. Dr. Gary Lehn will serve as MCNA's Associate Dental Director. He is the current President of the Nebraska Society of Pediatric Dentistry and a Diplomate of the American Board of Pediatric Dentistry.

MCNA's proposed strategic staffing plan utilizes top talent within our organization to fill many of the key staff positions. Resumes for these stellar performers can be found in **Attachment I-1**. We look forward to bringing on local Nebraskan talent to further add to our successful team. Job descriptions for all key staff positions are located in **Attachment 11-1**. The table below represents the key staff positions, primary responsibilities, and the names of the MCNA employees who will serve in these roles. We are currently recruiting for all open positions.

Key Position	Primary Responsibilities	Employee Name
Executive Director	1. The Executive Director must hold a Senior Executive or Management position in the DBPM's organization 2. The Executive Director must be authorized and empowered to represent the DBPM regarding all matters pertaining to the contract prior to such representation. The Executive Director must act as liaison between the DBPM and MLTC and must have responsibilities that include, but are not limited to: 3. Ensuring the DBPM's compliance with the terms of the contract, including securing and coordinating resources necessary for such compliance. 4. Receiving and responding to all inquiries and requests made by MLTC related to the contract, in the timeframes and formats specified by MLTC. Where practicable, MLTC will consult with the DPBM to establish mutually acceptable timeframes and formats. 5. Attending and participating in regular meetings or conference calls with MLTC. 6. Making best efforts to promptly resolve any issues identified either by the DBPM or MLTC that may arise and are related to the contract. 7. Meeting with MLTC representative(s) on a periodic or as needed basis to review the DBPM's performance and resolve issues. 8. Meeting with MLTC at the time and place requested by MLTC, if MLTC determines that the DBPM is not incompliance with the requirements of the contract.	Holly Portwood, DDS
Dental Director*	1. The Dental Director must be currently licensed as a Doctor of Dentistry ("dentist") with no restrictions or other licensure limitations.	Scott Wieting, DDS

	2. The Dental director must comply with applicable federal and state statutes and regulations. 3. The Dental Director must be available Monday through Friday, between 8am and 5pm CST for Utilization Review decisions, and must be authorized and empowered to represent the DBPM regarding clinical issues, Utilization Review and quality of care inquiries.	
Operations Manager	The Operations Manager is responsible for: 1. Managing the day-to-day operations of the DBPM's departments, staff, and functions to ensure that performance measures and MLTC and Federal requirements are met. 2. May serve as the primary contact with MLTC for all DBPM operational issues.	Shannon Boggs-Turner, JD
Finance Manager	The Finance Manager is responsible for overseeing all financial-related supervision of activities implemented by the DBPM, including all audit activities, accounting systems, financial reporting, and budgeting.	Edward Strongin, CPA
Program Integrity Officer	The Program Integrity Officer must have experience in health care and/or risk management and report directly to the Executive Director. The Program Integrity Officer is responsible for: 1. Overseeing all activities required by State and Federal rules and regulations related to the monitoring and enforcement of the fraud, waste, abuse, (FWA) and erroneous payment compliance program. 2. Developing/overseeing methods to prevent and detect potential FWA and erroneous payments. 3. Developing policies and procedures, investigating unusual incidents, and designing/implementing any corrective action plans. 4. Reviewing records and referring suspected member FWA to MLTC and other duly authorized enforcement agencies. 5. Managing the DBPM's Special Investigations Unit to communicate with the State's Medicaid Fraud Control Unit.	Open

Grievance System Manager	The Grievance System Manager is responsible for: 1. Managing/adjudicating member grievances, appeals, and requests for fair hearing. 2. Managing/adjudicating provider grievances and appeals.	Cynthia Johnson
Business Continuity Planning and Emergency Coordinator	The Business Continuity Planning and Emergency Coordinator is responsible for: 1. Ensuring continuity of benefits and services for members who may experience evacuation to other areas of the State, or out-of-state, during disasters. 2. Managing and overseeing the DBPM's emergency management plan.	Daniel Salama, BSE
Contract Compliance Coordinator	The Contract Compliance Coordinator will be the primary contact with MLTC on all DBPM contract compliance issues. This individual is responsible for: 1. Coordinating the preparation and execution of contract requirements. 2. Coordinating the tracking and submission of all contract deliverables. 3. Answering inquiries from MLTC. 4. Coordinating/performing random and periodic audits and ad hoc visits.	Open
Performance and Quality Improvement Coordinator	The Performance and Quality Improvement Coordinator must, at minimum, be a CPHQ or CHCQM or have comparable experience and education in data and outcomes measurement as described in 42 CFR 438.200 - 438.242. The Performance and Quality Improvement Coordinator serves as MLTC's contact person for quality performance measures. Primary responsibilities include: 1. Focusing organizational efforts on the improvement of clinical quality performance measures. 2. Utilizing data to develop intervention strategies to improve outcomes.	Open

	3. Developing and implementing performance improvement projects, both internal and across DBPMs. 4. Reporting quality improvement and performance outcomes to MLTC.	
Provider Services Manager	The Provider Services Manager is responsible for: 1. Provider contracting and credentialing activities. 2. Coordinating communications between the DBPM and its subcontracted providers. 3. Managing the Provider Services staff. 4. Working collaboratively with MLTC to establish methodologies for processing and responding to provider concerns. 5. Developing provider trainings in response to identified needs or changes in protocols, processes, and forms. 6. Enhancing DBPM-provider communication strategies. 7. Notifying MLTC of correspondence sent to providers for informational and training purposes.	Sherri O'Brien
Member Services Manager	The Member Services Manager is responsible for: 1. Coordinating communications between the DBPM and its members. 2. Ensuring there are sufficient member services representatives, including sufficient culturally and linguistically appropriate services, to enable members to receive prompt resolution of their problems or questions and appropriate education about participation in the Medicaid managed care program. 3. Managing the Member Services staff.	Sherri O'Brien
Claims Administrator	The Claims Administrator is responsible for: 1. Developing, implementing, and administering a comprehensive Nebraska Medicaid Managed Care claims processing system capable of paying claims in accordance with State and Federal requirements and the terms of this contract. 2. Developing cost avoidance processes. 3. Meeting claims processing timelines. 4. Ensuring minimization of claims recoupments.	Vonnie Schaeffer

	5. Meeting MLTC encounter reporting requirements.	
Information Management and Systems Director	The Information Management and Systems Director must have relevant training and a minimum of seven (7) years of experience in information systems, data processing, and data reporting to oversee all DBPM information systems functions. The position is responsible for: 1. Establishing and maintaining connectivity with MLTC information systems. 2. Providing necessary and timely data and reports to MLTC.	Daniel Salama, BSE
Encounter Data Quality Coordinator	The Encounter Data Quality Coordinator is responsible for: 1. Organizing and coordinating services and communication between DBPM administration and MLTC for the purpose of identifying, monitoring, and resolving encounter data validation and management issues. 2. Serving as the DBPM's encounter expert to answer questions, provide recommendations, and participate in problem solving and decision-making related to encounter data processing and submissions. 3. Analyzing activities related to the processing of encounter data and data validation studies to enhance accuracy and output.	Jeanette Logan, MBA
Tribal Network Liaison	The Tribal Network Liaison is responsible for: 1. Planning and working with Provider Services staff to expand and enhance dental services for American Indian members. 2. Serving as the single point of contact with tribal entities and all DBPM staff on American Indian issues and concerns. 3. Advocating for American Indian members with case management and member services staff.	Open

12	**Provide the DBPM's definition of medical necessity. Describe the process for developing and periodically reviewing and revising the definition. Describe the degree to which the definition is consistent with or differs from MLTC's definition of medically necessity per 471 NAC 1-002.02A.**

Amount, Duration, and Scope

MCNA's Nebraska members will have access to the full spectrum of dental care services required in this RFP. MCNA understands and shares the desire of MLTC to increase access to appropriate, quality dental care and improve oral health outcomes for its Medicaid population. **We have extensive experience delivering the quality dental care services required by the MLTC for its enrollees.**

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 Nebraska Medicaid State Plan. MCNA will not portray core dental benefits or services as an expanded health benefit. MCNA also provides for second opinions at the request of our members to ensure that the services and treatment proposed are appropriate for their condition. We will arrange for a second opinion from a qualified dental professional within our network, or, if unavailable, allow the member to obtain one outside of the network, at no cost to the member.

By tailoring our Utilization Management (UM) program to meet the needs of Nebraska, MCNA ensures that the provision of dental care services is high quality, cost-effective and provided in the most appropriate setting consistent with 42 CFR §456. Designed and guided by dentists, MCNA's UM program follows generally accepted dental standards of care and review criteria developed in conjunction with dental guidelines from the American Academy of Pediatric Dentistry, the American Dental Association, the American Association of Oral and Maxillofacial Surgeons, the American Association of Endodontists, the American Academy of Periodontology, and the American College of Prosthodontists. The goal of the UM program is to monitor the appropriateness, quality and necessity of dental services provided to our members.

Medical Necessity

As a provider owned organization, MCNA recognizes the importance of cooperation and agreement between providers and our Clinical Reviewers. The criteria and clinical guidelines used by MCNA ensure that all clinical terminology is clearly defined. We educate our Clinical Reviewers and providers on both the benefits and limitations of the plans we administer, as well as qualifying criteria related to

the amount, duration and scope of general and specialty treatment. MCNA understands that we may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. All Utilization Management decisions regarding covered benefits will be made by licensed dental professionals reviewing relevant clinical information and in consultation with the treating providers as appropriate. Requests for services are reviewed to determine that the service is medically necessary (as defined in **471 NAC 1-002.02A**), and that the service is being delivered consistent with MCNA's approved Utilization Review Criteria and Guidelines. For more information on our clinical guidelines and criteria, please see our response to Question 49.

MCNA's utilization management protocols ensure that appropriate limits are placed on services only on the basis of certain criteria, such as medical necessity, periodicity, or for the purpose of utilization control, provided the services furnished can be reasonably expected to achieve their purpose. 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 MLTC requirements with respect to provider reimbursement and timely claims payment.

MCNA defines medically necessary services as services provided in accordance with 42 CFR §438.210(a)(4). To be considered medically necessary, medical or allied care, goods, or services furnished or ordered must meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with the generally accepted professional standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

Our definition addresses the extent to which MCNA covers services related to: (1) the prevention, diagnosis, and treatment of health impairments, (2) the ability to achieve age-appropriate growth and development, and (3) the ability to attain, maintain, or regain functional capacity. MCNA applies medical necessity review to reduce the inappropriate and duplicative use of healthcare services. MCNA will not arbitrarily deny or reduce the amount, duration or scope of required services solely because of diagnosis, type of illness or condition of the member. MCNA will place appropriate limits on a service on the basis of medical necessity, with the exception of EPSDT services, provided the services furnished can reasonably be expected to achieve their purpose in accordance with 42 CFR §438.210. While worded slightly different, MCNA's definition is consistent with MLTC's definition for medical necessity in accordance with 471 NAC 1-002.02A. The following table cross-references the respective definitions of MLTC and MCNA.

MLTC Definition	MCNA Definition
1 **Necessary to meet the basic health needs of the member.**	1 Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain. 2 Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs.
2 **Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service.**	4 Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide.
3 **Consistent in type, frequency, and duration of treatment with scientifically-based guidelines of national medical, research, or health care coverage organizations or governmental agencies.**	3 Be consistent with the generally accepted professional standards as determined by the Medicaid program, and not experimental or investigational.
4 **Consistent with the diagnosis of the condition.**	2 Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs.
5 **Required for means other than convenience of the client or his/her provider.**	5 Be furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.
6 **No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency.**	4 Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide.
7 **Of demonstrated value.**	3 Be consistent with the generally accepted professional standards as determined by the Medicaid program, and not experimental or investigational.
8 **No more intensive level of service than can be safely provided.**	4 Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide.

MCNA maintains policies and procedures, with defined structures and processes for the utilization management (UM) program that incorporate procedures for evaluation of medical necessity. All UM policies and procedures are reviewed and revised as regulatory or accreditation requirements are updated, but no less than annually. Ad hoc or annual revisions can be made to the definition of medical necessity as determined necessary by Nebraska's Dental Director. Revisions to the definition of medical necessity may become evident as a result of ongoing monitoring of the following:

- Utilization reports that reveal gaps resulting in inappropriate or excess utilization;
- Appeal trends that reveal opportunities for expansion in, or tightening of, the definition; and
- Alterations of Medicaid benefit design that warrant further definition to assure medical necessity has been met.

MCNA will submit an electronic copy of the UM policies and procedures to MLTC for written approval within thirty (30) calendar days from the date of award, annually thereafter, and prior to any revisions.

13	**Provide a description of the value-added services the DBPM proposes to offer to members. For each service:** • **Define and describe the service.** • **Note any limitations or restrictions that apply to the service.** • **Propose how and when members and providers will be notified of the service's availability.** • **Describe how a member may obtain/access the service.** • **Describe how the DBPM will identify the expanded benefit in administrative or encounter data.**

Value-Added Services

MCNA offers Value-Added Services (VAS) designed to encourage proper oral hygiene habits as a complement to the standard benefits offered by state Medicaid programs. A clean, healthy mouth helps prevent not only dental disease and cavities, but also medical conditions like heart disease and premature births. We will provide members with supplies and educational materials to increase their oral health literacy and encourage them to seek care from a dentist.

Our VAS strategies have proven successful in other markets. For example, in Texas, our Walmart Card mailer is an integral part of MCNA's strategy to increase the number of members receiving a timely dental exam. In federal fiscal year 2015, Texas led the nation in children receiving a preventive dental service. (*Source: CMS-416 FFY 2015 data*)

A description of each VAS will be included in both the Member Handbook and the Provider Manual, and will be featured on MCNA's Nebraska Website. MCNA's Member Hotline will be available to answer any questions a member may have about our VAS.

Bright Beginnings

MCNA will utilize a program that has been successful in Texas called "Bright Beginnings." The Bright Beginnings program targets pregnant women and new mothers with young children enrolled in the Medicaid Dental Plan. The program is designed to provide outreach to mothers about available benefits and the importance of seeking routine preventive dental care for their child before their first birthday. Each MCNA member identified as a pregnant woman (through the eligibility file, provider referral, or via

outreach efforts) will receive educational materials and a dental kit, which includes a toothbrush, toothpaste, and dental floss upon program enrollment. Please see our "Healthy Smiles for Mom & Baby" educational flyer on the following pages.

Healthy Smiles for Mom & Baby [Page 1 of 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 protect the health of your unborn child. Research shows a link between gum disease and low birth weight babies. Women who are pregnant and have gum disease are more likely to have a baby that is born too early.

Pregnancy Gingivitis

Many pregnant women may notice that they have red and puffy gums. Their gums may be sore and bleed when they brush. This is known as pregnancy gingivitis. It often occurs during the 2nd through the 8th months of pregnancy. Hormone levels rise. This makes the gums more sensitive to plaque. You can reduce your risk of this by keeping your teeth clean. You should also keep the area between your gums and teeth clean.

A Healthy Diet

Eat a balanced diet to make sure you get the right amount of nutrients to nourish you and your baby. Your baby's teeth begin to develop between the 3rd and 6th months of pregnancy. Make sure you receive enough calcium, protein, and vitamins. Some healthy food choices are cheese, fresh fruits, and vegetables rich in vitamins. These are great for your teeth. Some say calcium is lost from the mother's teeth during pregnancy. The calcium goes to the baby. This is a myth! Your baby gets calcium from your diet and not from your teeth.

Healthy Smiles for Mom & Baby [Page 2 of 2]

Oral Hygiene Tips

Here are a few tips to help prevent cavities and gum disease during pregnancy:

- Brush your teeth 2 times a day with fluoride toothpaste
- Use floss daily to clean in between your teeth
- Eat a balanced diet
- Visit your dentist every 3-4 months

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 stay 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.

Baby bottle tooth decay often occurs on the upper front teeth. Other teeth can also be affected. 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 to help you prevent baby bottle tooth decay.

- Never allow your baby to fall asleep with a bottle containing anything but water.
- Wipe your baby's gums with a small piece of gauze or a washcloth after feedings.
- Start brushing your baby'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 baby is getting enough fluoride to help fight cavities. Find out if your local water supply has fluoride. If there is no fluoride, consult with your dentist or doctor.
- Take your baby to the dentist by their 1st birthday!

Visit our website at **www.mcna.net** for more oral hygiene tips.

mcnadental

Toll-Free: (800) 494-6262 • TTY: (800) 955-8771 • Web: http://www.mcna.net

[redacted]

MCNA's Case Management Program Flyer

MCNA Dental
Case Management Program

MCNA's Case Management Program assists:

- Members with special health care needs.
- Members with catastrophic dental conditions.

We assist members in the Program by:

- Finding dentists that speak the member's language.
- Identifying offices that can meet a member's special health care needs requirements.
- Assisting members with scheduling appointments.
- Facilitating referrals and pre-authorizations as requested by the member's treating dentist.
- Coordinating dental care covered by the member's health plan.
- Obtaining a translator for dental office visits.
- Aiding members with obtaining transportation.
- Assisting members with obtaining all medically necessary treatment ordered by their dentist.

If you have questions or would like to refer a member to the Case Management Program, please call us (Toll-Free) at **1-855-702-6262**. Our hours are 7am to 7pm (CST), Monday through Friday.

[redacted]

[redacted]

[redacted]

[redacted]

14	**Describe the DBPM's approach to member education and outreach regarding EPSDT, including any innovative mechanisms. Address the use of the DBPM's system for tracking each member's screening, diagnosis and treatment to ensure services are delivered within the established timeframes.**

Commitment to AAPD Periodicity Schedule and EPSDT Requirements

Dr. Philip Hunke, MCNA Insurance Company's 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 Nebraska 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 oral health outcomes in state sponsored Medicaid programs by continuously stressing prevention, diagnosis, and early treatment intervention. Our network dentists utilize the entire spectrum of diagnostic services available so early problems can be detected and addressed promptly. **All participants under 21** will receive medically necessary services in accordance with EPSDT requirements. MCNA will adhere to the AAPD Periodicity Schedule to ensure all children served have access to timely preventive care as well as other medically necessary restorative and therapeutic services.

Tracking EPSDT

We believe 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. Participating providers can view past treatment history via MCNA's online Provider Portal to ensure all EPSDT services are being rendered timely and to avoid duplication of services.

Member Eligibility Module

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. Each member record 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.

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.

Keeping the Focus on EPSDT

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.

Early	Assessing and identifying problems early
Periodic	Checking children's oral health at periodic, age-appropriate intervals
Screening	Providing dental and other related screening tests to detect potential problems
Diagnosis	Performing diagnostic tests to follow up when a risk is identified
Treatment	Control, correct or reduce oral health problems found

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.

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

MCNA's Nebraska outreach campaign is 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.

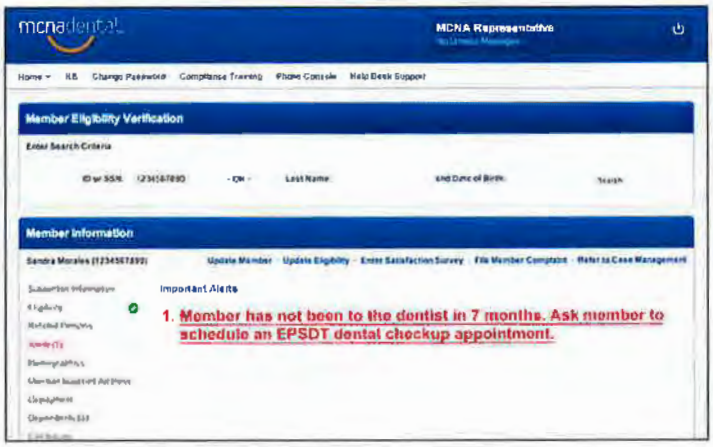
Member Education and Outreach to Enhance EPSDT Compliance

MCNA focuses primarily on prevention to lessen the occurrence of specific dental conditions or diseases. Through our experience, we know that educating our members and their parents or guardians is essential to making sure families understand the importance of achieving and maintaining good oral health. In addition to education via our Member Handbook, interactive website, and reminder postcards, MCNA also uses our internal staff, network providers, and community partners to reach out to our members and educate them about the importance of oral hygiene and timely dental care.

MCNA is committed to maintaining or increasing the preventive service measures for our members under 21 in the Nebraska program. We have **extensive expertise** in reporting the metrics required by the Form CMS-416: Annual EPSDT Participation Report. Our multi-faceted approach to improving or maintaining current Nebraska CMS-416 metrics includes driving increases in preventive services and appropriate sealant utilization. MCNA's continuous quality improvement activities include the use of

timely and meaningful data, multi-disciplinary team analysis, and active engagement of members, providers, and plan staff in intervention strategies.

Care Gap Alerts and Consistent Outreach



MCNA's management information system, DentalTrac™, **continuously analyzes** member eligibility data and claims data to identify members who are not receiving care in accordance with the EPSDT (AAPD) periodicity schedule. Our business intelligence functionality uses this data to generate actionable "Care Gap Alerts."

MCNA's experienced Quality Improvement staff, Member Advocate Outreach Specialists (MAOS), and our skilled Call Center Operations Team use this data to identify and coordinate education and outreach opportunities. Real-time Care Gap Alerts are used by our Member Services Representatives (MSRs) during incoming calls. The MSRs educate the member on the importance of preventive care and assist the member in scheduling an appointment. During 2015, MCNA's Member Hotline **assisted over 235,000 Florida, Texas, and Louisiana Medicaid and CHIP members in scheduling a dental appointment**. Please see a screenshot of a Care Gap Alert generated by DentalTrac™ above.

MCNA Care Connections and Outreach to Non-Compliant Members

MCNA's Care Connections Team (CCT) is a dedicated unit within the Call Center Operations Department. Care Connections Representatives are skilled in outbound call campaign processes and procedures. Our sophisticated suite of telephony software allows thousands of phone numbers to be dialed automatically over the length of the campaign. Each answered call is routed immediately to the next available Care Connections Representative.

The CCT provides targeted outreach to MCNA members to increase appropriate utilization of preventive services. For example, MCNA's skilled Care Connections staff conducts outbound calls to members who are overdue for a regular dental checkup according to the American Academy of Pediatric Dentistry (AAPD) Periodicity Schedule. We provide education and offer assistance scheduling an appointment.

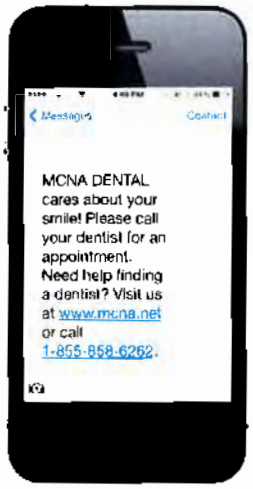
Other CCT preventive service campaigns include contacting members who are eligible for sealants but have not yet received them and targeted teen outreach calls to encourage receipt of routine dental care. The CCT also conducts service receipt confirmation calls to a random sample of members to verify the members actually received services submitted by their providers for reimbursement.

Text Messaging

Our Quality Improvement Department uses text messaging to increase the Annual Dental Visit (ADV) rate and the number of members receiving preventive services. MCNA encourages our members, and their parents and guardians, to schedule dental appointments in accordance with the AAPD Periodicity Schedule.

This approach is also used to follow up with members who have not visited a dentist within the previous 6 months of enrollment. This continuous outbound text messaging initiative has improved the screening rates for the members we currently serve.

In 2015, MCNA sent over 137,000 text messages to our members.



Example Text Message

15	**Describe member services processes including:** • **Training of customer service staff (both initial and ongoing).** • **Routing calls to appropriate persons, including escalation.** • **Making information available to customer service staff (the type of information and how it is provided, e.g. hard copy or on-line search capacity).** • **Handling calls from members with limited English proficiency and persons who are hearing impaired.** • **Monitoring and ensuring the quality and accuracy of information provided to members.** • **Monitoring and ensuring adherence to performance standards.** • **How MSRs will interact with other organizations including MLTC and other programs/social service entities (e.g., WIC, housing assistance, and homeless shelters).** • **After hours procedures.**

Call Center Commitment and Staff Training

Our Member Services Representatives (MSRs) are our **"key link"** to the **nearly 3,500,000 members** we serve. Our MSRs ensure that all members receive the accurate and timely information needed to access dental care. Each MSR is **extensively trained** to provide accurate and timely resolution of all inquiries and issues using quality-driven customer service skills.

MCNA operates fully integrated call centers in Texas and Florida. 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.

Martha Bailey, MCNA's Associate Vice President of Administration and 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

MCNA's Customer Service Leaders

Martha Bailey
AVP of Administration and Operations

Martha 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
Director of Training and Quality Assurance

Shawn Zielinske is a 21-year veteran of the United States Air Force with 20 years of experience creating, developing, and implementing training programs and training personnel.

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.

Our MSRs attend a four-week training program that prepares them to provide exceptional customer service to our members. The program includes a comprehensive training schedule that covers:

- Customer Service Skills and System Navigation
- Fraud, Waste, and Abuse
- HIPAA and Regulatory Compliance
- Plan Specific Requirements and Covered Services
- Member Rights and Responsibilities
- Policies and Procedures
- Member Eligibility
- Provider Selection
- Special Health Care Needs
- Coordination of Care (including assistance with transportation services)
- Claims, Pre-Authorizations, and Referrals
- Complaints, Grievances, Appeals, and State Fair Hearings
- MCNA's FORCE Factors Quality Monitoring Program

After successfully passing assessment tests throughout the training program, trainees transition into production through MCNA's **BRIDGE** program (Building Readiness Initiative to Deliver a Great Experience), a two-week, on-the-job training course in a controlled, live call center setting. Upon completion of the BRIDGE program, our MSRs are ready and willing to assist members with **understanding and accessing** their benefits and resolving any issues the member may encounter.

Call Routing and Escalation

MCNA's Call Center Operations Department is committed to be a **first-call solution-driven** department. Our **toll-free** Member Hotline is available **24x7x365**, and staffed **Monday through Friday** between the hours of **7:00 am to 7:00 pm 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 a variety of service options, including:

- Verify Member Eligibility
- Locate a Provider
- Choose a Primary Care Dentist (Dental Home)
- Receive Benefits Information
- Inquire about Claims, Pre-Authorizations, or Referrals
- Submit Complaints, Grievances, or Appeals

Our MSRs will be fully trained on MLTC 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, the resolution of the call, and other information as needed. 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, county, or city organizations when applicable

Keeping Call Center Staff Informed

Member Services Representatives are provided frequent updates called **GNUs Flashes** (General News Updates) to keep them informed of requirements. 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 Nebraska Dental Benefit Program Manager (DBPM) requirements have been developed and will be submitted for MLTC approval. These materials 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 Nebraska Dental Benefit Program including attendant reference manuals and supporting materials
- Cross-training from all MCNA operational departments
- 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, Compliance Program, incident reporting protocols, and the Business Continuity and Disaster Recovery Plan within 30 days of hire for all new employees

All MSR's are recertified annually on these programs. MSRs receive ongoing training on conflict resolution, DentalTrac™ features and functionality, and call center time management.

Availability of Bilingual Staff and Translation Services

MCNA satisfies the linguistic preferences of members whose primary language is not English by maintaining staff members who are culturally competent and fluent in Spanish, Haitian Creole, French Creole, Vietnamese, French, 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. MCNA has over 200 MSRs and over half are multi-lingual.

If there are no representatives that speak the member's preferred language, MCNA can access the translation and interpretive services of our vendor, LanguageLine, the largest interpretation service company in the industry. LanguageLine provides translation services for over 200 languages not directly available from MCNA staff, including those specifically listed for Nebraska in the 2010 census. This translation service is free to MCNA members and providers. A TTY/TDD line is also available for members who are deaf, hard of hearing, or speech impaired. Members who are unable to push telephone buttons are prompted to remain on the line while the call is routed to an MSR.

Monitoring Call Quality and the Accuracy of Information

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 call scripts, and policies and procedures; HIPAA compliance; professionalism and decorum; accuracy of information; and First Call Resolution.

MCNA takes quality call handling very seriously and has implemented a 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, the infraction may result in remediation or termination of the employee.

In conjunction with our Call Center Operations 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 assurance team monitors a minimum of eight (8) calls per agent per month. MCNA's Training and Quality Manager coordinates additional training for 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 the application of our 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 and Ensuring Adherence to Performance Standards

Monthly reports are generated and used by the 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 Director of Call Center Operations develops program improvement strategies to address the issue in question. Examples of program improvements include hiring additional staff and conducting additional Member Services training to improve performance.

The Call Center Operations management team reviews daily reports and ensures the following call center key performance indicators (KPI) meet or exceed our contractual requirements using monthly, quarterly, and annual system generated reports.

2015 MCNA Annual Performance Measures for Member and Provider Hotlines			
Performance Measure	**Nebraska Target**	**MCNA's Performance**	**Target Achieved**
ASA (average speed of answer in seconds)	Less than 30 seconds	Under 1 second	✔
Abandonment Call Rate (%)	Less than 3%	Less than 1%	✔

MCNA's Workforce Management Team produces monthly performance scorecards for each MSR, Team, and the overall Call Center. These scorecards are used for quarterly ranking of individual and team performance. Top performing MSRs and Teams are recognized on MCNA's "Wall of Fame." Additionally, MCNA has television displays throughout our call center to enable all team members to continuously monitor service level compliance, call volume, and agent availability. This allows the call center leadership to proactively respond to call spikes and appropriately adjust staffing needs.

[redacted]

Interaction with Other Customer Service Lines

MCNA values our relationships with other health care and social service organizations. We routinely contact other agencies to gain their assistance for our members. Our MSRs contact other service lines maintained by state agencies, county 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 MLTC 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 can use 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, and also allows callers to leave messages. Our system has the capacity to adequately receive and store all messages. Our staff monitors the message queues and returns all calls within one (1) business day of receipt. All after-hours calls are logged, and response times are monitored.

MCNA's Compliance Department routinely audits MCNA's after-hours call handling process by remotely calling the call center outside of normal business hours and validating the functionality of the system and the timeliness of the response from the call center staff.

16	Describe the informational materials the DBPM proposes to send to new members.

Member Welcome Packets

MCNA has over 20 years of experience administering full-risk dental insurance plans for Medicaid, CHIP, Medicare, Long Term Care, Affordable Care Act, and Commercial lines of business. This experience underscores our understanding of the importance of **timely and accurate** communication with new enrollees.

Since 2005, MCNA has produced and mailed over 12.3 million member materials.

MLTC-approved Enrollment Packets ("Welcome Packets") will be distributed to all members at least 10 business days prior to the go-live date and to all members who become eligible for covered services after the go-live date within 10 business days following receipt of eligibility files from MLTC. Our Welcome Packet includes a Welcome Letter, ID Card, Provider Directory, and an informative, and an easy-to-understand Member Handbook. The Member Handbook, Provider Directory, and the ability to print an ID Card will also be available online via MCNA's dedicated Nebraska website.

Mailing of ID Cards and Welcome Packets

Fiserv is a Fortune 500 Company that has served as MCNA's printing and fulfillment vendor since 2005. MCNA will ensure ID cards are mailed to each new enrollee within 10 business days following receipt of eligibility files from MLTC. Upon receipt of the enrollment file, the Enrollment Department transmits the data to Fiserv within 24 hours. Fiserv then mails a Welcome Packet to each new member (using the address provided by MLTC) within four (4) days of receiving the enrollment file from MCNA, which is sooner than the state standard of 10 business days. Fiserv provides MCNA with a confirmation that the mailing has been completed. Each member's record in DentalTrac™, MCNA's proprietary management information system, is automatically updated with the date the materials were sent.

Each ID card will include:

- Member's Name and Medicaid ID Number
- MCNA's Name and Address
- Instructions on What to Do in an Emergency
- The Member's Dental Home Provider Name and Telephone Number (including after-hours number if applicable)
- MCNA's Toll-Free Numbers for Member Services, Filing a Grievance, and Reporting Suspected Fraud

MCNA's Provider Directory

Our members can easily locate a participating dental provider by reviewing the Provider Directory included in their Welcome Packet, by visiting the dedicated MCNA Nebraska website, or by calling our toll-free Member Hotline for assistance. MCNA ensures the most current information is available, including the provider's name, location, telephone number, any restrictions, hours of operations, and languages spoken. MCNA will adhere to the requirements as specified in section IV.G.6 and in accordance with 42 CFR §438.10.

MCNA's Member Handbook

MCNA's Member Handbook is the cornerstone of our Orientation Packet and contains easy-to-understand program information for our members. Our Member Handbook is written at a 6th grade reading level, as determined by the Flesch-Kincaid index, and is available in alternate languages and formats. Topics addressed in MCNA's Member Handbook include the following:

- How to Contact MCNA
- Member Rights and Responsibilities
- Eligibility, including Enrollment and Disenrollment
- The Role of the Dental Home / Primary Care Dentist
- How to Change Dental Homes / Primary Care Dentists
- Covered Services
- How to Obtain Pre-Authorization for Dental Services
- The Importance of Good Oral Hygiene
- Accessing Dental Care
- Obtaining a Replacement ID Card (if applicable)
- What to Do in an Emergency Situation
- Benefit Exclusions and Limitations
- Notice of Privacy Practices
- Filing a Complaint, Grievance, Appeal, or 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
- Other MLTC Requirements

Please refer to **Attachment 16-1** for a copy of MCNA's draft Nebraska Member Handbook. MCNA understands that all member materials must be approved by MLTC prior to use.

17	**Describe the approach the DBPM will take to provide members with written material that is easily understood, including alternate formats and other languages. Address how the DBPM will ensure that materials are at the appropriate reading level.**

Communication Protocols to Enhance Understanding

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 for ease of understanding, at or below a 6th grade reading level based on 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

MCNA translates member materials needed to communicate to each member their benefits, rights and responsibilities, and how to access and utilize dental services. We understand that all written materials must be available in English and Spanish, and educational and other materials must also be made available in any other language spoken as a primary language by 5% of the Nebraska population statewide in accordance with 42 CFR §438.10(c)(3). Within 90 calendar days of notice from MLTC, MCNA will ensure that materials are translated and made available. We understand that materials must be made available at no charge in that specific language to assure a reasonable chance for all members to understand how to access and use MCNA's services appropriately as specified in 42 CFR §438.10(c)(4) and (5). Large print, Braille, and audio recordings are also available to members that are visually impaired. MCNA uses Teneo Linguistics Company, a Texas minority-owned business, for translation services.

Accuracy, ease of understanding, and readability are critical to ensuring compliance with the Social Security Act §1932 (d) and 42 CFR §438.104. To ensure that these requirements are met, we have developed a Communications Committee to provide interdepartmental oversight of the quality, accuracy, and appropriateness of all communications we develop and publish for our members and providers. MCNA's Communications Committee membership is comprised of leadership from Call Center Operations, Grievances and Appeals, Utilization Management, Provider Services, Quality Improvement, and Compliance.

The 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. The Compliance Department will then ensure that all member education materials, in all mediums, are submitted for review and written approval by MLTC or its designee in accordance with Social Security Act §1932 (d)(2)(A), 42 CFR §438.104, and the requirements of this RFP, including section IV.G.5 (Additional Member Educational Materials and Programs).

MCNA's Compliance Department and Communications Specialists will maintain a log of all approved MLTC member materials. The materials will include the date of issue, date of revision, and, if needed, language showing that the prior versions are obsolete. MCNA understands that we are responsible for the creation, production, and distribution of our own member education materials to our members.

Cultural Competency

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. Our dedication begins at the very highest level of our organization, with our Board of Directors being ultimately accountable for activities related to cultural competency.

The U.S. Department of Health and Human Services, Office of Minority Health, has issued national Culturally and Linguistically Appropriate Services (CLAS) standards, and MCNA is committed to a continuous effort to perform according to those standards and eliminate disparities in dental care between diverse populations. Our Director of Quality Improvement ensures that we meet our own internal cultural competency goals and externally mandated objectives, and drives cultural training throughout our company including training of all new employees within thirty (30) days of hire. By engaging each level of management in our program, we ensure that culturally competent services are delivered to people of all cultures, races, ethnic backgrounds, religions, and those with disabilities in a manner that recognizes the worth and dignity of each individual.

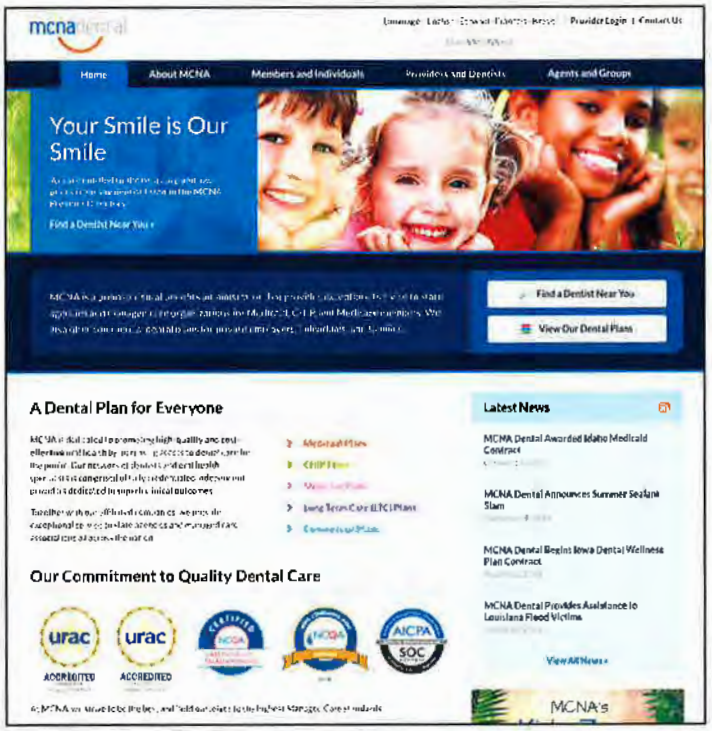
Our provider network is comprised of diverse dental practitioners who value people of all races, ethnicities, and socioeconomic backgrounds. We actively monitor our providers' ability to communicate in different languages to ensure all members are well-served. **All network providers are required to comply with MCNA's Cultural Competency Program and the Americans with Disabilities Act (ADA).**

MCNA accommodates the preferences of members whose primary language is not English by maintaining staff fluent in Spanish and other predominant regional languages. 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, Spanish, Braille, and large print. All member materials can be translated into other languages as needed.

18	**Provide an overview of the DBPM's proposed member website, including how it will satisfy requirements in this RFP. Provide examples of information that will be available on the website and on portals for members.**

MCNA's Website

With over 2.9 million visits for the first nine months of 2016, MCNA's member and provider websites are a proven solution for ensuring accurate and timely communication. The MCNA corporate website (http://www.mcna.net) is tailored to meet the needs of the providers and participants we serve. Our website is currently available in English, Spanish, French, and Haitian Creole.



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.

By leveraging this same technology, MCNA also develops state-specific websites tailored to meet the needs of individual states and contract regulations. The content, presentation, and functionality of these websites are carefully crafted to meet the needs of the local population, maintain compliance with our contract requirements, and adhere to industry standards for navigability and accessibility. MCNA's website for the Nebraska Medicaid dental program will be fully prepared by the time of Readiness Review and will include:

- An outline of covered services
- A link to download a PDF of the Member Handbook
- A link to MCNA's searchable online Provider Directory
- A link to MCNA's secure online Member Portal
- Information about how to obtain program information in languages other than English and alternative formats
- Information about how to submit grievances and appeals to MCNA
- Contact information with respect to all beneficiary matters, including covered services
- Information to assist network providers with regard to billing and/or pre-authorization processes and frequently asked questions
- A link to download a PDF of the Provider Manual
- A link to MCNA's secure online Provider Portal where providers may submit electronic claims, free of charge
- Schedule of provider informational webinar events and signup information

Our expert team of User Experience designers rely on the powerful analytics dashboards that continuously monitor our websites to understand the Internet browser preferences of our users. We strive to cater to all of our users by maintaining web applications that are compatible across the most common devices, operating systems, and browsers in the industry. MCNA's zero-footprint online Provider Portal and Member Portal offer access to all features from any desktop or mobile web browser without additional software or plug-ins. For the best user experience and fastest speeds, we recommend using a modern Internet browser such as:

- Google Chrome
- Apple Safari
- Mozilla Firefox
- Microsoft Internet Explorer (version 8.0 or newer)

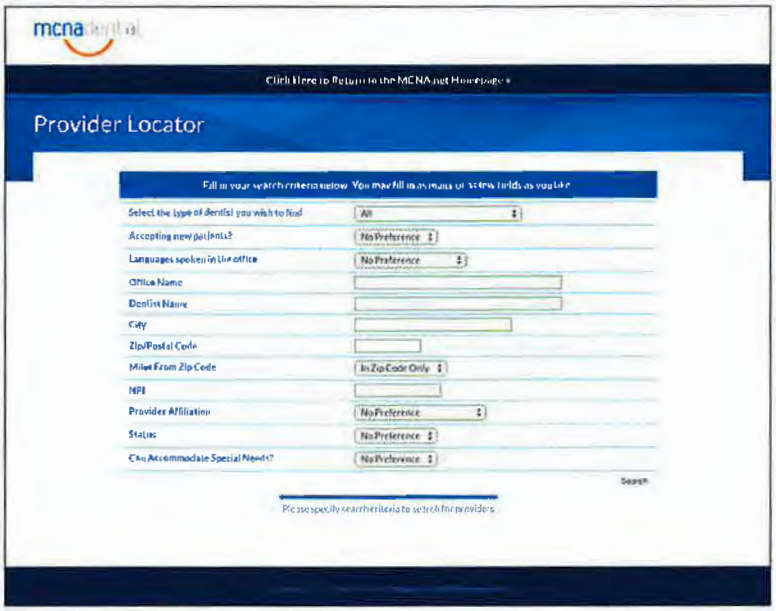
MCNA's Provider Directory

Our members can easily locate a participating dental provider by reviewing the Provider Directory included in their Welcome Packet, by visiting the dedicated MCNA Nebraska website, or by calling our toll-free Member Hotline for assistance. MCNA ensures the most current dental provider directory is available to participants upon request and will be sent within five (5) business days of said request. The mailing date of the Provider Directory, along with the date of request, is noted in the member record within DentalTrac™.

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 DentalTrac™, allowing any changes made in our provider network to be available online in real-time. As a result, members always have access to the latest, most accurate information regarding the nearest dental provider, including:

- Office name, locations, telephone numbers, and office hours

- Specialty
- Dentist name
- Languages spoken
- Ability to treat special needs members
- Ability to accept new patients and restrictions such as age
- Miles from the ZIP code requested



MCNA's Online Provider Directory

Members may contact the Member Hotline for assistance in selecting a dental provider and establishing a dental home. All members are free to choose a participating general dentist or pediatric dentist in our network, or if the member would like assistance selecting a provider, our Member Services Representatives (MSRs) are trained to ask the member questions about their preferences for a provider and recommend a provider that is likely to meet the member's needs.

[redacted]

MLTC may request a modification or addition of content to our Nebraska Medicaid-specific website at any time. MCNA values the opportunity to work with MLTC and will treat such requests with the highest priority while adhering to our process standards.

19	**Discuss the DBPM's approach to welcoming new members, addressing requirements listed in the RFP. Discuss any proposed alternate methods or plans the DBPM would use to effectively welcome members.**

Welcoming New Members

MLTC-approved Enrollment Packets ("Welcome Packets") will be distributed to all members at least 10 business days prior to the go-live date and to all members who become eligible for covered services after the go-live date within 10 business days of receiving the member file from MLTC. Our Welcome Packet includes a Welcome Letter, ID Card, Provider Directory, and an informative and easy-to-understand Member Handbook.

For additional information about the Welcome Packet materials, please see the response to Question 16.

Welcome Calls

MCNA's Member Services Representatives 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. Additionally, continuity of care information will be provided in our welcome calls, and members can seek assistance from MCNA's Member Advocate and Outreach Specialists should the members have questions or need assistance with continuity of care issues.

Over 741,000 Welcome Calls have been made to members in our Louisiana Medicaid and CHIP plans since the go-live date of July 1, 2014.

[redacted]

20	**Detail the strategies the DBPM will use to influence member behavior to access health care resources appropriately and adopt healthier lifestyles.**

Influencing Member Behavior

Preventive care is vital to MCNA's philosophy of cultivating and maintaining good oral hygiene outcomes for our members and cost savings for the Medicaid and CHIP programs. MCNA is committed to communication and education. We believe these 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.** MCNA's Member Advocate Outreach Specialists (MAOS), Care Connections Team members, and Case Managers are at the forefront of our efforts.

MCNA's Member Advocate Outreach Specialists (MAOS)

In Texas and Louisiana, MCNA employs experienced Member Advocate Outreach Specialists (MAOS) to ensure members receive appointment reminders, assistance with scheduling dental appointments, transportation coordination, oral health education, understanding plan benefits, and one-on-one assistance with submitting grievances and appeals. 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 AAPD 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 these 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 among races and ethnic groups.

Given MCNA's success with our MAOS approach, we will employ Nebraska-based MAOS to work with our Nebraska members and their families. The MAOS will be located throughout the state in order to be close to the populations they serve. Upon approval from MLTC, MAOS will implement outreach programs, 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.

MCNA's MAOS are available to provide a variety of services to members across the state, including:

- Working in communities across the state.
- Organizing visits with our members and providing education about good oral health.
- Working with other community partners.
- Attending health fairs and events.
- Giving oral health presentations at schools and organizations for children and adults.

Health Fairs

Over the past year, our MAOS Team has actively participated in **over 620 health fairs and outreach events** in Texas, Louisiana, and Florida. These health fairs are organized in coordination with faith-based organizations, county health departments, Head Start programs, public school systems, civic organizations, dental centers, and health plans.

MCNA has organized and sponsored health fairs across the states we serve to provide community members with vital healthcare information and services. At MCNA, we not only focus on dental, but also on total body wellness. The health fairs we participate in and sponsor include free services such as:

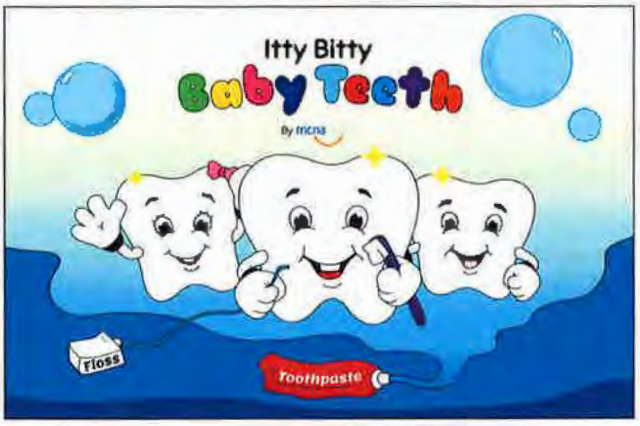
- Screenings (Vision, Dental, and Hearing)
- Vouchers for Free Exams (Mammograms, Well-Woman Checkups, and Colonoscopies)
- Educational Information About Community Supports (Food and Diaper Banks)

During outreach events, MCNA's MAOS team members:

- Discuss techniques to help maintain good oral hygiene and encourage members to follow the 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 preventive services such as dental sealants and fluoride.
- Encourage attendees and parents to visit the dentist regularly for a check-up.
- Discuss the stages of gum disease and the long-term effects of prolonged dental neglect.
- Engage participants by utilizing age appropriate "hands-on" activities to teach children the proper way to brush and floss their teeth
- Provide participants with dental kits that include a toothbrush, toothpaste and dental floss as well as informational flyers, water bottles, backpacks, hand sanitizer, and pencils.
- Share information with participants about other organizations that provide services for little or no cost.

Presentations and Meetings

MCNA's Member Advocate Outreach Specialists (MAOS) partner with local school districts and Head Start programs to organize and participate in health fairs. They also provide oral health presentations for students, faculty, staff and parents. MAOS utilize age appropriate interactive activities to engage children in learning about proper oral health. These activities include playing games and reading books, such as a children's book written and published by MCNA, *Itty Bitty Baby Teeth*. This book was created to ease children's fears about losing their baby teeth and to encourage healthy oral hygiene habits. The book is easy to read and is designed for pre-school through first grade. The book is available in both English and Spanish. The MAOS also attend various parent meetings to provide parents with important oral hygiene information as well as information about MCNA, the services available to members, and how to access those services.



MCNA's Itty Bitty Baby Teeth Book

Care Gap Alerts and Consistent Outreach

MCNA's experienced MAOS team uses data to identify and coordinate education and outreach opportunities. DentalTrac™ continuously mines member eligibility data received from the Medicaid Dental Plan, and current and historic claims data to identify members who are not receiving care in accordance with the AAPD Periodicity Schedule. Our business intelligence functionality uses this data to generate actionable "Care Gap Alerts."

Real-time Care Gap Alerts are used by our Member Services Representatives (MSRs) during incoming calls. The MSRs educate the member on the importance of preventive care and assist the member in scheduling an appointment. During 2015, MCNA's Member Hotline assisted over 235,000 Florida, Texas, and Louisiana members in scheduling a dental appointment.

Care Connections

MCNA's Care Connections Team (CCT) is a dedicated unit within the Call Center Operations Department. Care Connections Representatives are skilled in outbound call campaign processes and procedures. Our sophisticated suite of telephony software allows thousands of phone numbers to be

dialed automatically over the length of the campaign. Each answered call is routed immediately to the next available Care Connections Representative. The CCT provides targeted outreach to MCNA members to increase appropriate utilization of preventive services. For example, MCNA's skilled Care Connections staff conducts outbound calls to members who are overdue for a regular dental checkup according to the American Academy of Pediatric Dentistry (AAPD) Periodicity Schedule. We provide educational information and offer assistance scheduling a dental appointment during each call.

Other CCT preventive service campaigns include contacting members who are eligible for sealants but have not yet received them and targeted teen outreach calls to encourage receipt of routine dental care. The CCT also conducts service receipt confirmation calls to a random sample of members to verify the members actually received services submitted by their providers for reimbursement.

Engaging Providers in Outreach

Our providers play a pivotal role in the way we outreach to our members. MCNA's Provider Manual contains our Provider Outreach Form, which allows providers to inform MCNA when a member:

- Is behind in their routine dental checkups
- Is a chronic no-show for confirmed appointments
- Is non-compliant with the treatment plan or with office policies and/or other displays of unacceptable behavior in the office
- Is pregnant or has special needs

Once a provider completes this form, it can be mailed, emailed, or faxed to MCNA. Upon receipt, MCNA's Care Connections Team processes each form and attempts to reach out to the member regarding the reason the provider sent the form. If the member requires assistance scheduling an appointment, a Care Connections Team member conducts a three-way call with the provider's office and the member to schedule an appointment. If a provider indicates that a member has special health care needs, the member outreach form will be forwarded to MCNA's Case Management team for follow-up.

MCNA is proud to announce that commencing in 2017, providers will be able to advise MCNA of non-compliant members by including CDT code D9991, and refer members to case management by including CDT codes D9992 and D9993 in their claim submissions. This is an example of MCNA's commitment to continuous quality improvement.

Case Management for Members with Special Needs

MCNA takes pride in the quality of care and attention we give to recipients who require additional assistance. Individuals with developmental disabilities and those with special needs sometimes require a helping hand to navigate the dental care delivery system. We also work to identify providers that see adults and children with special needs and provide continuous follow-up to make sure these especially vulnerable recipients are getting covered dental services in a timely manner.

MCNA identifies those recipients eligible for case management through a variety of sources. Our Member Service Representatives (MSRs) are the primary source of this information. The MSRs are trained to ask whether a recipient is eligible for any of the Case Management categories. This information is then entered into the recipient's file in DentalTrac™ for use by Case Management Coordinators (CMC). Our Provider Relations Representatives also receive referrals to Case Management from participating providers.

Once identified, recipients are contacted telephonically by a CMC. The CMC explains the program to the recipient, and the recipient is encouraged to participate. Typically, most recipients welcome the opportunity to participate and receive assistance from our CMCs. MCNA makes no less than three (3) attempts to contact recipients in Case Management to remind them to seek routine or follow-up care.

MCNA's case managers provide a variety of services based on the needs of the individual recipient. A CMC may provide "one-time" assistance with transportation or locating a provider that treats patients with special health care needs. Some patients may require longer term support and assistance from Case Management, such as obtaining prior authorizations based on the recipient's treatment plan, conducting routine follow up calls ensuring the recipient is maintaining compliance with a given treatment plan, scheduling hospital based dentistry, or coordinating additional services (most commonly sedation services through an anesthesiologist).

21	**Describe proposed member education content and materials and attach examples used with Medicaid or CHIP populations in other states. Describe innovative methods the DBPM has used for member education.** **Describe how the DBPM will provide equitable member education throughout the State. Provide examples and descriptions of how member education will be used to improve service coordination including:** • **The use of technological tools, including social media and mobile technology.** • **Partnership with community-based organizations for education and outreach.**

Communication Protocols to Enhance Understanding

MCNA knows the importance of consistent (and persistent) communication with our members because of our extensive experience with the Medicaid and CHIP programs in Texas, Louisiana, Florida, Kentucky, and Iowa. Our outstanding clinical outcomes coupled with high rates of member and provider satisfaction illustrate the effectiveness of our approach.

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 for ease of understanding, at or below a 6th grade reading level based on the **Flesch-Kincaid grade level calculation formula**.

MCNA's "CONNECT" Outreach Goals
Centered on early prevention.
Oral diseases are reduced.
Needs of members are identified and addressed.
Number of cancelled appointments is decreased.
Enhanced provider access and availability.
Cost effective.
Targets routine preventive care services.

Text Messaging

Our Quality Improvement Department uses text messaging to increase the Annual Dental Visit (ADV) rate and the number of members receiving preventive services. MCNA encourages our members, and their parents and guardians, to schedule dental appointments in accordance with the AAPD Periodicity Schedule.

This approach is also used to follow up with members who have not visited a dentist within the previous 6 months of enrollment. This continuous outbound text messaging initiative has improved the screening rates for the members we currently serve.

In 2015, MCNA sent over 137,000 text messages to our members.

Online Educational Videos

MCNA's Member Advocate Outreach Specialists (MAOS) partner with local school districts, Head Start programs, and community agencies to organize and participate in health fairs. They also provide oral health presentations for students, faculty, staff and parents. To assist MAOS in these efforts, MCNA's Creative Services Department developed a series of custom oral health education videos. These videos engage children in easy-to-understand storylines about dental related topics, such as visiting the dentist, the effects of improper diet on oral health, and the importance of good oral hygiene. The MAOS incorporate these videos into their presentations at schools and health fairs. MCNA's video library is available on our YouTube channel at: http://youtube.com/MCNADental

MCNA's Outreach Program for Pregnant Women

Quality dental care is of paramount importance for expectant mothers. Studies have shown a link between poor oral health (specifically gum disease) and preterm births. MCNA will outreach to all identified pregnant women to provide education about the importance of seeing the dentist in a timely manner and how to use their dental benefits within ten (10) days of enrollment with MCNA.

MCNA will also utilize a program that has been successful in Texas we call "Bright Beginnings." The Bright Beginnings program is a Value Added Service that targets pregnant women and new mothers with young children enrolled in the Medicaid Dental Plan. The program is designed to provide outreach to mothers about available benefits and the importance of seeking routine preventive dental care for their child before their first birthday. Each identified pregnant woman in the program will receive educational materials and a dental kit, which includes a toothbrush, toothpaste, and dental floss upon enrollment.

[redacted]

MCNA's Website

Our website is integral to our cost-effective approach to member outreach. We provide newsletters, communications, brochures, and a website where visitors can easily find plan information. The site's lightweight back end technology is scalable and adaptable; anything from additional languages to new

pages to entirely new color schemes can be implemented with ease by our 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.

Education is an important goal of the MCNA website. MCNA makes our educational materials, ID card printing, and searchable provider directory available on our website at: http://www.mcna.net. In addition to downloadable educational materials, members also have access to educational videos and fun games in the "Kid's Zone" section of MCNA's website. The website is available in English, Spanish, French, and Creole. It 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 also meets the guidelines set by Section 508 of the US 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 needed to access essential site functionality.

Social Media

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. Upon approval from MLTC, MCNA will target multiple social media outlets to ensure maximum message penetration. The following are third party social media services that MCNA currently uses to reach our members and providers:

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

Twitter: Quick access to updates from our website, reminders, and oral health tips.

YouTube: An extended educational tool with informational videos.

Facebook: Additional communication with reminders, YouTube videos, and website links.

Sample Educational and Outreach Materials

MCNA has a comprehensive library of member educational materials. The following list includes examples of MCNA educational and outreach materials available free-of-charge to our Nebraska Medicaid dental plan members.

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://youtu.be/ewjzwqWNkus)

- **"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://youtu.be/DXFWwL9V3Uo)

- **"Emma's First Dental Visit":** Educates children on what to expect during their first visit to the dentist, including the exam room, x-rays, dental tools, fluoride, and brushing. (http://youtu.be/4a9p2JaWt3E)

- **"Tooth Trivia":** Shares some interesting oral health tips, including healthy foods, unhealthy foods, and information about dangerous dental diseases. (http://youtu.be/_Of2aZeCGDs)

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.

- **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).

- **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.

These and other MCNA educational flyers are available online at MCNA's Kid's Zone (http://mcna.net/kids).

Member Newsletter

- **The Tooth Tribune:** Provides members up-to-date information on maintaining good oral hygiene and health, along with other informational articles from MCNA.

MCNA Dental's Crossword Puzzle

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, or 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

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mcnadental

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. If 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. This 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. They 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!

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Sample Tooth Tribune Member Newsletter

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TOOTH TRIBUNE

ORAL HEALTH TIPS AND NEWS FOR MCNA DENTAL FAMILIES

MAY 2016 · LOUISIANA EDITION

PROTECT YOUR PRECIOUS TEETH!

SUMMER IS FULL OF FUN ACTIVITIES LIKE BIKING, SWIMMING, AND TEAM SPORTS.

These activities can lead to injuries to your mouth and teeth. Your teeth can get cracked or broken if you do not take steps to protect them. A mouth guard is the best way to protect your teeth. Mouth guards are plastic pieces that fit over your teeth. Remember to take your mouth guard along for all of your summer activities, even when you go to summer camp!

SUMMER CHECKUP

SCHOOL WILL SOON LET OUT FOR SUMMER VACATION. ARE YOU READY?

One important thing to do this summer is to get your regular dental checkup. You should visit the dentist two times a year to keep your teeth and gums healthy. The dentist will clean your teeth and fix any problems like cavities. Now is a great time to schedule your appointment for the start of summer. Ask your parent or caregiver to call the dentist's office today!

MCNA CARES ABOUT YOUR PRIVACY

MCNA is committed to protecting member privacy. We want you to know that we have policies and procedures in place to protect your privacy. We have the responsibility to protect the security of your personal health information.

By law we have to:

- Keep your personal health information private
- Tell you about your rights regarding the health information we keep about you
- Tell you how your health information may be used and disclosed
- Tell you how to get access to your information
- Tell you about a breach of unsecure personal information that affects you
- Give you information about our Privacy Practices

You have the right to ask for a copy of our Notice of Privacy Practices. You can also go to our website to see our Notice of Privacy Practices at http://www.mcna.net/hipaa.

Protect your teeth and get dental checkups twice a year. Receiving preventive care is important to maintaining good oral health.

NEED A DENTIST?
CALL (855) 702-6262
OR VISIT WWW.MCNA.NET

Follow us for great oral health tips and news from MCNA. You will also be the first to learn about our fun contests and cool giveaways!

Toll-Free: (855) 702-6262 · TTY: (800) 955-8771 · Web: http://www.mcna.net

Partnering with the Caring Community

MCNA has a long history of outreaching to the underserved. We partner with **social and civic groups, resident associations, faith-based, and other community-based organizations**. MCNA proactively deploys MAOS to educate families throughout the communities we serve by organizing and supporting local health fairs and giving oral health presentations. MCNA also uses several call and mail campaigns to provide education and outreach to our members. These outreach programs have produced extremely positive outcomes in a cost-effective manner.

From Health Fairs to Missions of Mercy, MCNA partners with organizations dedicated to serving the underserved. Our partnerships enable us to serve not only MCNA members, but also the underserved in our communities at large. MCNA is **eager to "lock arms" with the caring community** in Nebraska to continue our rich tradition.

Our outreach efforts are valued by our community partners. Please see below two sample certificates from our community partners.

Certificate of Participation

during Beaumont Public Health Department's 3rd Annual

National Infant Immunization Week 2016

Presented to:

MCNA Dental

BEAUMONT

April 20, 2016

Date

Public Health Director

22	**Provide a flowchart and comprehensive written description of the DBPM's member grievance and appeals process, including the approach for meeting the general requirements and plan to:** • **Ensure individuals who make decisions about grievances and appeals have the appropriate expertise and were not involved in any previous level of review.** • **Ensure an expedited process exists when taking the standard time could seriously jeopardize the member's health. As part of this process, explain how the DBPM will determine when the expedited process is necessary.** • **Use data from the grievance and appeals system to improve the DBPM's operational performance.**

MCNA's Grievance System

MCNA is **committed to ensuring prompt resolution** of all grievances and appeals. Our Grievances and Appeals (G&A) Department provides a fair, thorough, timely investigation and resolution of all grievances and appeals lodged by our members and providers acting as their authorized representatives. We will comply with all state, federal and MLTC requirements. Our grievance system includes our grievance process, appeal process, and access to the State's fair hearing process. MCNA will provide access to MLTC and/or its designee to any information related to grievances or appeals filed by its members. **In 2015, our average turnaround time (TAT) across all lines of business for addressing grievances was 12.38 days, and the TAT for member appeals was 12.01 days.**

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. A provider can file a grievance on behalf of a member when they are acting as the member's authorized representative. MCNA sends an acknowledgement letter to the member within 10 calendar days of receipt of the grievance.

When a grievance is received by our G&A Department, the case is assigned to a Grievances and Appeals Administrator (Administrator). The Administrator enters the grievance into the G&A module of DentalTrac™, MCNA's proprietary management information system, 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 G&A module and creates a disposition letter that addresses the member's concern.

This comprehensive process ensures that grievances are resolved quickly and satisfactorily. We will address each grievance and provide notice, as expeditiously as the member's health condition requires, within State-established timeframes. MCNA makes every effort to notify members of the disposition of the grievance within our internal goal of 30 calendar days, but will ensure all grievances are resolved within the 90 calendar day timeframe required by MLTC.

Appeal Process

MCNA defines an appeal as a request for review of an action. Members may file an appeal, orally or in writing, within 60 calendar days from the date on MCNA's notice of action or inaction. Oral requests for a standard appeal must be followed-up by a written request (unless the member or provider requests an expedited resolution). An authorized representative or provider acting on behalf of the member, with the member's written consent, may file an appeal. MCNA will ensure that members' benefits are continued if applicable criteria are met as described in section IV.H of the RFP.

Members are provided with a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The member or their authorized representative may examine the case file, including dental records and any other material to be considered during the process. An acknowledgement letter is sent to the member within 10 calendar days of receipt of the appeal. MCNA's Administrator documents the nature of the appeal in the G&A module of DentalTrac™. At this time, the Administrator prepares a case file including all pertinent information and all supporting documentation (x-rays, narratives, dental records, member benefits, claims, and other relevant materials) and routes the case file for investigation and review by a Clinical Reviewer who is a **dentist with the appropriate clinical expertise**.

Our Dental Director, **Dr. Scott Wieting**, a Nebraska licensed dentist and immediate Past President of the Nebraska Dental Association, will supervise our experienced team of Clinical Reviewers. MCNA Clinical Reviewers apply **evidence-based** clinical criteria and ensure all supporting documentation submitted by the provider is thoroughly reviewed. The Clinical Reviewer will be a licensed dentist **who was not involved in the initial determination and is not a subordinate of the dentist who made the initial determination**.

Upon receipt of the review findings, the Administrator analyzes the information and documents the findings in the G&A module and creates a disposition letter. MCNA makes every effort to promptly resolve all appeals as quickly as possible and within the 30 day required timeframe. However, the Administrator may extend the resolution timeframe up to 14 calendar days upon member request or if MCNA shows that there is a need for additional information and the delay is in the member's best interest. In circumstances where MCNA requests the extension, within two (2) calendar days, members are provided with written notification of the reasons for the decision to extend the time frame. MCNA will make reasonable efforts to give the member prompt verbal notice of the delay. The notice informs the member of their right to file a grievance should he or she disagree with the extension. We 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. Unless an extension is granted, an appeal disposition is sent to the member no later than 30 days from the date of appeal receipt.

Expedited Appeal Process

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, no additional member follow-up is required. MCNA's toll-free Member and Provider Hotline Representatives will assist members and providers with this process. All supporting documentation from the member or provider explaining the

rationale for the expedited review is maintained in the member's record. The request for an expedited appeal is routed to a Clinical Reviewer (who did not make the initial determination) to determine 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 prompt verbal notice of the denial followed by a written notice of the reason for denial to the member within two (2) calendar days. This notice will also contain information regarding the member's right to a state fair hearing. 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 as expeditiously as the member's health condition requires and in no event longer than **72 hours**, unless the timeframe is extended in accordance with MLTC requirements.

Access to the State's Fair Hearing Process

Once a member exhausts MCNA's internal appeal process, our G&A Department sends an appeal disposition letter advising the member of their right to request a state fair hearing. The member or the member's representative may request a state fair hearing within 120 calendar days from the date of MCNA's notice of resolution. Our staff works with MLTC throughout the **State Fair Hearing** process ensuring that all required information is readily available to those reviewing the case.

Reversed Appeals

If either MCNA or the State's fair hearing process overturns a decision to deny, limit, or delay services, MCNA must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours from the date MCNA receives notice reversing the determination. If the services were received while the appeal was pending, MCNA must promptly pay for the services if the denial is overturned.

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. All activities conducted by the G&A Committee are reported to the Quality Improvement Committee (QIC). MCNA utilizes data to conduct root cause analysis in order to address systemic issues/barriers, improve operational processes, and increase provider and member satisfaction through additional training and education.

For example, a Texas general dentist was identified as having a high volume of appeal submissions in relation to sedation denials. The provider did not meet MCNA's clinical criteria for sedation, because the amount provided was in excess of the member's needs. MCNA's Texas Dental Director identified that the provider was incorrectly billing based on the CDT code descriptor for sedation. The QIC recommended targeted provider education as an intervention to reduce the appeals trend. The Texas Provider Relations team reached out to the provider. The effort succeeded in decreasing the provider's appeals volume while increasing their satisfaction level with MCNA. Please see **Attachment 22-1** for a flowchart that depicts MCNA's grievance and appeals process.

23	**Describe the approach the DBPM will take to provide members with grievance, appeal, and State fair hearing information. Address how the DBPM will ensure 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.**

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 make every effort to inform and assist our members and their authorized representatives in accessing the grievances and appeals 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, and other predominant member languages as defined in this RFP. A detailed description of our processes, including the timeframes applicable for filing member grievances and appeals, can be found in the Member Handbook. The handbook and all written notifications are provided in the member's primary language and are written to **ensure ease of understanding**. The handbook is also available in alternative formats such as Braille and audio upon request.

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 in fully understanding and accessing our process.** MCNA provides information about the process to the member's authorized representative upon request. Our Member and Provider Service Representatives are thoroughly trained to assist members and providers via our toll-free hotlines.

In Texas, Louisiana, and Iowa, MCNA employs experienced **Member Advocate Outreach Specialists** (MAOS) to ensure members receive **one-on-one personalized assistance** with submitting grievances and appeals and understanding plan benefits. **This proven, member-centered approach will be replicated in Nebraska.**

MCNA also provides resources for members with disabilities and those requiring linguistic and translation services by utilizing the following:

- TTY/TDD line capability for hearing impaired members
- MSRs who speak English, Spanish, and other predominant languages
- Free translation services available for over 200 languages to assist members with completing forms and other steps in the grievance process
- Large print or Braille materials for members with impaired sight

- Additional accommodations for members with special needs

Informing Providers and Subcontractors

MCNA will provide the following grievance, appeal, and fair hearing procedures and timeframes to all providers and subcontractors at the time of entering into or renewing a contract:

- The member's right to a state fair hearing, how to obtain a hearing and representation rules at a hearing.
- The member's right to file grievances and appeals and the requirements and timeframes for filing them.
- The availability of assistance in filing grievances or appeals, and participating in state fair hearings.
- The toll-free number(s) to use to file verbal grievances and appeals.
- The member's right to timely request continuation of benefits during an appeal or state fair hearing filing and, if MCNA's action is upheld in a hearing, that the member may be liable for the cost of any continued benefits received while the appeal was pending.
- Any State-determined provider appeal rights to challenge the failure of the organization to cover a service.

This information will be also made available online via MCNA's dedicated Nebraska website and in the Provider Manual which is incorporated into MCNA's Dental Provider Agreement. **MCNA is committed to providing exceptional services for our members and providers to continually improve satisfaction with the plan.**

24	**Describe the DBPM's proposed provider network outreach approach and recruitment strategy. Provide a detailed work plan for developing an adequate network within the timeframe described in Section IV.I. Describe the method the DBPM plans to use on an ongoing basis to assess and ensure that MLTC's network standards are maintained, including standards related to:** • **Distance.** • **Appointment access.** • **Cultural competency.**

Provider Network Outreach and Recruitment Approach

MCNA's Network Development Department will continuously recruit and contract with providers during the RFP process and throughout the life of the contract. MCNA is an industry leader in building robust network solutions for state partners. Our provider network development and management approach is based on the analysis of providers in the community that deliver services to the Medicaid population; the experience we gain by being on-the-ground; collaborating with providers, community leaders, and advocacy groups; and listening to our members and their families describe the challenges they face as they maneuver the dental care system. Building our network strategies around this feedback creates a strong foundation for the repeatable and sustainable success of our networks.

In Nebraska, we will deliver a statewide provider network that meets or exceeds all network adequacy standards within ninety (90) calendar days of the contract effective date. Equally important, we will focus on addressing underlying member access to care issues that may not be addressed fully within the state's network adequacy standards. Our network will include providers who traditionally serve the population covered by the Nebraska Medicaid program, including Federally Qualified Health Centers (FQHCs), Indian Health Clinics (IHCs), and public health and university based providers. MCNA will maintain a written agreement with all subcontractors performing duties covered by this contract. Our draft Nebraska Participating Provider Agreement is **Attachment 24-1** of this response, and our Network Development Plan is included as **Attachment 24-2**.

MCNA has assembled a **strong leadership team** in Nebraska comprised of well-respected dental providers from the state. These providers have spent their entire careers caring for Medicaid and CHIP populations and know these members deserve the same access to care as any other individual with commercial coverage. Our network providers share this philosophy, and as part of their contract with MCNA agree to provide timely care to our members in accordance with the waiting times and office hour requirements of this RFP.

MCNA's Credentialing Department has been certified by the **National Committee for Quality Assurance (NCQA)** for credentialing and re-credentialing since 2011. Our Credentialing Committee reviews every application received from providers seeking to participate in our network to ensure that MCNA enrolls qualified providers who meet all requisite criteria.

Ensuring Access to Care

MCNA will contract with a sufficient number of dental providers to ensure we meet Nebraska's Geographic Access Standards:

- **Dentists**: At a minimum, MCNA will contract with:
  - 2 Dentists within 45 miles of the personal residences of members in urban counties.
  - 1 Dentist within 60 miles of the personal residences of members in rural counties.
  - 1 Dentist within 100 miles of the personal residences of members in frontier counties.
- **Specialists**: At a minimum, MCNA will contract with
  - 1 oral surgeon, 1 orthodontist, 1 periodontist, and 1 pediatric dentist within 45 miles of the personal residences of members in urban counties.
  - 1 oral surgeon, 1 orthodontist, 1 periodontist, and 1 pediatric dentist within 60 miles of the personal residences of members in rural counties.
  - 1 oral surgeon, 1 orthodontist, 1 periodontist, and 1 pediatric dentist within 100 miles of the personal residences of members in frontier counties.

In order to maximize the amount of time we have to build a robust network prior to the go-live date, we have already begun the recruitment process with an initial focus on the state's urban areas, such as Omaha, Sioux City, and Lincoln. We have established relationships with several general dentists and specialists throughout Nebraska and met with the Nebraska Dental Association (NDA) to gain insight into the issues facing Nebraska's dental community. **Our Dental Director, Dr. Scott Wieting, is the immediate past president of the NDA and will help spearhead our recruitment efforts.** His relationships with the dental community are invaluable to MCNA's development process.

Unlike many of our competitors, MCNA does not limit our networks. We welcome providers who are willing to accept the rates we pay and meet our contractual terms and conditions, especially those providers who currently participate in the Medicaid program.

Our Director of Network Development will continually monitor geoaccess reports to verify that we have a sufficient number of specialists, pediatric dentists, and general dentists to care for our members. We repeat the RECRUIT process throughout the life of the contract to ensure that all new dentists in Nebraska will be given an opportunity to join our network.

The mission of our Provider Relations Department is to ensure access for members to all medically necessary covered dental services. MCNA understands that ensuring patient access to care requires a stable and geographically distributed network of providers who are committed to maximizing their appointment availability for our members.

MCNA routinely monitors member complaints, enrollment data, and changes in the existing provider network in order to maintain network compliance with an emphasis on "lagging counties." Lagging counties include counties in which there is a shortage of dental care providers.

We will ensure that all members, including those with special health care needs, have access to both general and specialty dental care. MCNA understands and agrees that the Nebraska provider network must provide a member with appropriate access to medically necessary covered dental services by making available qualified providers within the travel distance of the member's residence.

Out-of-Network Access

In cases where there is no dentist available within the required radius of the member's home, MCNA will arrange for the member to see an out-of-network provider in a timely manner. The cost to the member is no greater than it would have been if the services were furnished in the network. Emergency and post-stabilization services can be received at any time, from any provider, regardless of whether they participate in MCNA's network.

For all non-emergent out-of-network care, MCNA validates out-of-network providers' licenses and Medicaid status, and enters into a letter of agreement (LOA) outlining the terms of reimbursement and the requirement for non-participating providers to deliver services in compliance with state and federal

law, and MCNA policies and procedures. MCNA will comply with all RFP requirements, including timeframes, regarding provider availability for our members.

To proactively strengthen the provider network before deficiencies can arise, MCNA will continuously review new geoaccess reports of members and Nebraska Medicaid participating providers to identify specific regions where capacity can be enhanced. Applying the contract requirements outlined in this RFP, MCNA will then identify general and specialty care providers within these regions who have not yet contracted with MCNA, and invite them to participate in our network. Our Nebraska Provider Relations Representatives will reach out to identified providers in their areas, educate them about MCNA, encourage them to join the network, and guide them through the application process.

Compliance with Appointment Availability Standards

MCNA will ensure that our network providers have an appointment system for core dental benefits and services and/or expanded services which are in accordance with prevailing dental community standards.

Formal policies and procedures establishing appointment standards will be implemented upon approval from the State. If changes to policies and procedures are expected to have a significant impact on the provider network or member services, the State staff will be notified in writing 30 calendar days prior to implementation. MCNA will disseminate these appointment standard policies and procedures to our in-network providers and to our members. MCNA will monitor compliance with appointment standards and will have a corrective action plan when appointment standards are not met.

The following appointment and availability standards will be in place:

- Urgent care must be provided within twenty-four (24) hours [42 CFR §438.206(c)(1)(i)].
- Urgent care may be provided directly by the primary care dentist or directed by the DBPM through other arrangements.
- Routine or preventative dental services within six (6) weeks.
- Wait times for scheduled appointments should not routinely exceed forty-five (45) minutes, including time spent in the waiting room and the examining room, unless the provider is unavailable or delayed because of an emergency. If a provider is delayed, the member should be notified immediately. If a wait of more than ninety (90) minutes is anticipated, the member should be offered a new appointment.

In an effort to monitor appointment and availability standards, MCNA conducts quarterly "secret shopper" calls to validate the availability of a new Medicaid participant to be seen, services offered, and other contractual requirements such as appointment availability standards, after-hours availability, and office hours available for Medicaid participants versus private fee-for-service patients. On a quarterly basis, our Provider Relations staff contacts 25% of our unduplicated enrolled providers to monitor their after-hours coverage for compliance with contract standards. Our process ensures that 100% of network providers are surveyed annually. All results will be reported to the State in the format and frequency of its choice.

Our Experience in Other Markets

In Texas for 2015, MCNA has the following Appointment Availability survey results:

MCNA's 2015 Appointment Availability for Texas Medicaid				
Appointment Type	Texas Medicaid Standard	MCNA's Compliance		
		Total Surveys	Affirmative	Percentage
Emergency Visit	Within 24 Hours	3,440	3,385	98.40%
Routine Symptomatic	Within 14 Days	3,440	3,385	98.40%
Routine Asymptomatic	Within 30 Days	3,440	3,339	97.06%

As indicated by the results above, MCNA is very successful in ensuring provider compliance with appointment availability timeframes. Our dedicated Provider Relations Department delivers ongoing education and outreach to our provider network regarding their responsibilities. If providers are found to be non-compliant with the contract 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.

Partnering with FQHCs, IHCs, and County Health Departments

MCNA will seek out and engage all FQHCs, IHCs, and outpatient health programs or facilities operated by Tribes or Tribal organizations as defined under 42 U.S.C §1396(d)(l)(2)(b) that provide dental services in Nebraska and states contiguous to Nebraska to ensure that they have an opportunity to participate in the Nebraska Medicaid dental program. MCNA has a rich history of partnering with FQHCs, Rural Health Clinics, Indian Health Service Providers, and County Health Departments in the markets we serve. We recognize the significant benefits to our members of collaborating with entities that serve the Native American Indian population, including IHCs and FQHCs operated by federally-recognized tribes in Nebraska, and urban Indian organizations within the State, as well as neighboring states. Every effort will be made to partner with these critical community providers as part of our network development strategy.

Provider Non-Discrimination

MCNA's utilization management and claims adjudication methods allow us to carefully control costs for the clients we serve. We value our relationships with our contracted network providers and we recognize they provide care to some of the most vulnerable citizens within the communities they serve. For this reason, we focus on maximizing the financial and clinical efficiency of the dental program in order to achieve high levels of satisfaction among our members, providers, and the states we serve. MCNA's policies do not allow discrimination against any provider who services high-risk populations or

who specializes in conditions that require costly treatment, or based upon that provider's licensure or certification.

MCNA requires that all initial credentialing conditions be met before a provider can begin treating members. We do not and shall not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of their license or certification under the laws of Nebraska and other applicable law. Additionally, MCNA understands that if individuals or groups of providers are declined participation in the network, MCNA must give the affected providers written notice of the reasons for the decision. MCNA does not require providers to participate in other lines of business as a condition to participating in our Medicaid dental program.

Cultural Competence

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 network providers will be responsive to the unique needs of our members, including the capacity to communicate with members in languages other than English or Spanish, and those who are deaf or hearing impaired. As part of their contract with MCNA, providers must agree to deliver timely care to our members in accordance with the waiting times established by MCNA in compliance with state and federal requirements. We also assist providers by ensuring our members have access to interpreters in the dental office.

The MCNA Participating Provider Agreement 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.

All network providers are required to comply with MCNA's Cultural Competency Program, as well as Americans with Disabilities Act Requirements.

25	**Provide a comprehensive discussion of the DBPM's approach to maximizing the number of members participating in a Dental Home, including:** • **The strategy the DBPM will use initially, and on an ongoing basis, to ensure Dental Home participation.** • **Examples of successful strategies and lessons learned in encouraging Dental Home participation.**

Dental Home Program

MCNA is committed to recruiting providers from across the state of Nebraska to serve our Medicaid members. Our network will include a sufficient number of general and pediatric dentists to ensure all Nebraska members will have access to a primary care dentist (PCD) who will serve as their Dental Home provider. MCNA allows both general and pediatric dentists to serve as Dental Homes for our members.

[redacted]

MCNA actively encourages all primary care dental providers to participate as Dental Homes for our members. The role of the Dental Home in a member's life and the provider's responsibilities as a dental home provider are thoroughly detailed in MCNA's Provider Manual, and in educational training sessions and site visits routinely conducted by our Provider Relations Department.

We also understand that members are more likely to be engaged if they feel their dentists are equally as engaged and invested in their oral health. Twice annually, we will pull assignment reports and share them with Dental Home provider offices, encouraging outreach from their office to schedule routine appointments. Provider Relations will maintain an active log of those offices indicating a willingness to proactively outreach to assigned members. Those indicating an inability or an unwillingness to outreach

will be removed from the list of providers eligible for auto-assignment, with exceptions made only for critical access areas.

Dental Home Selection and Assignment

In keeping with the AAPD policy on Dental Home, MCNA supports and encourages a dental home for all its members. We understand that young children assigned and active with a dental home are more likely to maintain good oral health practices throughout their lives. The AAPD adopted their policy because children having a dental home will have higher quality outcomes through receipt of early examinations and preventive care, with fewer emergency room visits.

[redacted]

[redacted] MCNA will send a letter to the member informing them of their assigned PCD's contact information and their ability to change their PCD at any time by calling MCNA's Member Hotline. Upon assignment of a PCD or changes to a member's PCD, MCNA will reissue the member's ID card within 10 business days of the selection or auto-assignment. As part of the mailing of the reissued card, MCNA will explain the purpose of the new card, the changes between the new and previous card, and that the member should destroy the previous card.

[redacted]

Main Dental Home Roles and Responsibilities

Within the Dental Home, dental care experts work together as a team with a member's family to ensure that each child receives the services he or she needs. The Dental Home provides culturally competent, individualized care to patients based upon their needs as assessed through a dental examination. The dental examination specifically evaluates the patient to identify any decay or gum disease. The Dental Home/PCD is responsible for providing comprehensive preventive, acute, and corrective care, and refers members to specialists as needed for services outside of the PCD's scope of practice.

In accordance with standards of practice and policy guidelines set forth by the American Academy of Pediatric Dentistry and the American Dental Association, **the PCD must also educate the member about the importance of receiving timely preventive care, how to properly care for the member's teeth and gums, and the benefits of a healthy diet (avoidance of sugar and acidic foods such as soda).**

Our participating dentists have the responsibility to develop a dentist/patient relationship based on trust and cooperation. Coordination of care strengthens the positive relationship between the member, the member's parent or guardian, and the provider. This coordination is a critical tool for achieving positive oral health outcomes.

For our pediatric members, it is important for the dental home provider to educate parents and guardians about their child's growth and development with respect to tooth eruption, exfoliation, and jaw growth. This anticipatory guidance helps families and caregivers fully understand the need for ongoing, routine dental care and proper oral hygiene.

Prompt Referral for Specialty Care

As part of our Dental Home approach, PCDs must assess the dental needs of members for referral to specialty care providers and complete the referrals on a timely basis. MCNA requires all PCDs to

register referrals with our Utilization Management (UM) Department, and to coordinate a member's care with specialty care providers after a referral is approved. Providers are able to submit referrals via MCNA's free, online Provider Portal or by paper. **Our Utilization Management (UM) Department processed 67,950 referrals in 2015 with an average turnaround time of 0.99 business days.**

All network providers are informed about the referral process during initial orientation with MCNA. Providers also have access to information about the requirements of the referral process with MCNA in our Provider Manual, including specific documentation requirements by specialty that may apply. Our dedicated Provider Hotline Representatives are available to answer questions about referring members for specialty care and can connect callers with the UM Department when necessary. Providers will find our call center courteous, prompt, and expertly trained.

MCNA's UM Department monitors provider referral patterns as a part of their regular review of key clinical and service indicators. Member complaints and grievances are also monitored for any trends with respect to concerns over not receiving a referral for specialty care and for timeliness issues related to referrals. Any provider identified as non-compliant will be given additional targeted education from their local MCNA Provider Relations Representative.

Lessons Learned: First Dental Home Initiative

MCNA's growth in the states we serve is the product of our tireless effort to learn from our experiences serving children and adults, and applying those lessons to maximize the effectiveness of our plans. MCNA's experience with Dental Home programs in our Texas and Louisiana programs have taught us that it is essential to actively engage patients with their Dental Home provider at a very early age.

Our dental home approach includes members of all ages, however, we recommend the unique approach Texas has taken for our youngest members. The Texas program is known as the First Dental Home Initiative and promotes the establishment of a dental home to provide opportunities for early intervention and prevention of dental disease in children 6-35 months of age.

The Texas program is unique in that general and pediatric dentists are required to complete certification as a Texas "First Dental Home Provider." The certification is issued by the Texas Health and Human Services Commission (HHSC) following a comprehensive training program. [redacted]

26	**Describe the DBPM's required Dental Home responsibilities and how the DBPM will verify Dental Home providers are performing them.**

Dental Home Responsibilities

MCNA promotes the establishment of a dental home for all members. Especially, our youngest members ages 6-35 months. MCNA allows both general and pediatric dentists to serve as Dental Home providers. Members are encouraged to select their own primary care dentist (PCD) to serve as their Dental Home. They may change their PCD any time by contacting MCNA's tool-free Member Hotline. If a member fails to select a PCD, MCNA will assign one based on an MLTC approved auto-assignment methodology.

Dental Home providers are required to educate members about the importance of good oral hygiene and timely preventive care such as sealants, cleanings, and fluoride applications. For members ages 6-35 months of age the education efforts are focused around providing anticipatory guidance to the parents or guardians in order to establish a lifetime of healthy dental habits.

All PCDs are required to educate members about what to do in a dental emergency. The PCD is responsible for coordination with other involved health care providers in the case of acute dental trauma or in situations involving members with cleft or craniofacial anomalies.

Within the Dental Home, dental care experts work together as a team with a member's family to ensure that the child receives the services he or she needs. Dental Home providers must assess the dental needs of members for referral to specialty care providers and provide referrals as needed. The PCD must ensure that an appropriate referral is made as expediently as the patient's clinical condition requires. The PCD/Dental Home must coordinate the member's care with specialty care providers after a referral takes place and ensure that all appropriate treatment was received.

Monitoring Dental Home Compliance

MCNA tracks provider Dental Home compliance with a variety of tools, including dental record reviews, member complaints, and claims data. 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, MLTC requirements, and state and federal law. MCNA's

dental record documentation requirements will be distributed to providers via their dental provider agreement, Provider Manual, and MCNA's Provider Portal. **Our record review process enables MCNA to ensure that primary care providers are adhering to our Dental Home requirements.**

Routine dental record reviews enable MCNA to verify that provider treatment is delivered in accordance with our dental guidelines and generally accepted practice parameters. 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. We 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:

- Chief complaint or purpose of the visit
- Diagnoses or medical impression (exam for decay and gum disease)
- Patient assessment findings including medications prescribed
- Studies ordered and results of those studies (e.g. labs and x-rays)
- Dental health education provided (oral hygiene guidance)
- Member identifying information
- Primary language spoken by the member and translation needs, if any
- Medical history
- Referrals and care coordination history
- Documentation of anticipatory guidance to parents of members ages 6-35 months
- Documentation of caries risk assessment as applicable

The reviews will be conducted for all offices. Each office will be reviewed at least once every three years. MCNA reviews a minimum of five (5) to ten (10) records for each office 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 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 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. Reports will also be provided to MLTC in any frequency requested.

MCNA tracks and trends all member complaints to evaluate any patterns with respect to particular Dental Home/PCD providers. If a pattern of dissatisfaction exists, or if a pattern of members leaving a Dental Home provider for a new PCD is identified, MCNA will follow-up with members to learn more

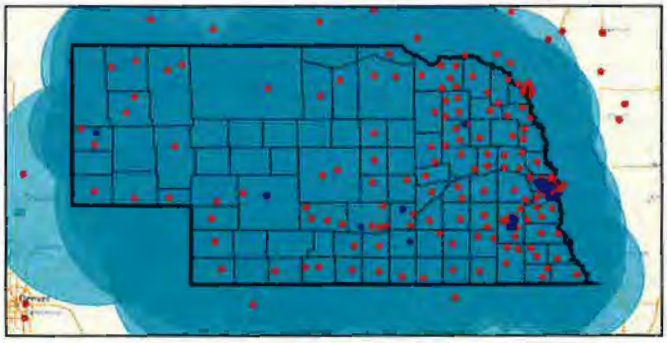
about the situation. Our Provider Relations Department will evaluate the findings and develop a remediation plan to educate the PCD on member retention and satisfaction strategies. Any quality of care issues identified are promptly investigated and the provider will be subject to corrective action which may include termination from MCNA's network.

Please see **Attachment 26-1** for a sample Dental Record Review Audit form used by MCNA in our Louisiana Medicaid and CHIP program.

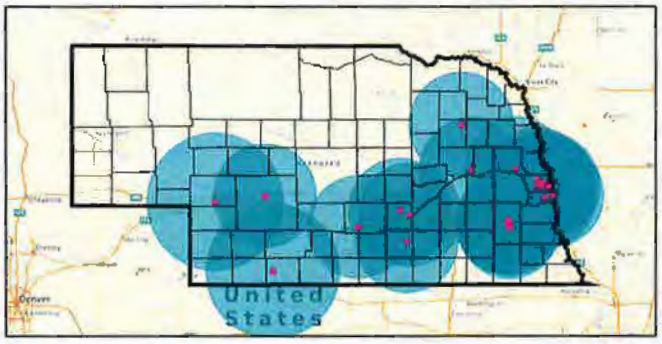
27	**Describe innovative strategies the DBPM's intends to use to identify specialty types for which member access is limited. Describe the DBPM's intended initiatives for increasing the number of specialists within those specialty types that participate in the DBPM's network.** **Identify potential challenges the DBPM anticipates in ensuring members receive appropriate care for specialties where access concerns exist, and explain how the DBPM will mitigate those challenges.**

We make every effort to ensure that care is available to our members within the time and distance standards required by MLTC. MCNA utilizes our sophisticated geomapping approach to identify specialties where member access is limited. Our proprietary mapping software calculates the distance from each member's residence to the nearest specialty care provider.

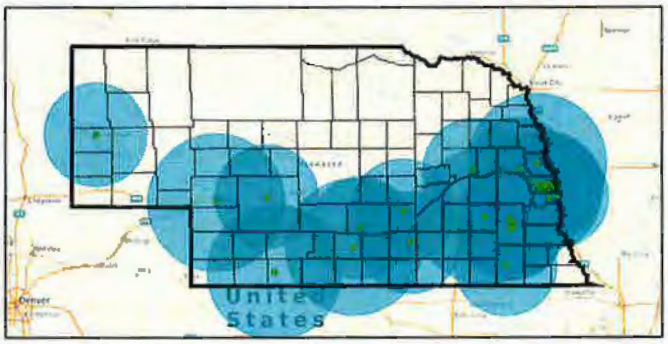
MCNA has analyzed access to specialty care in Nebraska and the following maps depict the geographic coverage of available dental specialists in relation to each zip code in the State. The providers illustrated in the sample maps below were obtained from the following website: https://www.insurekidsnow.gov. Each provider location is represented by a dot with a color that corresponds to the provider's specialty. The shaded circles indicate areas where coverage is available by a specialty provider based on the provider's location, since member addresses are unavailable.



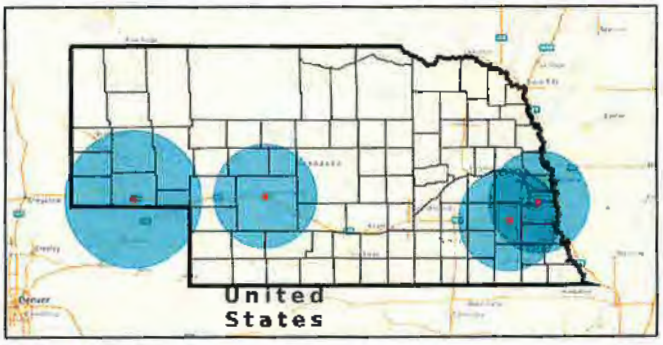
Primary Care Dentists
(General Dentists are Red, Pediatric Dentists are Blue)



Oral Surgeons



Orthodontists



Endodontists

Periodontists

Prosthodontists

As indicated by the maps, access to certain specialty provider types is extremely limited due to the State having a low volume of that specialty. Based on the data analyzed from Insure Kids Now, there are only four licensed endodontists in the State, seven licensed periodontists, and ten licensed prosthodontists. However, patterns of care based on our conversations with practicing Nebraska dentists indicate that the majority of these services are provided by general and pediatric dentists. MCNA allows both pediatric and general dentists to serve as Dental Homes (primary care dentists) for our members. In addition to situations where licensed providers are in short supply, access issues may also occur following the death, injury, illness, or involuntary relocation of a provider, when a provider chooses not to participate in MCNA's network, or when a provider must be terminated immediately due to quality of care issues.

To address access challenges, our Network Development Department monitors the performance of our network continuously to ensure that 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**.

In most instances participating general dentists provide the specialty services being sought. For situations where specialty services are unavailable due to the provider choosing not to join our network, MCNA will ensure that all members in the identified area can access the 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 Nebraska Board of Dentistry, MLTC's Medicaid provider list, and member requests.

Once a suitable non-par provider is identified and contacted, we perform a thorough background check of their credentials to ensure the member will receive the highest quality of treatment. If the non-par provider satisfies our credentialing requirements and there is mutual agreement with respect to the reimbursement rate for the services, an LOA is executed between MCNA and the provider, and the services may commence at no cost to the member.

28	**Describe the DBPM's process for monitoring and ensuring adherence to MLTC's requirements regarding appointment availability and wait times.**

Appointment Availability and Access to Care

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 are contractually required to meet the appointment availability and wait time standards set forth in Attachment 4 of this RFP. MCNA will include a provision in our dental provider agreement to ensure that our Nebraska Medicaid members are able to receive dental services on a timely basis as follows:

- Urgent Care must be provided within 24 hours [42 CFR §438.206(c)(1)(i)]; urgent care may be provided directly by the primary care dentist or directed by MCNA through other arrangements.
- Routine or preventative dental services within six (6) weeks.
- Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with appointment availability standards above.
- Wait times for scheduled appointments shall not exceed 45 minutes, including time spent in the waiting room and the examining room, unless the provider is unavailable or delayed because of an emergency. If a provider is delayed, the member shall be notified immediately. If a wait of more than 90 minutes is anticipated, the member shall be offered a new appointment.

MCNA will educate our Nebraska providers about the appointment availability and wait time standards. These provisions will be included in our Provider Orientation training sessions, the Provider Manual, and will be discussed in our monthly provider newsletter, *Dental Details*.

Our dental provider agreement also prohibits hours of operations that are less than the hours of operations offered to fee-for-service patients to discourage wait listing of our Medicaid members. MCNA monitors to ensure that our members are not placed on wait lists to receive covered services. This question is included on our site audit survey tool. If a provider utilizes wait lists, and the covered service is available through another network provider, MCNA will stop referrals to the provider until the provider has schedule availability to serve our members without the need for a wait list. We will refer members to other appropriate providers so that they can receive timely care without the need for a wait list. Please see **Attachment 28-1** for MCNA's Draft Nebraska Site Audit Survey Tool.

Ensuring Compliance

[redacted] Additionally, the survey results must be kept on file and be readily available for review by MLTC upon request. MCNA understands that we may be subject to sanctions for noncompliance of providers with applicable appointment and wait time requirements set forth in this RFP.

MCNA's Member Handbook includes the appointment availability standards and outlines the extent to which and how after-hours and urgent dental care can be obtained when medically necessary. We ensure provider compliance with after-hours access and telephone coverage standards by monitoring member complaints about appointment access on a daily basis to identify and address trends in collaboration with our Quality Improvement and Provider Relations departments. In collaboration with Provider Relations, MCNA's Care Connections team monitors compliance with appointment standards through "secret shopper" calls, feedback from member satisfaction surveys, and complaints.

MCNA will provide available, accessible, and adequate numbers of service locations, service sites, and dental professionals for the provision of core dental benefits and services. We will take corrective action if providers fail to comply with these standards. If providers are found to be non-compliant with the contractual standards for 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 for 30 days. If the provider passes the initial 30-day review, a final review will occur in six (6) months to ensure ongoing compliance.

29	**Describe the DBPM's approach to promoting and facilitating the capacity of its providers to provide:** • **Patient-centered care.** • **Improved health outcomes.** • **Member compliance.** • **Member satisfaction.** **Discuss the DBPM's successes with patient- centeredness in other Medicaid programs, what lessons have been learned, and the DBPM's planned approach in Nebraska.**

Helping Providers Improve Outcomes

MCNA is poised to offer innovative integrated care programs and services that will maximize the long-term viability, success, and value of the Nebraska Medicaid dental program. Our community-based model pairs local expertise and relationships with national resources and best practices. These solutions are the product of our years of experience in establishing commercial and state-sponsored dental programs. We successfully execute complex benefit programs for Medicaid participants.

We not only contract with providers, **we partner with them**. Our comprehensive Provider Manual sets forth the policies and procedures that providers need to serve our Nebraska members. In addition to the Provider Manual, MCNA utilizes provider bulletins, fax blasts, email, our YouTube channel, social media, and our provider newsletter, "Dental Details," to ensure that Nebraska's dental community is kept abreast of program requirements, industry trends, and innovations in dentistry.

Our Provider Hotline team is skilled in assisting dentists and their office staff with any needs that may arise. We will employ Nebraska based Provider Relations Representatives who will travel throughout the state providing education, training, and resolution of issues through face-to-face meetings with providers.

Our Dental Home model is focused on **patient- and family-centered care**. Each member's care plan is based on the individual's need as evaluated through an exam for tooth decay and gum problems. MCNA's Nebraska Plan President, Dr. Philip Hunke, helped develop and finalize the American Academy of Pediatric Dentistry's dental home guidelines during his tenure as President. For additional detail about our approach, please see our responses to Questions 25 and 26.

We believe in holistic, whole-person care. In full recognition of the nexus between physical health and oral health, MCNA developed a comprehensive case management program for members with special health care needs focused on maintaining the connection between the member's health plan case manager and our team of skilled professionals. The Case Management team outreaches to physicians and other providers who serve our members to ensure coordination of care. This high touch approach

is particularly useful in assisting members with cranio-facial anomalies that often require surgery and medical care in addition to complex dental services.

We drive improvements in quality and oral health outcomes in many ways. MCNA implements meaningful Performance Improvement Projects (PIPs) which **promote and facilitate the capacity of our providers** to achieve our primary goal of increasing the utilization of preventive care services and improving the oral health outcomes of our members. MCNA's PIPs utilize a variety of strategies, including outreach, targeted program incentives, and provider involvement to ensure the delivery of **patient-centered care**. We utilize industry standard metrics to continually measure the number of members who see the dentist and receive exams, sealants, fluoride, and prophylaxis services.

MCNA utilizes multiple channels to outreach to members who are in need of care. Our main goal for children is to **drive member compliance** with the periodicity schedule. We outreach to members through a dedicated outbound call team known as Care Connections. MCNA Member Advocate Outreach Specialists will be deployed across Nebraska to engage members in their communities through participation in health fairs and community events. Our network providers are actively engaged in our campaigns and we routinely incorporate their suggestions for **improving health outcomes** into our planned interventions.

MCNA invests in provider education and training to **increase provider and member satisfaction**. With this long-term perspective in mind, MCNA will conduct initial and ongoing provider orientations and online training seminars (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 reference and educational materials on our web-based Provider Portal. These materials include provider manuals, program descriptions, claim submission guidelines, "how-to" video tutorials, ADA claim form completion instructions, and claim coding and processing guidelines.

[redacted]

mcnadental

HealthKids

DENTAL APPOINTMENT FORM

It is time for your child to go see the dentist. Your child needs a dental checkup every 6 months for healthy teeth and gums.
There is no cost for your child's dental checkup!

FROM:

DR. _____

OFFICE: _____

REASON FOR APPOINTMENT: _____

_____

TO:

DENTAL APPOINTMENT: **DATE:** _____ **TIME:** _____

A list of MCNA Dental network dentists is attached. Choose one to treat your child.
When you call the office to make an appointment write the date and time here as a reminder.
You can also call MCNA Dental's Member Hotline at 1-855-858-6262 to ask for help choosing a dentist and with scheduling an appointment.

Please make a dental appointment as soon as you can. Good oral health is very important for your child's overall health.

DENTALLINK

30	**Describe how the DBPM would respond to the network termination or loss of a large- scale provider group. Take the following areas into consideration in the response:** • **Notification to MLTC.** • **The automated systems and membership supports used to assist affected members with provider transitions.** • **Systems and policies used for continuity of care of members experiencing provider transitions.** • **Impact if the loss is in a geographic area where other providers of the same provider type are not available and the DBPM's response to that impact.**

Handling a Termination or Loss of a Large-Scale Provider Group

MCNA is proud to provide our members with access to highly qualified, fully credentialed networks of participating general dentists and specialists. MCNA has a proven track record of establishing and maintaining networks of qualified dental providers across every state in which we operate. MCNA's Network Development and Management policies and procedures comply with 42 CFR §438.214(a) and (b). MCNA 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. **To date, MCNA has never experienced a material change in our network in any of our existing markets.** We will provide geomapping and coding of all network providers for each provider type by the deadline specified in Section IV.V in order to geographically demonstrate network capacity. Throughout the life of the contract we will provide updated geomapping and coding reports to MLTC on a quarterly basis in the event of any material changes to the network, and upon MLTC request. A material change is defined as:

- Any change that would cause more than five percent (5%) of members to change the location where services are received or rendered.
- A decrease in the total of individual dental homes by more than five percent (5%).
- A loss of any participating specialist which may impair or deny the members' adequate access to providers.
- Other adverse changes to the composition which may impair or deny the members' adequate access to providers.

Utilizing the advanced geoaccess analytic capabilities of the Network Management module in DentalTrac™, the Network Development team can quickly define, model, and implement effective provider networks based on product-specific criteria. The Network Development team reviews monthly geoaccess reports to identify any specific areas where capacity should be enhanced. Our Director of Network Development and Director of Quality Improvement 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 significant providers in shortage areas or a large-scale provider group, 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 a large-scale group may or may not have a material effect on network access depending on the geographic location of the group and distribution of network providers in the affected area. Access may be available in neighboring geographical areas within the time and distance requirements of the RFP. When there has been a significant change in operations such as expanded services, payments, or eligibility of a new population that could affect network capacity, MCNA will provide assurances to MLTC that these changes will not impact the access available through our network.

When MCNA has advance knowledge that a material network change will occur, our Director of Network Development will submit to MLTC a request for approval of the material change in the provider network, including a draft notification to affected members, at least 60 days prior to the expected implementation. The request 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 request will also include a draft notification to be sent to affected members 30 days prior to the expected implementation of the change. In the event of an emergency material change where advance knowledge is unavailable, MCNA will work with MLTC to expedite the process of requesting approval of the change and member notice.

Any notification to MLTC 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 MLTC at any time there has been a significant change in MCNA's operations affecting adequate capacity and services.

MCNA provider agreements include a provision requiring providers to give a 90-day advance written notification of their intent to terminate the contract. Upon receipt of a 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 providers who meet the time and distance standards of the RFP.

If a network termination or loss of a large-scale group impacts our access to care standards, MCNA will treat the situation as a material network change. **We will communicate the issue to MLTC within seven (7) business days.** MCNA will also notify MLTC within seven business days of any other unexpected changes that would impair our provider network as outlined in 42 CFR §438.207(c) and this RFP. This notification must include an explanation of how the provider network change will affect the delivery of covered services and MCNA's plan for maintaining the member's access to quality care, if the change is likely to affect the delivery of covered services.

Assisting Members with Provider Transitions

MCNA will give notice to our members within 15 calendar days after receipt or issuance of a termination notice to or from a provider, and ensure that the terminating provider completes treatment for members

in active care. We understand the impact that contract terminations can have on our members. To ease the transition, MCNA's MLTC-approved notification to affected members will contain a list of alternate network providers available within their surrounding area. The notice will also include information on how to contact MCNA's Member Hotline for assistance with selecting a new provider. Members with special health care needs or those who may be undergoing active treatment plans are assured of our commitment to continuity of their care.

When a provider is terminated by MCNA or gives us notice of their intent to terminate their participation, the Credentialing Department updates DentalTrac™ with the termination date. This documentation allows for an automated process by which our system identifies terminated providers. When the provider is a general dentist or pediatric dentist, the system flags all members that are assigned to the provider's panel who have received services within 18 months of the termination date and generates a Notice of Termination of Dentist, which is mailed to each member. When the provider is a specialist, the system uses claims data from the past 60 days to populate a list of members seen by the provider. A Member Notification of Specialist Termination is generated and sent to each identified member. The member's record in DentalTrac™ is updated to reflect the date the notice was mailed. Notification letters will also be made available to members via our online, secure Member Portal and Mobile App.

Ensuring Network Adequacy and 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 to 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. 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 coverage is still not available, MCNA will ensure that all members in the identified area can access non-participating providers 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 Nebraska Dental Association, MLTC's Medicaid provider list, and member requests.

Once a suitable non-participating provider is identified and contacted, we perform a thorough background check of their credentials to ensure our member will receive the highest quality of treatment. If the non-participating provider satisfies our credentialing requirements and there is mutual agreement with respect to the reimbursement rate for the services, an LOA is executed between MCNA and the provider, and the services may commence at no cost to the member. **MCNA will not hesitate to contract with a non-participating provider where network providers are not available in order to ensure that the member's oral health needs are met in a timely manner.**

31	**Describe the DBPM's credentialing and re-credentialing process including:** • **Ensuring that providers are enrolled in Medicaid and have a valid identification number.** • **Obtaining information on ownership and control.** • **Identifying excluded providers and persons convicted of crimes searches.** • **Using quality and utilization measures in the recredentialing process.**

Provider Credentialing and Re-Credentialing

MCNA's Credentialing Department has been NCQA-certified for credentialing and re-credentialing since 2011, and URAC accredited since 2014. This underscores our continuous commitment to operating under the highest quality standards in our industry and to ensuring the best service possible for our members, providers, and clients.

MCNA's Network Development team continuously strives to identify and recruit providers who are able to treat members with a variety of dental needs. Our first and foremost commitment is to provide access to quality care for our members. We credential general and specialty dental providers who may treat our members at dental offices, hospital and ambulatory surgical settings, IHS (Indian Health Service) facilities, FQHCs, and RHCs.

We look forward to expanding our community of participating dental providers across the country who accept Medicaid and CHIP beneficiaries, and will work to recruit all providers, including those not currently enrolled with the Nebraska Medicaid Program. All new providers will be credentialed in accordance with MCNA's credentialing and re-credentialing process.

MCNA's credentialing and re-credentialing policies and procedures detail the process for approval of new providers, and termination or suspension of providers. We encourage board certification as applicable. Our written credentialing and re-credentialing process complies with 42 CFR §438.12, §438.206, §438.214, §438.224, and §438.230, and governs our review of all licensed providers with whom we contract or employ. Any annual changes to our process will be submitted to MLTC for review and approval prior to implementation.

Our Credentialing Committee reviews every application received from providers seeking to participate in our network to ensure that MCNA enrolls qualified providers who meet all requisite criteria. To join MCNA's network of Nebraska dental providers, we will ensure, at a minimum, that the provider:

- Completes a credentialing application (paper, via our online electronic Credentialing Portal, or through CAQH).
- Completes the Enrollment Disclosure Form to clearly identify **ownership and control** details.
- Possesses the licenses and credentials necessary to render dental services under State law.

  - MCNA checks Dental License, DEA License, Controlled Substance Registration, and Sedation Permits at initial and re-credentialing time, and whenever the license expires mid-cycle.
- Is not suspended or excluded from federal healthcare programs, including Medicare and Medicaid.
  - MCNA queries the OIG, EPLS, and SAM databanks, and the Medicare Opt-Out List, at initial and re-credentialing, and as needed mid-cycle, to ensure that all providers identified are appropriately denied participation, or are contacted for removal from participation.
- Possesses current professional liability insurance.
  - MCNA checks documentation of insurance including limits, the provider's name, policy number, and expiration dates at initial and re-credentialing time, at the time of site audit by a Provider Relations Representative, and annually upon expiration.
- Is not under any current sanction or has a history of sanctions that would preclude them from participation in our network.
  - MCNA monitors the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank for information about sanction history and acts accordingly.
- Is enrolled to participate in the Nebraska Medicaid program
  - We will begin our credentialing process concurrently with the provider's Medicaid enrollment rather than requiring the provider to first complete enrollment in Medicaid.

MCNA's Nebraska Credentialing Committee will be chaired by our Dental Director, Dr. Scott Wieting. Once the verification process is complete, MCNA's staff presents a comprehensive applicant package to the Credentialing Committee for a final determination. A letter is then generated to each applicant notifying them of the approval or denial of the request for network participation.

Loading provider contract data and their respective business rules correctly is essential to ensuring a successful implementation. Our Provider Relations and Credentialing departments have well-documented policies and procedures that include the many checks and balances necessary to successfully verify that the correct provider data has been loaded. Our business operations, supported by our MIS, enforce business rules that result in **cleaner, faster, and error-free processes for loading provider data**. The provider file configuration process begins after a provider contract and credentialing application is received, and includes the following series of activities in the credentialing workflow:

- Review of contract and credentialing applications for completeness
- Verification of provider demographics and locations
- Verification of required licenses and identifiers (including National Provider Identifier, Taxonomy code, Medicaid ID Number, State License Number)
- Verification of education and malpractice insurance coverage
- Review of National Provider Databanks, Office of Inspector General (OIG), Excluded Parties List System (EPLS), and System for Award Management (SAM)
- Verification of program participation and fee schedules

- Presentation of the provider file to our Credentialing Committee for participation approval
- Notification to the provider of the Committee's decision within 5 business days

As the above major processes are completed, all data is incorporated into MCNA's management information system (MIS), DentalTrac™, to update the provider's record.

MCNA's credentialing and re-credentialing process contains a dispute and appeal process for sanctions, suspensions, and terminations imposed against network providers as specified in the contract. We understand that this process must be submitted for review and approval 30 calendar days from the date of award. This process will be detailed in MCNA's Provider Manual once approved.

MCNA understands that if credentialing is delegated to a subcontractor that credentials its own providers, there must be a written description of the delegation within the contract. We will require that the subcontractor ensure that all licensed dental professionals are credentialed in accordance with MLTC's credentialing requirements and NCQA standards, and MLTC will have final approval of the delegated entity.

MCNA will report any quality deficiencies which result in suspension or termination of a network provider to MLTC. We will submit a draft reporting process for review and approval 30 calendar days prior to the contract start date.

Re-Credentialing Cycle

MCNA re-credentials network providers every 36 months through a process that updates information obtained in initial credentialing, considers performance indicators such as those collected through the Quality Improvement (QI) program; the Utilization Management system; complaints, grievances, and appeals; enrollee satisfaction surveys; and other pertinent information. MCNA acknowledges that our credentialing and re-credentialing processes must be approved by MLTC.

MCNA's DentalTrac™ system maintains an initial credentialing date for all providers. A letter notifying a provider of the need to re-credential is generated and mailed six months prior to the expiration date of the current credentialing cycle. This letter contains information about how to complete the re-credentialing application, and how to submit re-credentialing information via MCNA's online Credentialing Portal.

If a provider has not completed the re-credentialing requirements within 90 days prior to the expiration of the current credentialing cycle, MCNA's dedicated Provider Relations Representative will reach out to the provider and offer additional assistance in completing the re-credentialing process. This process is repeated 30 days prior to the expiration of the current credentialing cycle if the provider still has not submitted all required information. Once the re-credentialing requirements are complete, the provider's file is submitted to MCNA's Credentialing Committee for a final determination. A letter notifying the provider of their status is sent within 5 business days of the Committee's determination.

MCNA's Provider Hotline Representatives and Provider Relations Representatives will assist providers as needed in completing the credentialing and re-credentialing processes.

32	**Explain the process the DBPM will put in place to maintain the provider file with detailed information on each provider sufficient to support provider payment, including issuance of IRS 1099 forms, meeting all federal and MLTC reporting requirements, and cross referencing State and Federal identification numbers to ensure excluded providers are identified.**

MCNA's credentialing and re-credentialing process gathers a significant amount of data on all providers who seek participation in our network. Our credentialing application and online Credentialing Portal collect all provider demographic data necessary to facilitate payment and issuance of IRS 1099 forms. The information collected includes: full name, license number, home address, office address, legal entity name of dental practice, billing address, National Provider Identifier (NPI) number, Medicaid provider number, Tax Identification Number (TIN), Employer Identification Number (EIN), and other relevant data.

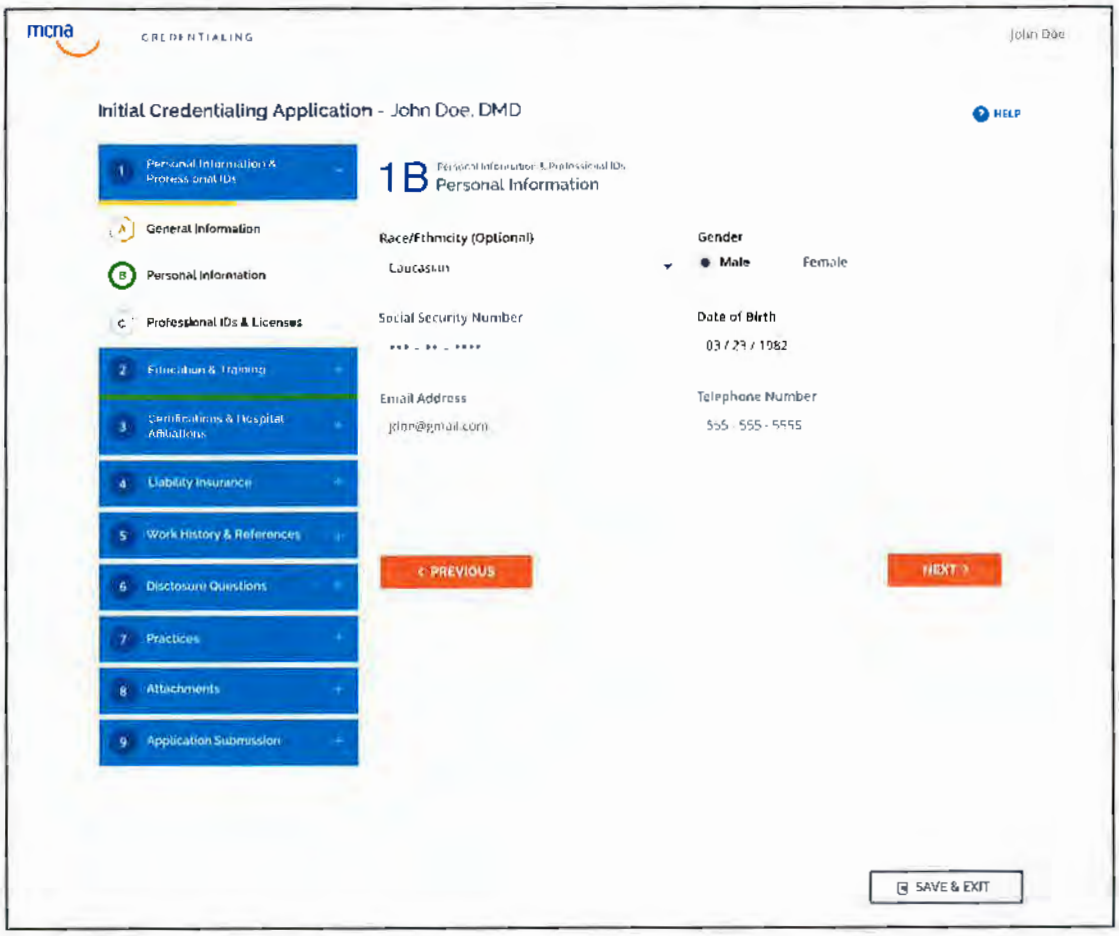
Loading provider contract data and their respective business rules correctly is essential to ensuring a successful implementation. The provider file configuration begins when a provider contract and credentialing application is received, beginning a series of activities in the credentialing workflow:

- Review of contract and credentialing applications for completeness
- Verification of provider demographics and locations
- Verification of required licenses and identifiers (including National Provider Identifier, Taxonomy code, Medicaid ID Number, State License Number)
- Verification of education and malpractice insurance coverage
- Review of National Provider Databanks, Office of Inspector General (OIG), Excluded Parties List System (EPLS), and System for Award Management (SAM)
- Verification of program participation and fee schedules

As the above major processes are completed, the Credentialing Data Entry team loads the data into our MIS. Additional operational activities take place at this time, including the presentation of the provider file to our Credentialing Committee for participation approval. All approved providers receive ongoing review throughout the life of their contract with MCNA to ensure that they remain in good standing and are not excluded or debarred.

All documentation, policies, and procedures with regard to provider contract loading and our business rules will be available to MLTC as part of the Readiness Review activities prior to go-live. MCNA reviews, approves, and periodically recertifies the credentials of all participating dental providers. We perform re-evaluation of provider's credentials at least every 36 months through a process that updates information obtained in initial credentialing, considers performance indicators such as those collected through the Quality Improvement (QI) program, the Utilization Management system, complaints, grievances, and appeals, enrollee satisfaction surveys, and other pertinent information. All credentialing and re-credentialing activities comply with the standards set forth by state and federal requirements.

MCNA's Credentialing Department has been NCQA-certified for credentialing and re-credentialing since 2011, and URAC accredited since 2014. We look forward to serving Nebraska members and providers. Please see below a screenshot of MCNA's online Credentialing Portal.



33	**Describe the DBPM's Provider Services toll-free telephone line, including:** • **How the DBPM will provide a fully- staffed line between the hours of 7:00 a.m. and 7:00 p.m. CST. Monday through Friday, to address non-emergency issues.** • **How the DBPM will ensure that provider calls are acknowledged and resolved within three business days of receipt.** • **The location of operations, and if out of state, describe how the DBPM will accommodate services for Nebraska.** • **How the DBPM will measure and monitor the accuracy of responses provided by call center staff, as well as caller satisfaction.**

Dedicated Nebraska Provider Hotline

MCNA's two fully integrated call centers, located in Texas and Florida, offer our dental professionals timely and accurate responses to all inquiries, questions, and concerns. To ensure providers receive prompt services, MCNA has established a toll-free Provider Hotline (844-353-6262) dedicated to our Nebraska providers. The hotline will be fully staffed from 7am - 7pm CST; Monday through Friday, excluding state approved holidays.

Timely Call Resolution

MCNA's interactive voice response (IVR) system is available 24x7x365 and provides a voice message system that informs providers of our business hours. It also offers an opportunity to leave a message after business hours, and all messages are returned within one (1) business day. When providers call our dedicated Nebraska toll-free Provider Hotline, our Interactive Voice Response (IVR) system answers within 3 rings and offers a series of prompts to ensure calls are routed correctly. Providers can choose to utilize our IVR system to verify eligibility and benefits or to speak with a Provider Service Representative.

MCNA's Provider Hotline is capably staffed by our Provider Services Representatives (PSRs). Our corporate culture focuses on giving our employees career path opportunities. All PSRs begin as Member Services Representatives. Once selected to be part of the Provider Hotline staff, the employee undergoes another two weeks of classroom training regarding provider focused service areas. MCNA understands the importance of building relationships with our network providers in order to deliver quality care, improve outcomes, and increase member satisfaction. As such, our PSRs are thoroughly trained to handle provider inquiries related to:

- Member Eligibility
- Fee Schedules and Claims Payments
- Credentialing
- Complaints, Grievances, and Appeals
- Pre-Authorizations and Referrals

- Coordination of Care and Case Management
- Peer-to-Peer Requests
- Provider Rights and Responsibilities, and Contract Requirements

All calls are documented in DentalTrac™, MCNA's proprietary management information system, for tracking and trending. The DentalTrac™ system captures the date, time, member or provider information, reason for the call, and the resolution of the call. Calls requiring a return call to the provider are captured with a disposition code noting that the provider requires an additional contact. Daily reports are reviewed by our Provider Hotline Team Leads to ensure that all calls are returned no later than the following business day, exceeding the RFP standard for all calls to be resolved within three (3) business days. All return calls are made by a Team Lead or higher to ensure that complex issues are handled by our most experienced staff members.

Monitoring and Tracking Provider Call Management Metrics

Our HIPAA compliant Automated Call Distribution (ACD) system ensures calls are answered timely and routed to our skilled Provider Services Representatives in a manner that can be audited for quality and efficiency. Our Computer Telephony Integration (CTI) system enables real-time performance monitoring to ensure that all performance metrics are met. Our Workforce Management team uses the state-of-the-art NICE IEX Workforce Management Solutions to forecast call volume and staffing needs.

[redacted]

Monitoring Call Accuracy and Provider Satisfaction

MCNA recognizes that our Provider Hotline is often the first point of contact for provider issue resolution. We understand that provider satisfaction is critical to our success in building and maintaining strong provider networks and access to care for our members. MCNA knows the service provided by our hotline representatives can significantly impact provider satisfaction and create a lasting impression. Making a great impression on our providers is very important to us, therefore, our hotline is staffed with highly qualified, experienced, and knowledgeable representatives.

MCNA's Quality Assurance (QA) team utilizes MCNA's "FORCE Factors" to audit provider calls (please refer to our response to question 15 of this RFP for more details). As part of our corporate employee development program, our QA team is comprised of staff who had previously served as Member and Provider Services Representatives. This assures calls are monitored and scored by QA staff who have extensive experience handling provider calls and responding to inquiries.

MCNA conducts satisfaction surveys that include questions specific to the services received by our Provider Hotline. Our Director of Call Center Operations utilizes this feedback to identify trends, and collaborates with our Director of Training and Quality Assurance and our Manager of Provider Relations to develop interventions to improve provider satisfaction as it relates to call handling.

Although MCNA met or exceeded our internal goal of 90% per category, we continue to strive to improve provider satisfaction. MCNA implemented the following initiatives to positively increase satisfaction with our Provider Hotline:

- Additional Provider Hotline Representatives were hired to improve response times
- Refresher training classes were conducted to increase knowledge of Provider Hotline Representatives
- Follow-up calls were implemented with all providers who submitted emails, faxes and voice messages to ensure providers were satisfied with the response time

Provider Relations Representatives followed-up with any provider who did not express 100% overall satisfaction with MCNA.

34	**Provide an overview of the DBPM's proposed provider website, including examples of information that will be available on the website and on portals for providers.** **Include proposed resources and tools that will be of use to providers. Please provide a description of technology that will be used to enhance the provider website.**

MCNA's Provider Website

MCNA websites are state-specific and designed to satisfy the unique requirements of the state agencies that we work with. The content, presentation, and functionality of these websites is carefully crafted to meet the needs of the local population and adhere to industry standards for navigability and accessibility. MCNA's website for the Nebraska Medicaid program will be fully prepared by the time of Readiness Review and will include the following information for providers:

- Information about how to submit grievances and appeals to MCNA
- Contact information
- Information to assist network providers with regards to billing or pre-authorization processes and frequently asked questions
- A link to download the Provider Manual and relevant MLTC bulletins
- Information on upcoming provider training sessions
- A link to download provider training materials
- Schedule of provider informational webinar events and signup information
- A link to MCNA's secure online Provider Portal which includes information on:
    - How to submit claims
    - How to obtain pre-authorizations and referrals
    - The provider grievance system
    - The contact information for MCNA's Provider Relations Representatives and a territory map showing assigned representatives by geographic location

For additional information regarding the design, functionality, quality assurance, and availability of our website, please see our response to Question 18 of this RFP.

Provider Portal

MCNA's online Provider Portal offers state-of-the-art web-based applications for our participating providers free of charge. MCNA's Provider Portal is a service module that is part of our management information system, DentalTrac™. This allows the Online Provider Portal to leverage our redundant, scalable, and secure technology framework that powers our MITA-aligned modular system. DentalTrac™'s technology framework includes all the network and communication hardware used to support our hosted applications as well as all security and viral scanning programs involved with the communication portion of the applications.

Providers have unlimited access to our secure Provider Portal that support their routine administrative transactions with MCNA. This integrated, easy-to-use online portal offers an ideal solution for providers to perform the following necessary day-to-day functions:

- Verify member eligibility
- Submit claims
- Request pre-authorizations and referrals
- Print Remittance Advices (RAs)
- Submit claim appeals and reconsiderations
- 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 MCNA's Provider Manual
- Access program announcements and updates
- Access detail on MCNA's Provider Relations team including contact information and territory assignment maps

[redacted]

Security at its Core

MCNA is committed to ensuring the security and efficiency of all data, systems, and online tools. We employ dedicated security specialists who assess, monitor, and continually improve the security of our systems. We adopt information security best practices for role-based access, account lockout, strong passwords, password expiration, and encryption techniques. All MCNA staff understand the importance of protecting our members' privacy and our clients' data. As such we take all measures necessary to ensure that DentalTrac™, our applications, and our entire technology framework meet and exceed all applicable standards for security, including but not limited to HIPAA, FIPS 140-2, and NIST 800-53r4, and compliance with 42 CFR Part 31, Subpart F.

We understand security concerns related to the highly sensitive nature of the data being exchanged over the public Internet. MCNA's online Member Portal and Provider Portal are designed to enforce the use of Secure Sockets Layer (SSL) web-based protocol to collect and store all data and records exchanged with our members, network providers, and MLTC. We ensure that SSL is present at all times in order to manage server authentication, client authentication, and all encrypted communications between our servers and our users.

Access to our Provider Portal is granted only to authorized users and enforced by the use of role-based security mechanisms. These mechanisms ensure users are limited to only the specific functions for which they are responsible.

Provider Portal Login Screen

[redacted]

35	**Describe the DBPM's proposed provider education and training program, including** • **A description of the training program.** • **A work plan that outlines education and training activities, including frequency of office visits to conduct activities.** • **A listing of the types of materials and content the DBPM will distribute (include three samples of materials).** • **How the DBPM will evaluate usefulness of educational sessions and utilize feedback to influence future training sessions.**

Initial and Ongoing Provider Education and Training

We understand that the Nebraska provider community may have some initial apprehension about the transition from fee-for-service to dental 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, filing grievances and appeals, periodicity schedules for preventive care, and our clinical practice guidelines.

Provider education is an integral component of our network development and retention strategy. In 2015, MCNA conducted over 6,000 provider orientations, in-office education sessions, and site audits.

MCNA believes the key to our previous successes can be attributed to extensive training of our staff on transitioning providers to our plans, and the strong relationships we build with our provider communities during and after transitions. With **over 20 years of experience**, we have learned that the most effective way to build relationships is by establishing trust. MCNA establishes trust with our provider communities with early and earnest communication and then by training our staff on the following five guiding principles:

- **Mutual Concern:** MCNA demonstrates shared concern with our providers about the oral health of our members and the challenges of participation in a Medicaid plan
- **Keeping Commitments:** MCNA values integrity, competence, and consistency in keeping commitments to our providers and members
- **Open Communication:** MCNA fosters an open communication environment with clients, employees, providers, and members

- **Active Collaboration:** MCNA actively collaborates with community partners, providers, and members to promote good oral health and an efficient Medicaid plan

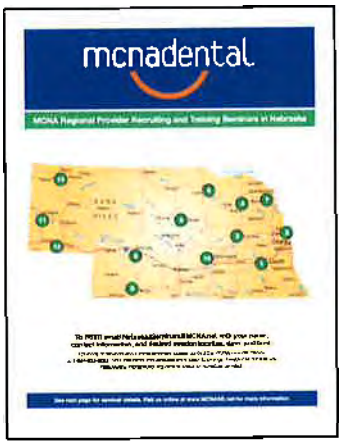
- **Long Term Perspective:** MCNA invests in provider education and training to contribute to overall provider and member satisfaction

Building trust with the Nebraska provider community is a top network development priority. With this long-term perspective in mind, MCNA will conduct initial and ongoing provider orientations and online training seminars (webinars), and provide a wealth of information through our 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 reference and educational materials on our web-based Provider Portal. These materials include provider manuals, program descriptions, claim submission guidelines, "how-to" 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.

Provider Training Prior to Go-Live

MCNA will conduct regional training workshops prior to the operational start date to ensure providers experience a smooth transition to our program. MCNA will submit the training schedule to MLTC for review and approval a minimum of 30 calendar days from the date of award. Our draft provider orientation schedule is included in this submission as **Attachment 35-1**. These workshops will be the building blocks for winning their 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 Provider Manual and learn about the operational aspects of the Nebraska plan.



All network providers receive initial training on the following topics:

- The detailed benefit plans for each eligible population
- Dental record keeping requirements and MCNA's dental record review process
- Information about MCNA's Grievance System
- Information about MCNA's free, online Provider Portal including: how to verify eligibility, and submit claims, authorization requests, and referrals
- The role of the Primary Care Dentist (Dental Home)
- Frequently asked questions and answers

- Clinical criteria and guidelines
- Member rights and responsibilities, and provider rights and responsibilities
- Information about MCNA's quality improvement program
- Details about MCNA's DentalLink initiative to increase collaboration between primary care dentists and physicians
- Details on MCNA's program integrity efforts including how to report suspected waste, fraud, and abuse
- Information about MCNA's credentialing and re-credentialing process
- Provider non-discrimination and cultural competency information
- MCNA and MLTC contact information such as addresses and phone numbers

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 on any changes in policies and procedures. Webinars will also 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.

Quarterly Regional 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 to MLTC or federal requirements. The same content will again be available via webinars for providers and their office staff.

Provider education content for the workshops is developed by evaluating:

- Results from surveys and audits
- Identified trends from:
  - Claim and authorization submissions
  - Provider complaints, grievances, or inquiries
  - Member complaints and grievances
- Provider requests for personalized training topics
- Changes in covered benefits or dental policy

Ad Hoc Meetings

Personalized training sessions at the provider's office 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.

Provider Education Work Plan

MCNA created the provider education work plan below to ensure that the needs of the Nebraska dental community are met through ample training opportunities throughout the year and upon request.

Type of Education	Audience and Focus	Frequency	Method
Provider Orientation	Newly participating providers: Full overview of MCNA and the Nebraska Medicaid program	Conducted within 45 days of go-live, and available upon request thereafter	Face-to-face or webinar with material available via MCNA's Provider Portal
Site Audit	All participating offices: Site review to evaluate ADA compliance, conduct appointment availability surveys, ensure proper emergency protocols are in place, and staff are properly trained	Minimum of 25% of offices per quarter	Face-to-face in the provider office
Webinars	All participating providers: Variety of topics including "How To" series of topics such as accessing the Provider Portal, filing a claim, requesting a pre-authorization, verifying eligibility, and more	Monthly and ad hoc	Online and providers may also choose to join via phone only
Regional Workshops	All participating providers: Variety of topics based on feedback from members and providers, the grievances and appeals system, quality improvement initiatives and trends	Quarterly	Face-to-face
Ad Hoc Requests	All participating providers: Providers may request training on any topic and MCNA's team will conduct in the manner selected by the provider	Ad hoc	Face-to-face, teleconference, or webinar
Dental Advisory Committee	Panel of providers nominated by dental organizations such as the Nebraska Dental Association and the University of Nebraska Medical Center College of Dentistry: Discuss dental issues and help shape policy, quality initiatives, and administrative processes	Quarterly	Face-to-face and teleconference for members who cannot attend in-person

Dental Details	All participating providers who choose to receive it: Our monthly newsletter that includes a variety of information about trending dental topics of interest and MCNA's clinical policies	Monthly	Via email and also maintained in the Provider Portal
Provider Portal Videos	All providers: Educational videos that illustrate how to perform tasks via MCNA's online Provider Portal	Always available	Via YouTube and the Provider Portal

Types of Material Distributed

MCNA will use the Provider Manual, Provider Portal, provider bulletins, educational videos, our dedicated Nebraska website, and our monthly newsletter as ongoing training tools for the provider community. A copy of the presentation will be made available to all Provider Orientation and Regional Workshop attendees and the materials will also be posted in MCNA's online Provider Portal.

We will work with MLTC and other MLTC contractors as necessary to develop dental education materials tailored for children that address multiple topics including EPSDT requirements. We will educate our network providers on the availability of these materials via MCNA's dedicated Nebraska website and our innovative Member Portal and App. MCNA has a variety of member materials designed for children that address the importance of proper oral hygiene and emphasize the need to see a dentist regularly. These materials will also be made available free of charge to our providers for use with their patients.

Please see the following sample provider education material: Louisiana Medicaid Provider Manual (**Attachment 35-2**), Iowa Medicaid Provider Orientation presentation (**Attachment 35-3**), and our Idaho Medicaid Credentialing training presentation (**Attachment 35-4**). For additional examples of provider training content, please visit our YouTube Channel (http://youtube.com/MCNADental). The image to the right is from our online tutorial video about submitting a Prior Authorization via MCNA's Provider Portal.

Evaluating Effectiveness

MCNA seeks provider feedback on all training opportunities. The representative providing the training sends out an evaluation tool to all participants and solicits their comments about the content, format, and presenter. The comments received shape our future training sessions by enabling our team to recognize preferred formats and identify any additional information that should be added to the content covered in the session. Please see **Attachment 35-5** for a copy of our evaluation form.

36	**Provide a description of the DBPM's proposed approach to handling provider complaints. Include intended interaction and correspondence, as well as timeframes in which the DBPM will acknowledge and resolve inquiries and grievances. Explain how the DBPM will track provider complaints and how the DBPM will use this type of information to improve provider services. Include a description of any type of internal reporting the DBPM will perform, and how the DBPM will use reporting information to influence the activities of the DBPM's provider services representatives.**

Our Approach to Handling Provider Complaints

MCNA maintains a provider complaint process for in and out-of-network providers in Nebraska 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 am until 7:00 pm CST throughout the State of Nebraska, 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, Provider Portal, provider education materials, and for non-network providers, on our Remittance Advices. The information will include specific content about the Provider Hotline, how to contact your Provider Relations Representative, and details on how to submit a complaint via email or surface mail. Additionally, instructions are provided on how to request a face-to-face meeting to present a case to MCNA, and how to request a hard copy of our policies and procedures at no charge. Providers may file a written complaint within 30 calendar days. MCNA will respond to the complaint within 30 calendar days of receipt.

Complaint Resolution Process

MCNA's dedicated Provider Hotline Representatives and Provider Relations Representatives investigate each complaint. Their thorough analysis 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 DentalTrac™, our proprietary management information 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. MCNA's Grievances and Appeals Department handles all member grievances

and appeals whether submitted by the member or by the member's provider on behalf of the member. 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.

When MCNA receives a provider complaint, the complaint is date stamped, triaged, and logged into the Grievances and Appeals module of DentalTrac™, which houses our electronic complaint tracking log. Once the case is logged, it is assigned to a designated Provider Relations Representative who is responsible for conducting a thorough investigation, including reviewing all pertinent facts and regulations, and ensuring all issues presented in the complaint are completely addressed.

The Provider Relations Representative acknowledges the complaint in writing **within 5 business days** of its receipt by MCNA. The acknowledgement letter outlines the member's or provider's rights and explains the complaint process. The Provider Relations Representative immediately researches the issue, assesses the nature and urgency of the case to determine the appropriate resolution path, and coordinates with dental offices, involved parties, and the staff of other MCNA departments.

After thoroughly investigating the complaint and determining a resolution, the designated Provider Relations Representative prepares a written notification of the resolution of the complaint to be sent to the provider. The response notice includes a statement of the issues raised and pertinent facts determined by the investigation. A statement of the specific coverage or policy or procedure provision is included when applicable. The notice also includes the decision or resolution of the complaint and a reasoned statement explaining the basis for the decision or resolution. All provider complaints are resolved within 30 calendar days of receipt.

MCNA will maintain and implement written policies and procedures that detail the operation of the provider complaint process. The policies and procedures will comply with all requirements of the RFP and will be submitted to MLTC for review and approval within 30 calendar days of the contract award date. The status of all provider complaints and their resolution will be provided to MLTC on a monthly basis in the format required by MLTC.

Using Provider Feedback for Quality Improvement

As part of MCNA's Quality Improvement activities, all key performance indicators (KPIs) for our Complaint process are tracked and trended by MCNA's Grievance, Complaints, and Appeals Committee. 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, Claims, 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 Grievances, Complaints, and Appeals Committee are reported to the Quality Improvement Committee (QIC).

Our QIC, in conjunction with the Director of Call Center Operations and Associate Vice President of Administration and Operations, analyzes reports to identify trends and implement appropriate interventions and Performance Improvement Projects (PIPs). MCNA utilizes data to conduct root cause analysis in order to address systemic issues and barriers, improve operational processes, and increase provider and member satisfaction through additional training and education.

Texas Success Story

A Texas provider complained to MCNA regarding a denial of payment for non-intravenous conscious sedation services billed. Our Provider Relations (PR) Representative contacted the provider and explained that he did not have the proper sedation certification from the Texas State Board of Dental Examiners to provide that level of sedation. The PR Representative offered to coordinate a peer-to-peer discussion with MCNA's Dental Director regarding sedation billing requirements. The provider was very pleased and understood the information communicated in the peer-to-peer discussion. The provider recognized the need for the additional level of anesthesia permit as a mechanism to prevent potential adverse sedation outcomes. The provider scheduled his additional training and was issued a Level 2 Permit, and now properly administers non-intravenous conscious sedation to patients when appropriate.

37	**Describe the approach the DBPM will take to assess provider satisfaction, including tools the DBPM plans to use, frequency of assessment, and responsible parties. Provide relevant examples of how the DBPM has utilized survey results to implement quality improvements in similar programs and how these changes have improved outcomes.**

[redacted]

[redacted]

Excerpts from MCNA's Diagnostic Quality Provider Training Slideshow

mcnadental

Provider Training

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" Provider Newsletter

mcnadental

DentalDetails

Monthly Provider Newsletter

Louisiana Edition • August 2018

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Sculpture - Tooth Book Fold

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• Autumn Equinox

mcnadental

CORPORATE WEBSITE

www.MCNA.net

SOCIAL MEDIA PROFILES

Facebook Twitter YouTube

LOUISIANA PROVIDER HOTLINE

1-855-701-6262

CORPORATE HEADQUARTERS

Managed Care of North America

QUALITY IMPROVEMENT

Encouraging Patients to Commit to Preventive Care

MCNA's Quality Improvement Program engages in a wide range of outreach and support activities designed to encourage the regular utilization of preventive dental services by our members. Prevention is key in the fight against ...

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YOUR PRACTICE

Discover the Power of MCNA's Provider Portal

MCNA's free online Provider Portal presents you with secure access to all of the most important information you need, when you need it. Our Provider Portal puts easy-to-use, effective patient and practice management tools at your...

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UTILIZATION MANAGEMENT

Authorization of Sedation and Hospitalization

When submitting a pre-authorization request for IV sedation or hospitalization for members over the age of six, please ensure your request is accompanied by the proper documentation. This includes documentation of the member's medical, cognitive, and/or psychological condition. You may use a medical diagnosis code to document the member's condition, or write a narrative.

Read More »

MCNA UPDATES

Preventing Claims Delays Due to LOI

We have assembled the following collection of tips to help your office avoid delays in the prompt processing of your claims due to

MCNA UPDATES

What is an Appeal?

You may file an appeal with MCNA when one of your claims for services rendered has been denied for determinations based on medical necessity and benefit coverage. Appeals must be filed

38	**For each subcontractor included in the proposal, provide the organization's role in this project, corporate background, size, resources and details addressing the following:** • **The date the company was formed, established or created.** • **Ownership structure (whether public, partnership, subsidiary, or specified other).** • **Organizational chart.** • **Total number of employees.** • **Whether the subcontractor is currently providing services for the DBPM in other states and the subcontractor's location.**

Subcontracting

We are committed to ensuring that our Nebraska Medicaid members receive quality dental services and that our providers are supported in the delivery of that care. MCNA Insurance Company has maintained a relationship with our affiliate subcontractor, Managed Care of North America, Inc., since our inception. On the following page, we provide detailed information about that relationship as requested by this RFP.

Managed Care of North America, Inc. (d/b/a MCNA Dental Plans)

Managed Care of North America, Inc., is a Florida S-Corporation chartered on May 3, 1991, and licensed as a Pre-Paid Limited Health Services Organization by the Florida Office of Insurance Regulation on January 30, 1992. Managed Care of North America, Inc., is a wholly-owned subsidiary of MCNA Health Care Holdings, LLC, a Florida limited liability company. Managed Care of North America, Inc., provides third-party administrative services to MCNA Insurance Company for its Medicaid and CHIP programs in Texas, Louisiana, Iowa, and Idaho. The company is headquartered at 200 West Cypress Creek Road, Suite 500, Fort Lauderdale, Florida, 33309, and has approximately 200 employees. Please see below the organizational chart for Managed Care of North America, Inc.

39	**For subcontracted roles included in the proposal, describe the DBPM's process for monitoring and evaluating performance and compliance, including but not limited to how the DBPM will:** • **Ensure receipt of all required data including encounter data.** • **Ensure that utilization of health care services is at an appropriate level.** • **Ensure delivery of administrative and health care services at an acceptable or higher level of care to meet all standards required by this RFP.** • **Ensure adherence to required grievance policies and procedures.**

Description of Subcontractor Relationship

MCNA Insurance Company, the bidder, will comply with the requirements of the MLTC contract by underwriting the cost of the dental benefits, ensuring all Provider Relations and Outreach responsibilities are fulfilled, providing a robust team of general and specialty dentists to provide clinical review services, managing a robust network of general dentists and specialists, and overseeing our affiliated subcontractor who will provide additional administrative services.

Our affiliate, **Managed Care of North America, Inc.**, d/b/a MCNA Dental Plans, will provide administrative services to the bidder, MCNA Insurance Company, including:

[redacted]

Subcontractor Oversight

MCNA's subcontract contains rigorous performance standards designed to ensure compliance with MLTC requirements. [redacted]

We are responsible for oversight of all subcontractors' performance as required by 42 CFR §§438.6 and 438.230. We remain fully accountable for any delegated functions. MCNA evaluates prospective subcontractors to assess their financial stability and operational capabilities with respect to the

delegated activities. Our subcontract agreement specifies all activities and reporting responsibilities delegated to the subcontractor and establishes penalties and sanctions including possible contract termination for failure to perform.

MCNA will submit all subcontracts for the provision of any services under this RFP to MLTC for review and approval a minimum of ninety (90) calendar days prior to their planned implementation. We understand that MLTC has the right to review and approve or disapprove all subcontracts entered into for the provision of any services under this RFP. Additionally, MCNA ensures that all subcontractors have not been excluded from participation in the Medicare and/or Medicaid program pursuant to Section 1128 of the Social Security Act (42 U.S.C. §1320a-7), or who/which is otherwise barred from participation in the Medicaid or Medicare programs. MCNA will not enter into any relationship with anyone or any entity debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.

We oversee the subcontractor's performance through our Quality Improvement Committee process on a periodic schedule consistent with industry standards [redacted] The Quality Improvement Committee evaluates the subcontractor's ability to perform the activities to be delegated; monitors the subcontractor's performance on an ongoing basis; subjects the subcontractor to formal review on an annual basis; identifies deficiencies or areas for improvement; and takes corrective action as necessary.

MCNA's Quality Improvement (QI) Department continuously monitors plan operations to identify areas for improvement. [redacted]

[redacted]

All performance measures must meet or exceed expectations. In the event of substandard performance, MCNA will require the subcontractor to submit a remediation plan within five (5) days of identifying performance issues, which will be implemented immediately upon approval by the Executive Director. MCNA may require the subcontractors to modify the remediation plan. Performance will be continually monitored throughout the corrective action period.

MCNA will remain fully responsible for the obligations, services, and functions performed by our subcontractor to the same extent as if such obligations, services, and functions were performed by MCNA Insurance Company.

40	**Describe how the DBPM will assist members to identify and gain access to community resources that provide services the Medicaid program does not cover.**

MCNA recognizes the importance of informing our members about how to identify and gain access to community resources that provide services not covered through the Nebraska Medicaid dental program. We engage our staff and resources in a multifaceted approach to provide targeted education to our members about these resources.

MCNA's experienced Member Advocate and Outreach Specialists (MAOS) team cooperates with community-based organizations on a regular basis to reach children and families in the communities we serve. Through these partnerships, we are able to organize, attend, and support local health fairs and other community events. Our MAOS team provides education to our members and their parents about oral health and hygiene, covered dental benefits, and the EPSDT periodicity schedule. We also explain how they can obtain assistance from other organizations and utilize available community resources. In the past year, our MAOS team members have actively participated in **over 620 health fairs and outreach events**. MCNA routinely organizes and coordinates these events with county health

departments, Head Start programs, public school systems, civic organizations, dental centers, health plans, and faith-based organizations.

In addition to external outreach efforts, MCNA's Call Center staff identify when members have needs that extend beyond the services covered in Nebraska's Medicaid program. This identification occurs during inbound calls. Each representative has access to a list of community resources local to the member calling and utilizes that to provide assistance in obtaining needed services.

Our MAOS, call center, utilization management, and grievances and appeals teams are trained to recognize when members require assistance with care coordination, and to refer those members to the Case Management Program as needed. Additionally, we inform our network providers about the program and provide them with guidance on how to refer members they identify as eligible for case management services. Providers are first introduced to this information during initial provider orientation and have continual access to it in the Provider Manual.

MCNA recognizes that we must maintain close relationships with the community organizations that support the communities we serve.

MCNA's support of our local communities in this manner helps us develop and maintain the close relationships with key community organizations that allow us to quickly and effectively navigate the system of resources available on behalf of our members.

41	**Provide a description of the DBPM's proposed QAPI program. Include the following in the description:** • **The proposed structure, and policies and procedures that explain the accountability of each organizational unit.** • **The program's infrastructure, including coordination with subcontractors and corporate entities, if applicable.** • **Proposed QAPI committee membership and committee responsibilities.** • **How focus areas will be selected, including how data will be used in the selection process.** • **The proposed QAPI work plan, including planned initiatives.**

MCNA's Quality Assurance and Performance Improvement Program (QI Program)

MCNA has over a decade of experience in developing process improvements and interventions that enhance clinical efficiency, provide effective utilization, and improve outcome management for the Medicaid and CHIP members we serve. With a current membership of 3,500,000, MCNA holds the most full-risk, dental managed care contracts with state agencies. Together with MCNA, our state clients have achieved some of the highest levels of success with preventive care and other quality measures in the nation. MCNA has been providing comprehensive dental benefits to Florida CHIP members through a contract with the Florida Healthy Kids Corporation since 2005. Our most recent audited HEDIS scores exceed the Medicaid national mean for all age cohorts. We have managed the dental benefits of Texas Medicaid and CHIP members since 2012, and Texas is ranked first in the percentage of children receiving preventive dental care in the nation. (source: FFY 2015 CMS 416 preventive care measure)

Our Quality Assurance and Performance Improvement Program (QI Program) is designed in accordance with 42 CFR §438.330. The QI Program systematically monitors and evaluates the quality and appropriateness of care and services, and promotes improved patient outcomes. MCNA's policies and procedures define the scope of the QI Program including, but not limited to: the line of authority and accountability; the infrastructure and coordination with corporate entities; the Quality Improvement Committee's (QIC) membership and committee responsibilities; the integration of focus groups; data use criteria; process for selection of performance improvement projects (including prioritization of high risk populations); and the development of our QI Work Plan that outlines the planned initiatives.

QI Program Structure, Focus, and Subcommittees

The QI Program structure has been established by MCNA's Health Plan Board of Directors, who retains ultimate authority and accountability for the QI Program. The Board oversees and evaluates the impact and effectiveness of the QI Program, provides strategic direction, and ensures incorporation of the program into MCNA's business operations. The Board has delegated the development, implementation

and review of the QI Program to the Quality Improvement Committee (QIC), chaired by MCNA's Chief Dental Officer (CDO), Dr. Ronald Ruth, and co-chaired by our Nebraska Dental Director, Dr. Scott Wieting.

The QIC meets on a quarterly basis and is accountable for the development, implementation and oversight of Nebraska's comprehensive annual QI Program Description, Work Plan, and annual Program Evaluation. The QIC selects, directs and utilizes task forces, other MCNA committees, Member and Provider focus groups, and other plan activities to define the scope, develop the goals and objectives of the QI Program, and identify, define and direction quality improvement activities. Meeting minutes are maintained for all meetings and will be reported to MLTC following the end of each quarter.

Members of the Quality Improvement Committee are appointed by the Board of Directors. All provider advisory appointments and member appointments are at the discretion of the chair.

- Chaired by: Chief Dental Officer
- Co-Chair: Nebraska Dental Director
- Plan President
- Nebraska Executive Director
- Vice President of Dental Management and Quality Improvement
- Director of Quality Improvement and Risk Management
- Chief Operating Officer
- Chief Information and Security Officer
- Chief Compliance and Privacy Officer
- Senior Vice President and General Counsel
- Vice President of External Affairs and Deputy General Counsel

Quality Improvement Leadership

Ronald Ruth, DDS

Chief Dental Officer

Dr. Ronald Ruth has over 45 years of dental practice experience as a Florida-licensed General Dentist and co-founded the first dental managed care plan in the State of Florida. Dr. Ruth currently serves on the URAC Dental Advisory Board.

Scott Wieting, DDS

Dental Director

Dr. Scott Wieting serves as Dental Director for Nebraska. He is the immediate Past President of the Nebraska Dental Association, has been a practicing general dentist in the State for 37 years, and is a graduate of the University of Nebraska.

DeDe Davis

VP of Dental Management and Quality Improvement

Ms. Davis has over 25 years of healthcare experience, with a focus on ensuring members receive the right care, at the right time, in the right setting.

- Vice President of Operations
- Associate Vice President of Administration and Operations
- Director of Utilization Management and Case Management
- Director of Grievances and Appeals
- Director of Call Center Operations
- Director of Network Development
- Director of Credentialing
- Director of Claims Management
- Director of Human Resources
- Clinical Reviewers (licensed dentists)
- Participating Network Dentists
- Member or member representative from an advocacy group

MCNA understands that we must submit our QI Program description to MLTC for written approval within 60 calendar days prior to the contract start date. The following QIC functions are incorporated into the QI Program Description. For a complete listing, please see **Attachment 41-1**, MCNA's draft Nebraska QI Program.

- Providing oversight and review of the QI Program's subcommittees;
- Evaluating quality training materials prior to their dissemination, including ensuring compliance with CMS protocols;
- Implementing quality training for providers about standards for dental record keeping, utilization of preventive services (sealants, prophylaxis, and fluoride), missed appointments and continuity of care, oral hygiene instruction (brushing and flossing), and compliance with the American Academy of Pediatric Dentistry's periodicity schedule;
- Developing educational materials to teach parents and members about oral health and preventative services;
- Tracking indicators, reviewing studies and quarterly reports, and ensuring follow up on the resolution of opportunities for improvement;
- Suggesting and reviewing new and/or improved QI activities;
- Reviewing and approving all policies and procedures;
- Reviewing and approving the Dental Utilization Management Program and Plan;
- Assessing the quality and appropriateness of dental care furnished to members with special healthcare needs;
- Assuring the communication of necessary information with departments and services when problems or opportunities arise to improve patient care;
- Determining issues and subjects for review (e.g., accessibility and availability studies);
- Approving quality indicators for each of the reporting departments;

- Approving the selection of PIPs and/or focused studies, as well as the study design procedures;
- Monitoring the QI Work Plan and program activities to ensure assigned tasks are initiated and completed according to schedule, and overseeing the documentation of the results of activities;
- Monitoring progress in meeting QI goals;
- Reviewing, approving, and monitoring corrective action plans;
- Conducting individual primary care dentist (Dental Home) and dental practice quality performance measure profiling;
- Reviewing performance reporting on measures from delegated entities;
- Reporting findings to the Board of Directors, relevant stakeholders, other departments, and contracted providers (if applicable), as required but no less than quarterly; and
- Reviewing the scope, objectives, organization, and effectiveness of the QI Program at least annually, or more frequently as necessary, and presenting the results to the Board of Directors.

The QIC has the authority to promote organizational accountability by identifying, assessing, and correcting quality of care issues, to improve dental care services. The QIC and its four subcommittees are responsible for the implementation and operation of the QI Program. Meeting minutes are taken for the QIC and all subcommittees, and MCNA will submit a summary of the meeting minutes to MLTC with other quarterly reports.

The QIC's four subcommittees, and their scope of accountability are as follows:

- **Credentialing Subcommittee** supports MCNA's credentialing and recredentialing efforts. This committee is chaired by the CDO and co-chaired by Dr. Scott Wieting, MCNA's Nebraska Dental Director. The committee meets or more frequently as needed. Primary functions under the committee's accountability include:
    - Review and approval or denial of applicants seeking network participation and those existing providers seeking recredentialing;
    - Review and evaluation of issues and/or trends for prospective and existing providers; and
    - Conducting ongoing monitoring and oversight of existing providers.

- **Peer Review Subcommittee** supports MCNA's efforts to provide due diligence to network providers regarding professional competence and provider disputes. It also works to ensure members receive high quality dental care according to prevailing standards of the dental care industry. The committee objectively and methodically assesses, evaluates and resolves issues related to the quality and appropriateness of care, safety and services. The Peer Review Subcommittee is chaired by MCNA's Nebraska Dental Director, or his designee, and meets on an as needed basis. Primary functions under the committee's jurisdiction include:
    - Providing resolution to provider disputes involving adverse patient incidents associated with professional competence, professional conduct, and the quality of care and services delivered to members; and

  - Reviewing complaints or allegations against a provider and evaluating whether the severity of the issue requires a corrective action for that provider up to and including limitations, suspension, or termination from MCNA's participating provider network.

- **Utilization Management (UM) Subcommittee** supports MCNA's policy development and oversight process for dental utilization management. This committee monitors the medical appropriateness and necessity of dental care services utilizing clinical criteria. The committee uses both qualitative and quantitative analysis to discern dental practice patterns and utilization trends. The UM committee is chaired by our Nebraska Dental Director, Dr. Scott Wieting, and meets on a quarterly basis or more frequently as needed. Primary functions under the committee's jurisdiction include:
  - Developing and assessing the UM portion of the QI Work Plan;
  - Monitoring for the consistent application of medical necessity criteria and clinical practice guidelines;
  - Reducing inappropriate and/or unnecessary dental services without adversely affecting the outcome of service delivery;
  - Monitoring service utilization patterns of members;
  - Reviewing and assessing trends in clinical grievances and appeals, and providing recommendations to improve the effectiveness of the utilization review process based upon findings; and
  - Reviewing the effectiveness of the case management program and recommending changes to improve processes as needed.

- **Grievances and Appeals (GAC) Subcommittee** supports the implementation and management of processes for member and provider complaints, grievances and appeals. This committee is chaired by our Nebraska Dental Director, Dr. Scott Wieting, and meets on a quarterly basis. Primary functions under the committee's jurisdiction include:
  - Reviewing complaints, grievances, and appeals reports; and
  - Trending of complaints, grievances and appeals by nature and outcome to identify and target quality improvement opportunities.

Monitoring Key Performance Indicators

The QI Program structure assures accountability throughout the organization, with all staff members and leadership playing an active role in driving improvement in the delivery and quality of medically necessary oral health services. The QI Program's goals and objectives are established so that routine and systematic monitoring occurs across the following key performance areas and measures:

- Focused clinical studies and performance improvement projects;
- Dental record audits;
- Member and provider satisfaction survey analysis;
- Clinical performance (including peer review);
- Access to primary and specialty care services;
- Out of network use;

- Appropriate use of diagnostic tests, studies, and dental services (e.g. lab, x-ray);
- Call performance results for member and provider hotlines including average speed of answer, abandonment rate, call wait times, and percent of callers receiving a busy signal;
- Claims processing turnaround time, stratified by clean, unclean, paper, and electronic;
- Financial and procedural accuracy of claims payment;
- Approval and denial trends in utilization management and claims payment;
- Clinical and preventive care guideline assessments;
- Credentialing and re-credentialing results monitored against NCQA, URAC and MLTC requirements;
- Incident reporting outcomes;
- Overutilization and underutilization reports;
- Case management results inclusive of special needs populations and pregnant women;
- Claims utilization trends;
- Provider and member grievances and appeals turnaround times and trends;
- Provider profiling;
- Emergency department use data (as made available by MLTC); and
- Key clinical indicators for adults and children including but not limited to the rates of annual dental visits, preventive visits, and age appropriate sealants with minimal stratification by the geographic location, age, and primary language of the member.

MCNA's departmental leadership is accountable for the daily and monthly ongoing monitoring of KPIs in relation to their performance. On a quarterly basis the directors will present their results and analysis to the QIC for review, input, and guidance. This analysis includes both quantitative and qualitative results and is trended over time to fully evaluate changes in performance or care patterns. The KPI dashboard is utilized to establish the ongoing delta between current performance rates and goals, including year-end quality metrics such as the HEDIS ADV rate, CMS 416 metrics, and DQA measures.

All MCNA staff dedicated to support the Nebraska contract will receive training on the program and its requirements through new hire orientation as outlined in Section X of our QI Program. Subsequent to initial orientation and training, staff will be further trained by their leadership regarding individual department and company-wide quality improvement goals, and the role they play in achieving those goals. **Section III of the QI Program emphasizes that management and staff are all active participants in the QI Program and the importance of each employee's contribution to identifying, planning, evaluating, and monitoring systems, processes, services, and outcomes.**

QI Program Goals, Approach, and Work Plan

The goals and approach of MCNA's QI Program have been established to align with, and strategically support, the National Quality Strategy (NQS), spearheaded by the Agency for Healthcare Research and Quality on behalf of the U.S. Department of Health and Human Services (HHS). The NQS consists of three aims, six health care priorities, and nine levers/actionable items to execute their strategy. MCNA has adopted the NQS' three aims as our overarching goals to drive better, more affordable health care for Nebraska's Medicaid recipients.

- **Better Care:** Improve the overall quality, by making oral health care more patient-centered, reliable, accessible, and safe.
- **Healthy People/Healthy Communities:** Improve the health of the Nebraska population by supporting proven interventions to address behavioral, social, and environmental determinants of oral health in addition to delivering higher-quality care.
- **Affordable Care:** Reduce the cost of quality oral health care for individuals, families, and government.

To achieve these goals, MCNA will select and focus on **Nebraska specific initiatives** that improve the oral health of Medicaid enrollees, and contribute to the financial strength of this essential, publicly funded program. Through extensive research, we identify and prioritize initiatives based on those high risk and high volume areas of patient care. Our experienced QI staff focuses on materials published by state External Quality Review Organizations (EQROs), oral health coalitions, child advocacy groups, academic institutions, and healthcare agencies. Our state specific research is complemented with materials published by similar institutions on a national level to establish objectives and **best-practice strategies** to achieve our Client's performance goals.

The QIC develops and implements a QI Work Plan which incorporates the strategic direction provided by MCNA's Board of Directors. The QI Work Plan shall be submitted by MCNA to MLTC within 60 calendar days prior to the contract start date, annually thereafter, and prior to any revisions being implemented. The QI work plan includes the following key components:

- A coordinated strategy to implement the QI Program, including planning, decision making, interventions, and assessment of results.
- The processes to evaluate the impact and effectiveness of the QI Program.
- A description of the MCNA staff assigned to the QI Program, their specific training, how they are organized, and their responsibilities.
- A description of the role of our dental providers giving input to the QAPI Program.

QI Program Evaluation

The QI Department, in collaboration with the Quality Improvement Committee, develops an Annual Work Plan (QI Work Plan). MLTC and EQRO recommendations and input from our departmental leadership team are taken into consideration for annual updates to the QI Work Plan. Results are reported to the QIC. On an annual basis, the Work Plan is reviewed by the QIC and reported to the Board of Directors. As necessary, selected areas of performance from the Work Plan may be brought to the QIC and Board of Directors more frequently. The Annual Work Plan may be

expanded whenever additional opportunities for quality improvement are identified.

Under the direction of the CDO and Vice President of Dental Management and Quality Improvement, and with input from department heads, the Director of Quality Improvement and Risk Management produces a formal written assessment of the effectiveness of the QI Program. Without limitation, the QI Program Evaluation:

- Measures the progress of key performance indicators and quality improvement activities
- Identifies the interventions and activities that resulted in meaningful improvement
- Evaluates the progress made towards improving and/or sustaining service levels
- Evaluates PIP initiatives against established goals
- Integrates feedback and recommendations from MLTC and its EQRO
- Identifies and eliminates barriers to success
- Integrates member and provider feedback from the advisory groups
- Assesses adequacy of resources allocated to execute the QI Program
- Evaluates the overall effectiveness of the QI Program

The QI Program Evaluation guides the development of the QI Program and work plan for the following year. The evaluation assists staff in identifying the priority areas for study, annual quality improvement initiatives, resources needed to achieve objectives, and timeframes for the implementation of and the completion of initiatives.

The QIC reviews the evaluation report and assesses the adequacy of the program. The QIC approves the evaluation, revised QI Program and QI work plan for the upcoming year and presents it to MCNA's Board of Directors for final approval. Information about this evaluation is published in the MCNA Provider newsletter. Providers are informed that the evaluation is in hard copy upon request. MCNA's Chief Operating Officer is an official member of the Board and assures the QI Program is incorporated into all MCNA operations. The annual evaluation results are shared with all MCNA staff through summaries presented in departmental and staff meetings, and the entire evaluation report is posted on the MCNA Intranet site.

Collaboration with MLTC

We will continue to work closely with the MLTC and its EQRO throughout the contract term to ensure that our QI Program is focused on meeting MLTC's quality goals, and to ensure positive oral health outcomes for our members. MCNA will submit Nebraska's QI Program to MLTC 60 calendar days prior to the contract start date for written approval. Following MLTC approval, MCNA will submit QI Program reports annually to MLTC which, at a minimum, will include:

- QI activities;
- Recommended new and/or improved QI activities; and
- Evaluation of the impact and effectiveness of the QI Program, including all care management activities.

MCNA acknowledges and agrees to comply with any additional report requests by MLTC. Please see **Attachment 41-1**, MCNA's draft Nebraska QI Program.

Our Experience Using the QI Program to Drive Improvement

The National Committee for Quality Assurance's (NCQA) HEDIS Annual Dental Visit (ADV) measure is a nationally accepted quality of care indicator for oral health and access to care. All HEDIS measures undergo systematic assessment of face validity with review by measurement advisory panels, expert panels, a formal public comment process, and approval by NCQA's Committee on Performance Measurement and its Board of Directors. All measures undergo formal reliability testing of the performance measure score using a beta-binomial model.

MCNA's innovative interventions and years of experience serving Medicaid and CHIP members have culminated in the achievement of HEDIS scores that are among the highest in the nation for our Texas program. The following are examples of our success in increasing access to care for our members by ensuring a large portion received an annual dental visit. Our track record of superior HEDIS scores and targeted outreach solutions makes MCNA an excellent choice for the State of Nebraska.

Texas

MCNA has been administering the Texas Health and Human Services Commission (HHSC) Medicaid and CHIP dental programs since March 1, 2012, with current membership of 1.5 million children. For the initial 10 months of the program in 2012, MCNA's composite HEDIS ADV measure was 69.12. The partial year methodology used by HHSC for 2012 looked at members with continuous enrollment of 9 out of 10 months. For years 2013, 2014, and 2015, HHSC utilized traditional HEDIS methodology. As illustrated by the graph below, MCNA's results show the substantial improvement achieved through our efforts to increase the HEDIS ADV measure.

Our HEDIS scores for 2013, 2014, and 2015 all exceed the 90th percentile and are among the highest in the country. MCNA's total HEDIS score has increased year-over-year since the inception of managed care for the Texas Medicaid and CHIP program. **MCNA is extremely proud that our utilization for members ages 4-6 and 7-10 years exceeded 81% for calendar year 2015.**

Texas HEDIS Scores							
Year	**2-3 yrs**	**4-6 yrs**	**7-10 yrs**	**11-14 yrs**	**15-18 yrs**	**19-21 yrs**	**Total**
2012	68.30	72.00	71.83	68.77	61.48	48.72	**69.12**
2013	76.18	78.41	78.36	74.39	66.50	49.23	**75.26**
2014	75.86	79.68	79.51	75.27	66.43	49.59	**75.89**
2015	**76.13**	**81.12**	**81.49**	**77.71**	**68.76**	**51.12**	**77.41**

Florida

MCNA's decade of experience serving FHKC members has given us an understanding of the barriers to routine and preventive dental care confronting this population and helped us take innovative steps to improve performance. This knowledge enabled us to create population-specific outreach call campaign scripts, postcards, and member education materials.

MCNA's FHKC HEDIS Scores:

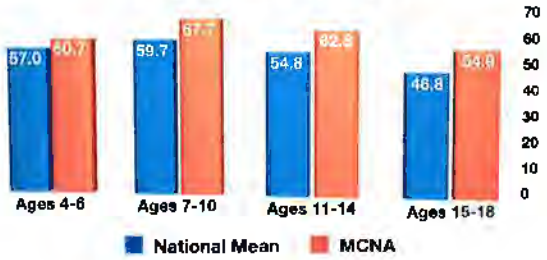
- 2014: **61.71%**
- 2013: **60.38%**
- 2012: **58.82%**
- 2011: **57.93%**
- 2010: **55.35%**

Increasing the ADV is one of our most important deliverables to our clients, and MCNA has continually achieved increases in the HEDIS ADV score for the Florida Healthy Kids program. Over the past five years, MCNA has **achieved an 11.5% increase** in the HEDIS ADV measure. The measure rose from 55.35 to 61.71, a statistically significant improvement. Audited results for calendar year 2015 have not been provided by the plan's EQRO as of the date of this response.

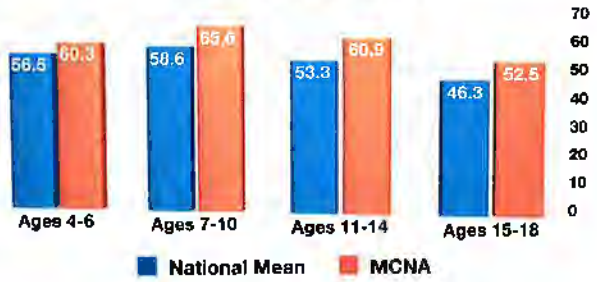
MCNA consistently exceeds the HEDIS benchmark for the Florida Healthy Kids Corporation. **In 2014, we had the highest dental HEDIS scores in each HEDIS age band across all dental plans for this program. MCNA was the only dental plan that exceeded the HEDIS 75th benchmark percentile.**

The following charts compare the most recent FHKC HEDIS results for 2012, 2013, and 2014 to the national Medicaid HEDIS mean:

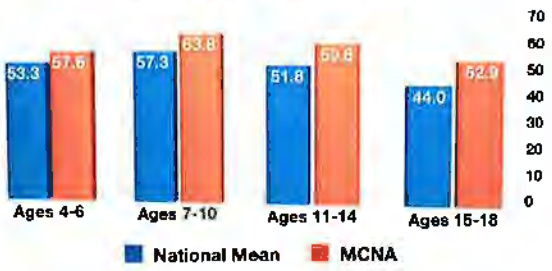
2014 HEDIS Results



2013 HEDIS Results



2012 HEDIS Results



42	**Describe experience in using results of performance measures, member satisfaction surveys, and other data to drive improvements and positive affect the health care status of members. Provide examples of changes implemented to improve the program and members' health outcomes.**

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

43	**Describe the DBPM's process for soliciting feedback and recommendations from key stakeholders, members, and families/caregivers, and using the feedback to improve the DBPM's quality of care.**

MCNA views our provider and member feedback as the "true voice" of our customers. The information we gather serves to illuminate the changing requirements of our members and providers, and allows us to proactively tailor our approach to improving the quality of care and services they receive.

[redacted]

Member Input

We solicit member input in a variety of ways, from satisfaction survey results to topic-specific focus groups. We reach out to state agencies and advocacy organizations to help identify candidates to participate in our focus groups and topic-specific workgroups. Once we have determined committee membership, we make every effort to select meeting locations that are central to their residences and ensure scheduled meeting times do not cause workday interruptions.

MCNA will establish agendas for the group based upon trends noted by MCNA's Quality Improvement Committee (QIC) and feedback gathered from members and network providers. At each focus group meeting, meeting minutes will be taken, which will then be presented to the QIC on a quarterly basis. This process will ensure that advisory committee feedback is integrated into the QI Program.

Proven Experience

Population-specific, **leading-edge outreach** efforts are MCNA's specialty. We solicit member input to assist with targeted population outreach efforts for underserved groups to reduce health care disparities based on factors such as racial, ethnic, and socioeconomic status. Children of Migrant Farm Workers (CMFWs) are one example of a special population identified as needing additional assistance because of unconventional living conditions, migratory work patterns, unhealthy working conditions, poor nutrition, limited English proficiency.

Sample CMFW Outreach Postcard

MCNA recognizes the importance of ensuring that this very mobile population remains compliant with the EPSDT periodicity schedule. 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.

With input from migrant families, 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. **The Texas Health and Human Services Commission commended MCNA's "out of the box" outreach approach.** Please see our response to Question 54 for our fotonovela flyer. Pictured above is a sample postcard that MCNA sends monthly to CMFWs who are not compliant with the periodicity schedule. This has led to a continual increase in the number of CMFWs who receive preventive care.

MCNA looks forward to partnering with agencies across the State of Nebraska to identify and outreach to CMFWs and other underserved populations.

44	**Describe the DBPM's proposed methodology to identify, design, implement, and evaluate PIPs. Provide examples of PIPs conducted by the DBPM, and how operations improved because of their results.**

Performance Improvement Projects

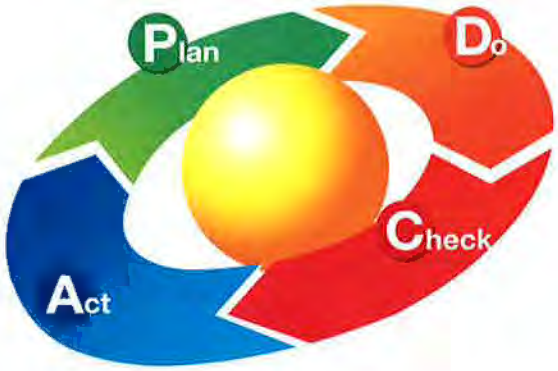
MCNA will select and focus on **Nebraska-specific initiatives** that improve the oral health of Medicaid beneficiaries, and contribute to the financial strength of these essential, publicly funded programs. Our experienced Quality Improvement (QI) staff identifies barriers to care that our members may experience through extensive research utilizing materials published by state External Quality Review Organizations (EQROs), oral health coalitions, child advocacy groups, academic institutions, and healthcare agencies. We complement our state-specific research with select materials published by similar institutions on a national level to establish objectives and **best-practice strategies** to achieve our performance goals.

For MLTC we understand that one clinical and one non-clinical PIP will be conducted. Our PIPs are designed in accordance with all relevant CMS requirements such as clear study questions, defined and measurable goals and objectives, specific population descriptions, objective measurement methodology, clear evaluation criteria, targeted interventions and effectiveness evaluation processes, documented data collection methodology, and planned activities to increase and sustain improvement.

We understand that each PIP must be completed in a reasonable time period to allow the results to guide our quality improvement activities. Information about the success and challenges of PIPs will be available to MLTC for its annual review of MCNA's quality assessment and performance improvement program as required by 42 CFR §438.330(d). MCNA's PIPs will also address our annual QI work plan and program evaluation.

We identify and prioritize strategies to improve the oral health care and services available to our members using the Plan-Do-Check-Act approach. This cycle is repeated until all targeted outcomes are achieved.

- **Plan**: Research the needs of the target population
- **Do**: Implement specific interventions
- **Check**: Evaluate for effectiveness
- **Act**: Make corrections or add interventions



Total Quality Management Methodology (The Deming Cycle)

We coordinate performance improvement projects (PIPs) with the external quality review organizations (EQROs) that work with the states we serve. The EQROs work with us to finalize target initiatives and identify reporting metrics in order to determine the effectiveness of our interventions and approaches.

The QI Department monitors our progress and **evaluates our interventions** by analyzing both clinical and operational performance data, tracking our performance over time. Interventions are evaluated based on the impact they have on member and provider behavior, as well as plan service delivery metrics. MCNA's Quality Improvement Committee (QIC) is responsible for reviewing these analyses and ensuring the appropriate action is taken to ensure each PIP continues to be implemented successfully. Examples of PIP effectiveness measures reviewed by the QIC include:

- CMS-416 report metrics
- Key performance indicators
- HEDIS scores
- Dental Quality Alliance (DQA) metrics

All findings, conclusions, recommendations, actions taken, and post-action assessments are documented and reported to the QIC, Board of Directors, and relevant staff for the integration of best practices, quality assurance, and accountability. If opportunities for improvement are identified, the QIC initiates the planning of appropriate activities designed to increase and sustain improvement. MCNA will submit the progress reports and results with respect to our quality improvement initiatives to MLTC annually as a part of the QAPI Program Evaluation. Additional status reports can be provided to MLTC monthly, quarterly, or upon request. We understand that MCNA will be notified of additional reporting requirements no less than 30 calendar days prior to the due date of a report. MCNA will implement the PIP recommendations from the QAPI Program Evaluation on approval by MLTC and the QIC. MCNA understands that CMS may require additional performance measures and PIPs to be undertaken.

45	**Discuss the DBPM's approaches to annual member satisfaction surveys. Provide relevant examples of how the DBPM has utilized survey results to implement quality improvements in similar programs and how these changes have improved outcomes.**

[redacted]

46	**Describe the DBPM's practice of profiling the quality of care delivered by dental providers, including the methodology for determining which and how many providers will be profiled.** • **Submit sample quality reports.** • **Describe the rationale for selected the measures that are gathered/reported.** • **Describe the proposed frequency of profiling activities.**

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 determine which providers and metrics to profile. The number of providers profiled is based on the focus area or provider type being reviewed. 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 our response to question 48 of this RFP.

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 member 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 sample **PDP Wait Time Scorecard** at the end of our response to this question, 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 Nebraska 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 sample **Sedation Cluster Scorecard** at the end of our response to this question.

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 offices 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 QI Program 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 Nebraska State Board of Dentistry as appropriate.

Example of Provider Quality Profiling

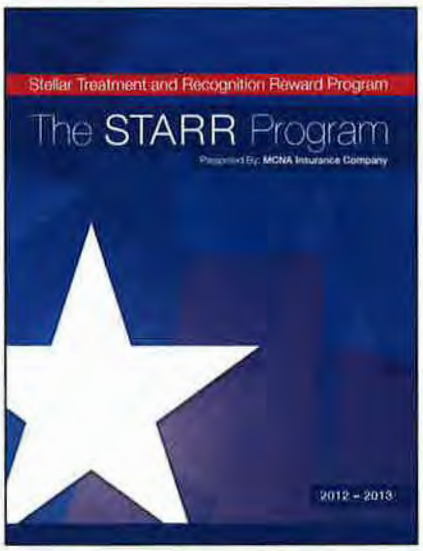
In addition to our targeted profiling efforts, MCNA also seeks to identify and recognize providers who engage in best practices. Participating general and pediatric dentists are considered to be primary care

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 Nebraska 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 Nebraska to identify "preferred providers." Preferred providers are those who consistently demonstrate their commitment to the delivery of preventive care to our members. High scoring Nebraska 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 began in 2012 and 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.

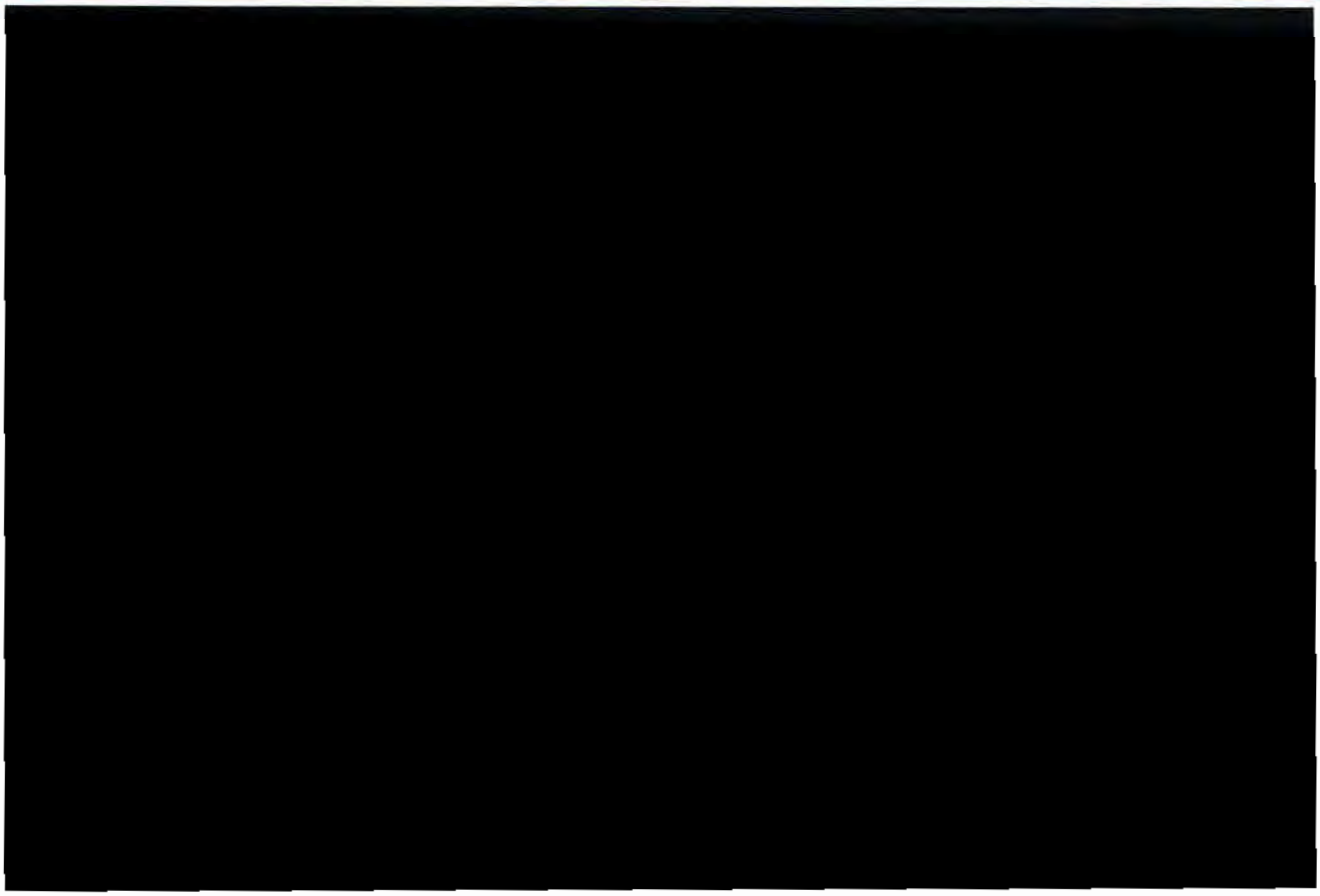
Specific Quality Improvements Targeted and Rationale

To qualify for participation in the STARR program, a provider must have treated at least 150 MCNA members during the state fiscal year and conducted an initial comprehensive examination on at least 40% of MCNA members within 210 days of enrollment.

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 (restorative services re-treated 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.

An example of a qualifying provider's cumulative STARR total is illustrated in the **STARR Provider Scorecard** at the end of our response to this question.

[redacted]



47	**Describe the information the DBPM will provide to members and providers about the QAPI program.**

Informing Members About the QAPI Program (QI Program)

MCNA engages our members in the quality improvement process by sharing information about our initiatives and goals. We use our member newsletter, *The Tooth Tribune*, to provide general information about quality and the need to receive timely dental care and preventive services such as fluoride and sealants. Our QI Program goals and initiatives are developed based on the utilization goals addressed in our MLTC approved performance improvement projects (PIPs). We outreach to members throughout the term of the contract by providing information about quality initiatives at health fairs and through targeted information campaigns.

For example, in the Louisiana Medicaid and CHIP program, MCNA is focused on increasing the number of children 6-9 years of age who receive dental sealants. The measure used is the CMS 416 sealant metric, and it is part of MCNA's Louisiana PIP. One of the interventions for calendar year 2016 is the "Summer Sealant Slam." This initiative was focused on reminding children in the targeted age cohort to get dental sealants to prevent decay. Our educational materials are designed to be colorful and engaging. Please see below the member postcard used for this initiative.

Provider Communication About MCNA's QI Program

Our providers are educated about MCNA's QAPI program (QI Program) during our Provider Orientation training sessions, via the Provider Manual, and in our monthly provider newsletter, *Dental Details*. Like our member communications, we engage providers in targeted campaigns to improve utilization metrics for key services such as sealants and exams. These intervention-specific communications are developed based on the need to meet the QI Program goals set forth in our state-specific PIPs. For an example of provider communications specific to our Louisiana Summer Sealant Slam initiative, please see **Attachment 43-1**.

The following excerpt from MCNA's Provider Manual for the Texas Medicaid and CHIP program, which provides an example of how we educate providers on their role in the QI Program.

Provider Manual: Texas Medicaid and CHIP

mcnadental

Your Role in Quality

Every MCNA network provider is a participant in the Quality Improvement Program through his or her contractual agreement with MCNA. You may be asked to serve on any of the committees that are part of the Quality Improvement Program or contribute to the development of clinical practice guidelines, audits, member education programs, for example. Participation on a committee is voluntary and encouraged.

You can help us identify any issues that may directly or indirectly impact member care by reporting them on an Incident Report Form located in Forms section of this manual. This can be submitted to MCNA via fax, email, or alternate means.

The MCNA Dental Director might contact your office regarding your incident report. Please keep a copy of the completed Incident Report Form in the appropriate member dental record.

Quality Enhancement Programs (Focus Studies)

MCNA monitors and evaluates the quality and appropriateness of care and service delivery (or the failure to provide care or deliver services) to members and providers through performance improvement projects (PIPs), dental record audits, performance measures, surveys, and related activities. As a provider for Medicaid, MCNA will perform no less than two (2) state-approved performance improvement projects (PIPs) per year. The PIPs will focus on clinical and non-clinical areas.

48

Describe the DBPM's approach to utilization management, including:

- **Innovations and automation the DBPM will use for its UM program.**
- **Accountability for developing, implementing, and monitoring compliance with utilization policies and procedures, and consistent application of criteria by individual clinical reviewers.**
- **Mechanisms to detect and document over- and under- utilization of dental services.**
- **Processes and resources used to develop and regularly review utilization review criteria.**
- **How the DBPM will use its UM Committee to support UM activities.**

Ensuring Appropriate Services

MCNA has proven experience in managing state mandated, covered dental services for nearly 3,500,000 children and adults in the Medicaid and CHIP plans of Texas, Louisiana, Florida, and Iowa. Our Nebraska members will have access to the full spectrum of dental care services required in this RFP, including diagnostic, preventive, restorative, pediatric, endodontic, periodontic, prosthodontic, orthodontic, emergency, and oral and maxillofacial surgery.

MCNA understands and shares the desire of MLTC to increase access to appropriate, quality dental care and improve oral health outcomes for its Medicaid population. **We have extensive experience delivering the quality dental care services required by the MLTC for its enrollees.**

Key Facts About MCNA

- MCNA employs **over 40 licensed general and specialty care dentists** to review all utilization management cases that require medical necessity review.
- 2015 processing time for UM cases in Texas: **1.44 business days**
- 2015 processing time for UM cases in Louisiana: **0.99 business days**
- 2015 processing time for UM cases in Florida: **1.26 business days**

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 ensures that the provision of dental care services is high quality, cost-effective and provided in the most appropriate setting consistent with 42 CFR §438.

Superior Data Management via DentalTrac™

MCNA maintains well-defined procedures for logging, tracking and monitoring prior authorization requests from initial receipt through the final determination. DentalTrac™ time stamps each request enabling the creation of a complete audit trail to ensure compliance with all timeliness requirements. All cases are assigned a unique authorization number in the DentalTrac™ system in a manner that enables complete case detail retrieval and unparalleled reporting capability. This unique number is available to both participating and non-participating providers.

Our electronic log within the DentalTrac™ system maintains all key prior authorization elements, including:

- Date of request
- Member name and ID number
- Name of requesting provider
- Date of determination
- Reason for the determination (including all clinical data utilized)
- Name of MCNA reviewer who made the determination
- Date of member and provider determination notification

MCNA's tracking system also supports our complaint process and has the capability to track cases when they are received and resolved, as well as those that are in the process of resolution, and the system allows the UM Department to store all documents related to the authorization request. All prior authorization requests are tracked to ensure prompt resolution.

DentalTrac™'s reporting capabilities allow for the generation of customized reports, and reports in formats that will fully comply with all MLTC reporting requirements. MCNA is committed to meeting and exceeding performance standards and reporting requirements, as outlined in this RFP.

Utilization Management Program Design

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 Endodontists, the American Academy of Periodontology, and the American College of Prosthodontists. The goal of the UM program is to monitor the appropriateness, quality and necessity of dental services provided to our members. The monitoring methodologies include prospective, concurrent, and retrospective review and evaluation. MCNA's UM Program is not structured with any incentive that would limit, deny, or discontinue medically necessary covered services to any member.

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 applied appropriately and consistently by our Clinical Reviewers through comprehensive inter-rater reliability audits on an annual basis and unscheduled random audits as needed.** If any deficiencies are noted, corrective action is taken, such as specific clinical education and continued monitoring 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 by the MLTC.

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 Care 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 (QIC) 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 data 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
- Non-compliant patient dental chart record keeping
- Member treatment histories

DentalTrac™, captures and processes prior authorizations and utilization data. The DentalTrac™ claims module collects this data and reports are generated routinely to determine utilization patterns that fall outside of the norm.

If MCNA detects a pattern of provider underutilization of medically necessary services, such as EPSDT screenings, we 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.

When an 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. All MCNA Clinical Reviewers are licensed dentists. If a quality of care issue is suspected, the Clinical Reviewer will examine the provider's request for services and utilize the supporting documentation to determine if the treatment met the qualifying criteria and current standards of care. 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.

Utilization Review Criteria and 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 UM Committee oversees the development of the guidelines and includes participating primary care dentists and specialists in the development and review process.

Our Nebraska Dental Director will ensure 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. For example, MCNA can and will exceed the standard service limits if an EPSDT member's individual needs indicate that the services are medically necessary.

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 QIC, and appoints its members. **Each UM Committee is chaired by the Dental Director of its state and meets on a quarterly basis.** Annually, the Board receives a written summary and evaluation of the Utilization Management Program and proposed plan amendments from the QIC.

Our Nebraska Dental Director, Dr. Scott Wieting, chairs the UM Committee. Dr. Wieting is the immediate past President of the Nebraska Dental Association (NDA). Our UM Committee also includes Dr. Holly Portwood, MCNA's Executive Director, who currently serves as the AAPD's Public Policy Advocate for Nebraska. The UM Committee 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.

49	**Describe the process the DBPM will have in place to determine appropriate practice guidelines notify providers of new practice guidelines, and monitor implementation of those guidelines.**

Clinical Practice Guidelines

Our Utilization Review Criteria and Guidelines are based on the needs of our enrolled membership and contracted state plan requirements. The clinical guidelines address the provision of acute and chronic dental care services. Our Nebraska Dental Director, Dr. Scott Wieting, will preside over a panel of participating primary and specialty care dentists to gather their input with respect to MCNA's clinical practice guidelines. As immediate past President of the Nebraska Dental Association, Dr. Wieting will leverage his extensive relationships throughout the state to recruit participating dentists and board-certified specialists.

MCNA's Nebraska Dental Director

Dr. Scott Wieting serves as Dental Director for Nebraska. He is the immediate Past President of the Nebraska Dental Association, has been a practicing general dentist in the State for 37 years, and is a graduate of the University of Nebraska.

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 Endodontists, American Academy of Periodontology, and American College of Prosthodontists.

As President of the American Academy of Pediatric Dentistry, Dr. Philip Hunke, MCNA's Plan 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 QIC for final consideration and approval by the Board of Directors. **MCNA's Texas clinical guidelines were last approved by the QIC on September 27, 2016, and our Florida, Louisiana, and Iowa clinical guidelines were last approved by the QIC on October 19, 2016.**

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.

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 fraud or abuse be suspected or identified during the dental record review process, the case will be referred to MCNA's Special Investigation Unit (SIU) for additional review and reporting to MLTC's Program Integrity Unit. For more information on MCNA's efforts to combat fraud and abuse, please refer to questions 55, 56, and 57 of this RFP response.

50	**Describe the DBPM's proposed approach to prior authorization, including:** • **The data sources and processes to determine which services require prior authorization, and how often these requirements will be reevaluated. Describe what will be considered in the reevaluation of need for current prior authorization requirements.** • **The proposed prior authorization processes for members requiring services from non-participating providers and expedited prior authorization.** • **The DBPM's process for notifying providers either verbally or in writing, and the member in writing, of denials or decisions to authorize services in amount duration or scope that is less than requested.**

Monitoring Appropriateness of Services

Our dedicated Utilization Management (UM) Department monitors internal service utilization patterns as well as national trends and guidelines to determine which services should require prior authorization. MCNA's UM Department reviews the prior authorization requirements at least annually through the UM Committee process. This review will take into account service authorization rates, propensity for abuse, clinical considerations, and industry trends. Any proposed modifications are then reported to the Quality Improvement Committee (QIC) for review and approval. Should a service be submitted as an addition to or deletion from MCNA's prior authorization list, we will submit a request to MLTC along with our draft member and provider communication materials for MLTC approval prior to distribution.

MCNA will **ensure** that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope. By tailoring our UM program to meet the needs of Nebraska, MCNA ensures that the provision of dental care services is high quality, cost-effective, and provided in the most appropriate setting consistent with the principles set forth in 42 CFR §456 (Utilization Control).

Prior Authorization Process

All types of care are reviewed for dental necessity, appropriateness of services, level of care, location of care, and quality of care as well as benefit and coverage determinations. Our UM program generates operational data and integrates captured information into the UM and Quality Improvement processes. Reports generated by our Quality Improvement Department are used to continuously monitor the efficacy of the UM program and the appropriateness of the dental care received by our members.

MCNA accepts prior authorization requests submitted by providers **electronically**, via our free, easy to use online **Provider Portal**, or on **paper**. Paper requests are scanned and 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®**. Members may

also submit a service authorization request for the provision of services either via mail or by contacting our Member Hotline.

DentalTrac™ adjudicates the prior 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 prior authorization request must include any related radiographs, photos, charting, models, and narratives as outlined in the Provider Manual. Providers are responsible for verifying member eligibility and benefits before providing services to MCNA members.

Upon receipt of an authorization request, the Utilization Management Coordinator (UMC) verifies the member's eligibility and benefits as well as the requesting provider's network affiliation. All prior authorizations requiring medical necessity determinations are routed to a Clinical Reviewer through our state-of-the-art management information system, DentalTrac™.

MCNA maintains a staff of active licensed primary and specialty care dentists who serve as Clinical Reviewers and review all requests for authorization. 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 prior authorization and relate the existing conditions to the qualifying criteria to determine approval. They use criteria to evaluate information submitted by dentists 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.

Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by MCNA's Dental Director. MCNA ensures that our Dental Director and Clinical Reviewers have no history of disciplinary action or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinician's physical, mental, or professional or moral character. The MCNA Dental Director and all Clinical Reviewers are required to attest that no adverse determinations will be made regarding any dental procedure or service outside of the scope of their expertise.

Continuity of Care

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

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. This is especially true for members

whose health condition has been treated by specialty care providers or whose health could be placed in jeopardy if medically necessary covered services are disrupted or interrupted.

To facilitate continuity of care, every new member in active treatment transitioning into MCNA will be allowed to continue medically necessary covered services with an in-network or non-network provider, without prior authorization from MCNA for a period of 30 days, in accordance with the requirements of this RFP.

Prior Authorization Exemptions

MCNA ensures that our members have access to emergency dental care services for issues such as trauma or acute infection without any delay or hindrance. Our members have access to emergency care without the need to obtain prior authorization and can receive services through any emergency facility or provider, regardless of whether the facility is in or out-of-network.

We do not require prior authorization for any medically necessary preventive services for pediatric patients. Our EPSDT experience ensures that children under 21 will have access to these services without the need for submission of a prior authorization.

Notifying Providers and Members

MCNA providers requesting a prior authorization are notified of the UM determination via MCNA's online Provider Portal. The notification will include the authorization number and effective dates for all approvals. If a provider does not have access to the Provider Portal, a determination letter is mailed. The provider also receives telephonic notification of MCNA's determination for any urgent or emergent requests.

We notify 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 MLTC. Member notices are written to ensure ease of understanding and are in compliance with all state, federal, and MLTC requirements. MCNA fully complies with all language requirements including the translation of member notices into Spanish and other languages as required. MCNA will also enable members to see any adverse action notification in real-time via our HIPAA compliant and innovative Member Portal.

Member and provider notifications explain, at a minimum, the:

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

In the case of expedited services authorizations, the member will be notified within 72 hours of receipt of the request for authorization. Notification to both the member and provider is telephonic and will be followed by a written notice.

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 unless an extension is granted. An extension may be granted for an additional 14 calendar days if the member or the provider or authorized representative requests an extension or if MCNA justifies to MLTC a need for additional information and the extension is in the member's best interest. In no instance must any determination of standard service authorization be made later than twenty-five (25) calendar days from receipt of the request.

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.

TX and LA Pre-Authorizations	2014	2015
Total Received	**105,614**	**146,810**
Received Electronically	**92.9%**	**96.7%**
Turnaround Time in Calendar Days	**1.88**	**1.70**

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.

MCNA exceeded all contractually required turnaround times in 2014 and 2015 for authorization review services in all markets served.

Please see **Attachment 50-1** for MCNA's Prior Authorization Process Flowchart.

51	**Provide a listing of services for which the DBPM will require prior authorization and describe how the DBPM will communicate this information, as well as the results of authorization decisions, to providers and members.**

Educating Providers and Members about Prior Authorization

MCNA educates our providers about prior authorization requirements via the Provider Manual, provider newsletters, postings to the online Provider Portal, and during site visits, orientations, and provider webinars. Our Provider Manual is designed to clearly illustrate what services require prior authorization and also what documentation should be provided with each service authorization request.

For our Texas market, MCNA developed a Pre-Authorization Requirements and Dental Guidelines Quick Reference Manual, which is posted on our Texas website. Please see below an excerpt:

Pre-Authorization Requirements and Dental Guidelines
MCNA Dental · Texas Medicaid and CHIP Programs
mcnadental

Criteria for Excision of Bone Tissue

Code D7471 is related to the removal of the lateral exostosis. This code is subject to authorization and may be reimbursed for when submitted in conjunction with a treatment plan that includes removable prosthetics. This determination will be made by a licensed dentist.

Documentation Required for Authorization of Excision of Bone Tissue

- Appropriate radiographs and/or intraoral photographs which clearly identify the lateral exostosis must be submitted for authorization review; bitewings, periapical or panorex.
- Study models identifying the lateral exostosis (es) to be removed.

Members are educated about the prior authorization process via their MCNA Member Handbook. All members will receive a Member Handbook at the time of enrollment. Our Member Handbook is also available online via MCNA's dedicated Nebraska website and in the Member Portal. Please see a sample excerpt below from MCNA's Louisiana Adult Denture Program which illustrates the prior authorization process for denture services.

How do I get covered denture services authorized?

If the dentist thinks you need denture services and meet the requirements for coverage, the dentist will send MCNA a request (prior authorization) before you can get the service. If you believe you need covered denture plan services, MCNA will accept your request for care through the Member Hotline or in writing, and we will refer you to a dentist for evaluation. 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 2 business days for regular requests.

We will let your dentist know if we approve the request. The dentist will contact you to make an appointment. We will tell you and your dentist if we deny or limit the services.

If you would like to check the status of your dentist's request, call our Member Hotline toll-free at **1-855-702-6262.**

Communicating the Results of Authorization Decisions

The requesting provider is notified of the UM determination via MCNA's online Provider Portal. The notification will include the authorization number and effective dates for all approvals. If a provider does not have access to the Provider Portal, a determination letter is mailed. The provider also receives telephonic notification of MCNA's determination for any urgent or emergent request.

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 MLTC. Member notices are written to ensure ease of understanding and are in compliance with all state, federal, and MLTC requirements. We use "plain language" rather than dental terminology, and the member's additional review rights are included in every notice. MCNA fully complies with all language requirements including the translation of member notices into Spanish and other languages as required.

Member and provider notifications explain, at a minimum, the:

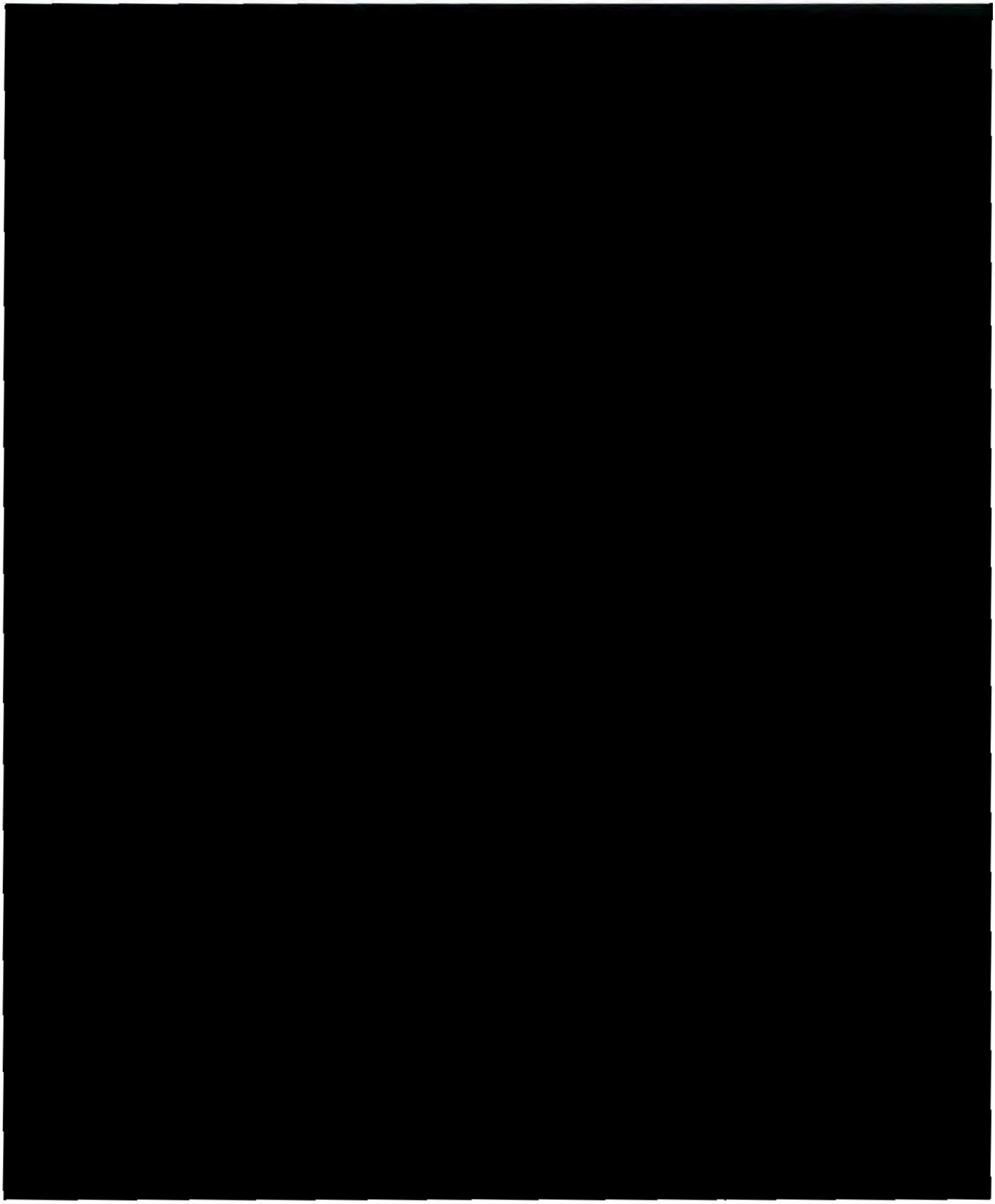
- Action MCNA has taken or intends to take
- Reasons for the action
- Member or provider's right to file a grievance or appeal

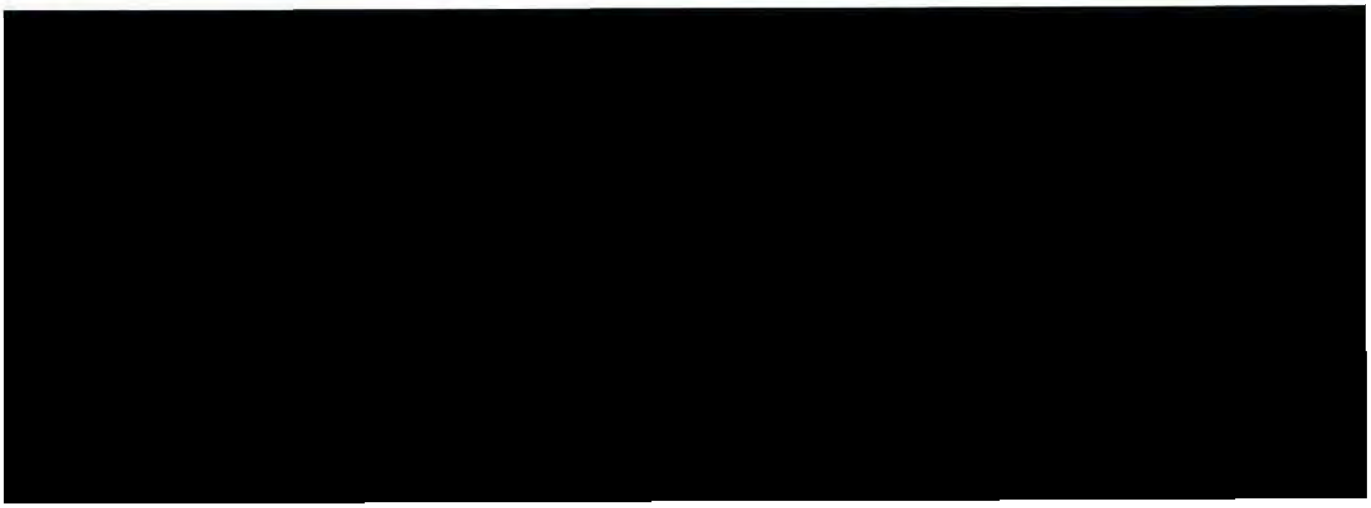
In the case of expedited service authorizations, the member will be notified within 72 hours of receipt of the request for authorization. Notification to both the member and provider is telephonic and will be followed by a written notice.

MCNA will also enable members to see any adverse action notification in real-time via our HIPAA compliant and innovative Member Portal. The posted notice will be an exact duplicate of the letter that is mailed to the member. We exceeded all contractually required turnaround times in 2014 and 2015 for authorization review services in all markets served. Our turnaround time currently exceeds all MLTC performance standards.

Please see the following table for a list of services that will require prior authorization or pre-payment review in Nebraska.

[redacted]





52	**Describe how the DBPM will ensure members receive written and timely notice of action relating to adverse actions taken by the DBPM.**

Timely Member Notification

MCNA strives to process all standard prior authorization requests within two business days of receipt, but no later than 14 days following receipt unless an extension is granted. The notification letter is mailed to the member within one (1) business day of the determination. In the case of expedited service authorizations, the member will be notified within 72 hours of receipt of the request for authorization. Notification to both the member and provider is telephonic and will be followed by a written notice. MCNA will also enable members to see any adverse action notification in MCNA's Member Portal.

Monitoring to Ensure Performance Standards

Monthly reports are generated and used by the Vice President of Dental Management and Quality Improvement, and the Director of Utilization Management and Case Management to identify trends and ensure compliance with our contractual requirements. If a deficiency occurs, they develop process improvement strategies to address the issue in question. Examples of process improvements include hiring additional staff and conducting additional training to improve performance.

[redacted]

53	**Describe the DBPM's process for conducting retrospective reviews to examine trends, issues, and problems in utilization.**

Retrospective Reviews

In general, MCNA conducts retrospective analysis of all service authorization types and monitors for overutilization, underutilization, potential fraud, waste, or abuse, and quality of care issues.

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 statistics
- Preventive services (HEDIS measures)
- Provider referral patterns
- Member complaints, grievances, and appeals
- Potential quality of care issues
- Primary Care Dentist change request data
- Referral and authorization data
- Member and provider demographics

Utilization Management Objectives

- Routinely assess the efficacy of our clinical criteria and guidelines, and service authorization practices
- Evaluate the use of dental treatment technologies by our providers
- Detect overutilization and underutilization of diagnostic, preventive, and restorative services with a priority on ensuring that EPSDT screenings and preventive services 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, utilization policies, and quality improvement goals

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, provider-specific trends, and service 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
- 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.

Addressing Provider Overutilization and Underutilization

Retrospective reviews allow MCNA to detect instances of over- and underutilization of services and outlier practice patterns. 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's clinical practice guidelines may be considered for termination from our network. The most common underutilization of dental services includes:

- Provider failing to render a fluoride treatment at the time of a dental prophylaxis (cleaning)
- Provider rendering a prophylaxis 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 overutilization pattern is identified for a provider, they are requested to submit supporting documentation. Common examples of provider overutilization include:

- Performance of an unnecessary pulpotomy in conjunction with providing a crown
- Extracting a tooth that could be restored (filling)
- Surgical extractions of asymptomatic third molars

Once the information is received, it is forwarded to our Quality Improvement Department for analysis by a Clinical Reviewer. All MCNA Clinical Reviewers are licensed dentists. If a quality of care issue is suspected, the Clinical Reviewer will examine the provider's request 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 action 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. If fraudulent activity is suspected, the information is referred to MCNA's Special Investigations Unit.

54	**Describe the DBPM's methodology to assess disparities in treatment among races and ethnic groups and correct those disparities.**

Improving Health Literacy

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 among diverse populations.

Members can reach MCNA via a dedicated toll-free Member Hotline from 7:00 am to 7:00 pm CST, Monday through Friday. Our call center is staffed with individuals who speak a variety of languages including English, Spanish, Haitian Creole, French Creole, Vietnamese, and French. Any languages not spoken by our call center staff are easily available through the use of our translation vendor, LanguageLine. A TTY/TDD line is also available for members who are deaf, hard of hearing, or speech impaired. Members who are unable to push telephone buttons are prompted to remain on the line while the call is routed to a Member Services Representative.

MCNA's website enables members to access resources 24 hours a day, 7 days a week; members are able to send secure email messages to MCNA, download oral health and hygiene information, and select a dentist. We also have an interactive section of the website called "MCNA Kids Zone," which contains games and videos geared toward improving the oral health literacy of our members. MCNA utilizes social media tools such as Facebook, Twitter, and YouTube to connect with members and educate them about the importance of proper oral hygiene and the need to seek timely dental care.

Reducing Health Care Disparities

MCNA assesses health care disparities among races and ethnic groups by evaluating available demographic and utilization data (including claims data). Additionally, we monitor census data and state-specific sources of information, such as reports produced by the Nebraska Office of Health Disparities and Health Equity (OHDHE). **MCNA looks forward to partnering with the OHDHE to eliminate disparities for culturally diverse populations in Nebraska.**

Population-specific, **leading-edge outreach** efforts are MCNA's specialty. In Texas, MCNA's Member Advocate Outreach Specialists (MAOS) assist with targeted population outreach efforts for underserved racial and ethnic groups. For example, Children of Migrant Farm Workers (CMFWs) are a special population identified as needing additional assistance because of unconventional living conditions, migratory work patterns, unhealthy working conditions, poor nutrition, and limited English proficiency.

MCNA recognizes the importance of ensuring that this very mobile population remains compliant with the EPSDT periodicity schedule. Our 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. **The Texas Health and Human Services Commission commended MCNA's "out of the box" outreach approach.**

In addition to designing culturally favored outreach materials, MCNA MAOS partner with other organizations who serve the CMFW population to increase outreach and awareness about the need for timely dental care. MCNA's **unique** outreach efforts yielded very positive results in our Texas program. In state fiscal year 2016, MCNA identified 9,960 CMFWs throughout all regions in Texas. In 2015, we **ranked #1 in Migrant Incentive Points**, a measure used by the Texas Health and Human Services Commission to quantify CMFW outreach efforts.

We look forward to replicating this proven approach to reducing disparities among Nebraska's racial and ethnic populations.

55	**Describe the DBPM's approach for meeting the Program Integrity requirements described in the RFP, including but not limited to a compliance plan for the prevention, detection, reporting, and implementation of corrective actions for suspected cases of FWA and erroneous payments. Include best practices the DBPM has utilized in other states.**

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, Waste, and Abuse (FWA) and Erroneous Payments Compliance Plan (known as 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 Nebraska Fraud and Abuse Program will adhere to all requirements outlined in section IV.O of the RFP, and includes all required components of the plan outlined in section IV.O.8. Our Fraud and Abuse Program will also comply with all applicable State and federal requirements, including 42 CFR §438.1 - §438.812, relating to FWA and erroneous payments.

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 by participating and non-participating providers. **Our SIU is a dedicated team of Certified Fraud Examiners (CFEs), profiling analysts, investigators and clinical reviewers with over 200 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 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 fraud related matters. Our SIU team will meet with MLTC, the Nebraska Medicaid Program Integrity Unit (NMPI), and the Attorney General's Medicaid Fraud and Patient Abuse Unit (MFPAU) to discuss FWA and overpayment issues.

Training for Employees and Subcontractors

The training of employees at all levels is an essential component of an effective Fraud and Abuse Program. All MCNA employees receive FWA training within 30 days of initial hiring, upon adoption of updates to the Fraud and Abuse Program, and annually as a condition of employment. Thirty days before an employee's anniversary, our Human Resources Department begins the process of reminding

all employees of their upcoming annual training. Members of the Board of Directors also receive compliance training annually. All subcontractors are educated about their responsibilities regarding FWA and erroneous payments. Information about the Fraud and Abuse Program is part of all provider contracts and MCNA's Provider Manual.

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. If an employee has not completed scheduled training within the required timeframe, the Human Resources Director notifies the employee's supervisor of his or her non-compliance, and the employee may be removed from his or her duties until training is complete. Ongoing training is provided to departments affected by a material change in policies or procedures, and state and federal regulations.

Screening for Excluded or Disbarred Entities

MCNA recognizes that we are prohibited from entering into or maintaining relationships with any person or entity who is debarred, suspended, or excluded from participation in a federal healthcare program as described in 42 CFR §438.610. Our Fraud and Abuse Program provides written policies and procedures that outline MCNA's commitment to comply with all state and federal requirements and to use established protocols to identify debarred individuals or excluded providers. The Credentialing and Human Resources departments are responsible for ensuring that MCNA does not hire, or enter into contracts with individuals or entities that are listed as debarred, suspended, excluded or otherwise ineligible for participation in state and federal health care programs including both Medicaid and Medicare. Upon initial employment and contracting, and monthly thereafter, the following websites are monitored to ensure that prospective and current employees, providers, subcontractors, and other individuals affiliated with MCNA are not listed:

- The Office of the Inspector General's (OIG) List of Excluded Individuals and Entities database
- Federal System for Award Management (SAM) sanctions and debarment reports
- Nebraska Medicaid Excluded Providers list and Nebraska Board of Dentistry
- Healthcare Integrity and Protection Data Bank (HIPDB)

If MCNA discovers that any owner, employee, network provider, subcontractor, or subcontractor's employee has been excluded, suspended, or debarred from any state or federal healthcare program or any program listed in Executive Order 12549, the Chief Compliance and Privacy Officer will report such information to the NMPI within three (3) business days. **MCNA will immediately initiate efforts to sever the relationship with the debarred or excluded individual or entity.**

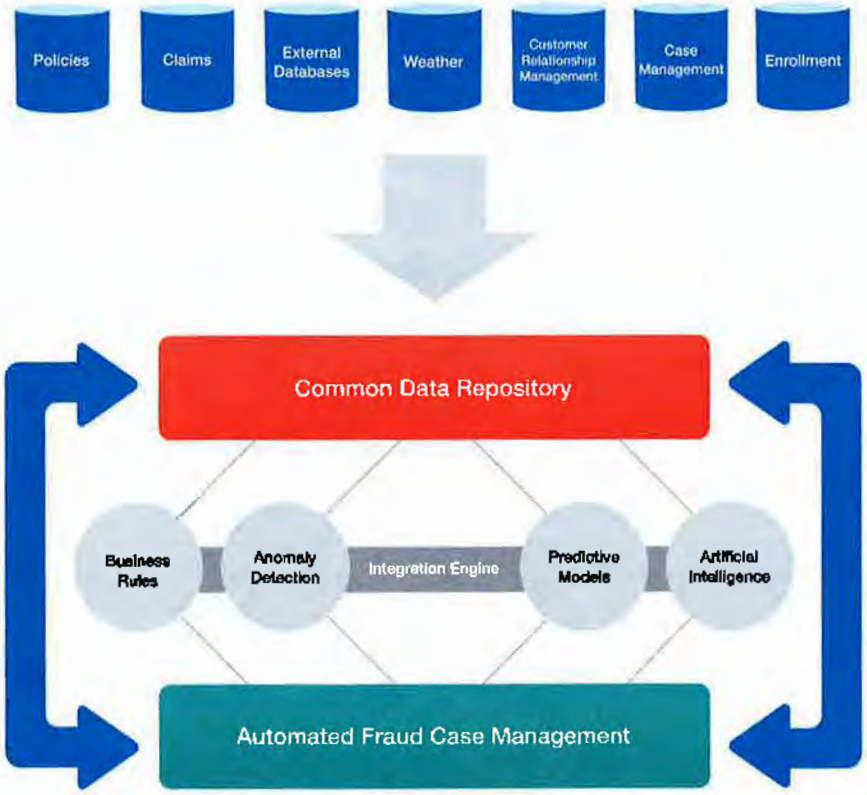
Fraud Prevention and Detection Measures

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 (MIS), DentalTrac™, allows for powerful, **data-driven**

predictive analytics. Our system generates trends and predictive models that are critical indicators used on a daily basis by our SIU for combating fraud and abuse. DentalTrac™'s extensive 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 diagram to the right outlines our comprehensive detection approach.



Every claim is passed through a series of intelligent filters in DentalTrac™ for a complete profiling analysis. Our MIS applies the proven algorithms in real-time throughout the lifecycle of the claims:

- Prior to adjudication
- Post-adjudication but prior to payment
- Post-payment (retrospective)

[redacted]

56	Describe how the DBPM currently works with other entities that investigate and prosecute provider and member fraud, waste, and abuse. How will the DBPM apply methods in Nebraska?

We are committed to maintaining close relationships with MLTC and other Nebraska state agencies. In Texas, Louisiana, and Iowa, our SIU and clinical review teams have routinely met with the State agencies responsible for program integrity activities to assist them with their investigation and recoupment efforts, and to participate in training sessions with the agencies' staff. We look forward to working with the NMPI and MFPAU.

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. In the past, **the Texas Attorney General invited MCNA's SIU Manager to train their 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.

It is MCNA's mission to support and aid state agencies in their fight against fraud, waste, and abuse, and improve the integrity of their Medicaid Programs. We will cooperate and assist MLTC and any state or federal agency charged with identifying, investigating, sanctioning, or prosecuting suspected fraud and abuse. Access to originals and copies of all records, computer files, appropriate staff, and other information requested will be provided, and MCNA will allow access to our premises and provide records to MLTC or its authorized agents, CMS, the U.S. DHHS, the FBI, and other units of state or federal government. We will also participate in periodic FWA and erroneous payments training sessions, meetings, and joint reviews of network providers or members. MCNA will also participate in and attend the quarterly Nebraska Health Care Fraud Task force meeting.

MCNA commits to applying the highest ethical standards and diligence to prevent the occurrence of fraud and abuse of Nebraska Medicaid resources. Every dollar saved benefits those members that are truly in need of Medicaid program assistance.

57	**Currently, how does the DBPM educate members and providers to prevent fraud, waste, abuse, and erroneous payments? How will the DBPM apply methods in Nebraska?**

Member Education

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 fraud, waste, abuse, and erroneous payments requires the use of multiple channels of communication. MCNA provides information on our website about what constitutes FWA and how to report any suspicious activity to MCNA. We let members know that card sharing is also a form of FWA and is prohibited. This information is included in our Member Handbook, along with instructions on how to report suspicious activities to MCNA and/or the State. Please see page 38 of **Attachment 16-1**, MCNA's Draft Member Handbook, for sample content.

Provider Education

MCNA's education efforts with the provider community begin with coverage of FWA in our Provider Orientation training sessions. Our Dental Provider Agreement and Provider Manual educate providers about prohibited practices and affiliations. We disseminate a monthly provider newsletter, *Dental Details*, which contains frequent reminders to providers about their responsibilities regarding FWA and erroneous billing. MCNA's dedicated website also provides information on how to identify and report suspected FWA or erroneous billing activities.

Applying Proven Methods to Nebraska

In addition to continuing the communication methods described above for both members and providers, MCNA will implement several of the techniques that have proven successful in combatting FWA and erroneous billing in other markets.

Member Verification of Services Billed

MCNA has a process in place for verifying with members whether services billed by providers were received in accordance with 42 CFR §455.20 (Beneficiary Verification Procedure). On a monthly basis, the SIU will run a random sampling and select a predetermined percentage of members. The verification process will be conducted by sending members a copy of their Explanation of Benefits (EOB) or by member phone interviews. MCNA will report all member verification activities to:

- MCNA's FWA Committee and Compliance Committee on a quarterly basis; and
- To MLTC in the frequency required by the Agency.

MCNA reserves the right to send additional verification of services letters to members and conduct member phone interviews in connection with targeted provider investigations, provider profiling

activities, and other program integrity undertakings. Excessive visits or services, questionable services, or recurring billing patterns may warrant contact with the member to ascertain whether the billed services were actually rendered.

SIU will request dental records for discrepancies identified during the verification process. Those records will be evaluated and if the billed services are not listed in the record, a full investigation will be opened and funds will be recouped.

Provider Profiling Analysis, Peer Outlier Reports, and Claims Authentication

As noted in our response to Question 55, MCNA generates provider profiles based on analysis of claims, prior authorizations, and other available data. The most common analytics we utilize are:

- Historical data aggregation
- Data consolidation from various data sources
- Fraud scoring using various statistical approaches (e.g. STDV, z-scores)
- Ranking and prioritization of fraud using fraud scores and different detection alerts
- Incorporation of clinical guidelines to determine outliers
- Integration with external data sources to augment profiling patterns

These extensive datasets are then analyzed to determine which providers are outliers with regard to their clinical practices and/or billing patterns. MCNA uses Peer Outlier Reports to compare provider statistics against industry-defined benchmarks for Medicaid 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 Peer Outlier Reports include:

- 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 treated
- Average number of services billed per member
- Number of members billed per day
- Claims volume by provider by month

Texas example: A large, multi-provider facility was found to be consistently billing replacement composite resins less than 12 months after the original date of service. MCNA's Texas Dental Director and Pediatric Dental clinical reviewer met with the owner/lead dentist in a peer-to-peer phone conference to discuss:

- Billing guidelines and patterns
- Documentation to support the medical necessity for replacement restorations
- Root cause analysis to determine the reasons for performing and billing replacement fillings
- Recommendation to review techniques and materials with associate dentists to ensure restorations are performed within the standard of care

The education session yielded positive results by decreasing the facility's billing of replacement fillings. The facility now produces evidence of medical necessity by submitting x-rays and/or intraoral photographs with prior authorizations and claims.

MCNA views our relationship with providers as a partnership. Increased provider education as a corrective action has greatly reduced abuse and overutilization, and strengthened the professional relationships we enjoy with our providers.

58	**Describe the DBPM's method and process for capturing TPL and payment information from its claims system. Explain how the DBPM will use this information.**

Ensuring Medicaid is the Payer of Last Resort

MCNA's coordination of benefits (COB), third party liability (TPL), and subrogation processes are designed to ensure that Medicaid is the payer of last resort and any other available TPL resource is pursued. We exercise full assignment rights, as applicable. We understand that MCNA must demonstrate to MLTC that reasonable effort has been made to seek, collect, and report TPL, and our cost avoidance and recovery efforts. Further, we acknowledge that MLTC has the sole responsibility for determining whether or not reasonable efforts have been demonstrated, and this determination will consider reasonable industry standards and practices.

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 COB or the subrogation process using DentalTrac™'s COB and TPL module. MCNA also identifies the existence of potential TPL through the use of diagnosis and trauma code editing in accordance with 42 CFR §433.138(e). 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. DentalTrac™ auto-generates 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 ensures Medicaid is the payer of last resort by enforcing third-party recovery, including alerting MCNA staff when COB situations are identified post-payment. We acknowledge that TPL amounts collected may be retained in accordance with the RFP provisions, and the TPL recoveries will be considered during the MLTC rate setting process.

We acknowledge that MCNA, its subcontractors, and providers must not pursue collection from the member, but directly from the liable third party, except as allowed in 468 NAC Chapter 4-002 and 471 NAC Chapter 3-004. If a TPL insurer requires the member to pay any co-payments, coinsurance, or deductibles, MCNA acknowledges that we are responsible for making these payments even if the services are provided outside of our network.

MCNA understands that MLTC may require a MLTC-contracted TPL vendor to review paid claims that are over ninety (90) calendar days old and pursue TPL (excluding subrogation) for those claims that do not indicate recovery amounts in our encounter data. MLTC may pursue recovery if MCNA fails to

recover reimbursement from a third party to the limit of legal liability 365 days from the date of service of the claim(s).

Cost Avoidance

All claims are cost-avoided if MCNA establishes the probable existence of TPL at the time the claim is filed. TPL is established when MCNA receives confirmation that another party is, by statute, contract, or agreement, legally responsible for the payment of a claim for a health care item or service delivered to a member. MCNA coordinates benefits in accordance with 42 CFR §433.135, et seq., and 471 NAC 3-004 in order to avoid costs and recover payments from liable parties as appropriate.

MCNA will include in our Nebraska provider agreement provisions specifying the provider's responsibility regarding TPL, including identifying TPL coverage (including Medicare and long-term care insurance as applicable), and seeking TPL payments before submitting claims to MCNA.

Post-Payment Recovery

In situations where the probable existence of TPL cannot be established, MCNA must adjudicate the claim and later pursue post-payment recovery if new information is obtained. MCNA will seek recovery within sixty (60) calendar days after the end of the month it learns of the existence of a liable third party after a claim is paid. We also pay and chase claims for which third-party liability is derived from an absent parent whose obligation to pay support is being enforced by the DHHS Division of Children and Family Services.

MCNA has established procedures for recovering post-payments that will be submitted to MLTC for review and approval during the readiness review. We seek recovery from auto insurance and property and casualty carriers in instances where accident and trauma-related claims exceed $250.00. MCNA seeks subrogation amounts regardless of the amount believed to be available as required by Federal law. The amount of any recoveries collected by MCNA outside of the claims processing system is treated as an offset to medical expenses for the purposes of reporting. We understand that all encounters for claims that are recouped in full must be voided, and partial recoupments must be submitted as adjusted encounters.

Coordination of Benefits for Dual Eligible Members

MCNA is responsible for providing medically necessary covered services to members who are also eligible for Medicare if the service is not covered by Medicare. We ensure that services covered and provided under this contract are delivered without charge to members who are dually eligible for Medicare and Medicaid, and we coordinate benefits with Medicare payers, Medicare Advantage Plans, and Medicare providers. MCNA's claims system will identify all dual eligible members. We will then reach out to each member telephonically via the Care Connections Team to identify the member's plan in order to determine any dental coverage that might exist.

MCNA will sign a Coordination of Benefits Agreement and participate in the automated crossover process administered by Medicare. Under this crossover process, a Medicare provider, who may or may not be part of our network, must submit a claim to Medicare and there is an automatic crossover to MLTC for whatever Medicaid payment is due.

Capturing and Using TPL Information

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 MLTC TPL files, enrollment data, claims data, and statements recorded directly from members or providers during discussions with our call center representatives.

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 Recovery and Subrogation Unit (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 accordance with the requirements set forth in this RFP.

TPL Reporting Requirements

MCNA will provide any third party resource information to MLTC in the frequency and format specified by MLTC. We will fully cooperate with MLTC and its vendors. Any money recovered from third parties will be retained by MCNA and reported monthly to MLTC. We will submit an annual report of all health insurance collections for our members plus copies of any Form 1099s received from insurance companies for that period of time.

We will post all third-party payments to claim level detail by member. Our encounter data will include the collections and claims information, including any retrospective findings via encounter adjustments.

At the request of MLTC, MCNA agrees to provide information not included in encounter data submissions that may be necessary for the administration of TPL activity. This information must be provided within thirty (30) calendar days of MLTC's request. This information may include, but is not limited to, individual medical records to determine liability for the services rendered.

MCNA will report members with third party coverage to MLTC on a monthly basis, reporting additions and updates of TPL information in a format and medium specified by MLTC.

59	**Describe the DBPM's approach to ensuring that out of network prior authorization and payment issues are resolved expeditiously in instances when the DBPM is unable to provide necessary services to a member within its network.**

Continuity of Care During Transition

MCNA has extensive experience in large-scale member enrollments. Our experience in Louisiana **illustrates our flawless process** for ensuring continuity of care during the transition of 1.2 million members. For example, thousands of Louisiana members had existing approved prior authorizations for services when the fee-for-service program transitioned to MCNA as the sole DBPM on July 1, 2014. MCNA educated both members and providers about the MCNA continuity of care process, and enabled members to receive care from out-of-network providers for a period of 30 days after the go-live date.

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. MCNA will accept all active authorizations from MLTC and load them into our system to enable members to receive care during the transition without the need to submit a new prior authorization request. We will honor approved prior authorizations from out-of-network providers during the transition and will ensure that the out-of-network providers are paid timely and in accordance with the requirements of the RFP.

During the initial 90 calendar days of the Nebraska DBPM contract, MCNA will pay out-of-network providers 100% percent of the Medicaid rate. Every member transitioning into MCNA is allowed to continue previously authorized, medically necessary covered services with an in-network or out-of-network provider, without any additional prior authorization requirements from MCNA. The member will be able to continue this care for a period of 30 calendar days after go-live. Ongoing authorization of services for continued treatment beyond 30 days will be reviewed through the standard authorization process.

The MCNA Provider Relations Department seizes every opportunity to enhance our network by inviting our members' non-participating providers to join. Should the provider choose not to participate, MCNA's Member Advocate and Outreach Specialists (MAOS) will contact the dental office to assist in transferring the member's dental records to their newly selected in-network provider.

Access to Emergency Services

MCNA ensures that our members have access to covered emergency dental care services without any delay or hindrance. Our members have access to emergency and post-stabilization care without the need to obtain pre-authorization and can receive services through any emergency facility or provider, regardless of whether the facility is in or out-of-network. We reimburse emergency service providers at 100% of the Medicaid rate in effect on the date of service in order to comply with Section 6085 of the Deficit Reduction Act of 2005.

Out-of-Network Care

MCNA makes every effort to ensure that all medically necessary covered services are available through our robust network of general and specialty care dentists. If we are unable to provide services through a network provider MCNA will adequately and timely arrange for the member to receive care from an out-of-network dentist. We will ensure that all prior authorization and payment issues are resolved as quickly as possible.

After the transition period, MCNA executes a letter of agreement (LOA) with out-of-network providers who provide authorized, non-emergency care to our members. The LOA sets forth the terms of payment and includes a provision against balance billing to ensure that the cost of care for the member is no greater than if the provider was in-network. MCNA collects enough detail about the out-of-network provider to screen for any exclusions, debarments, or licensure actions that would prevent the provider from being able to provide services to the member. The provider's NPI and other details are loaded into the DentalTrac™ system to ensure accurate payment and enable the generation of a 1099 for tax purposes.

MCNA understands that for services that do not meet the definition of emergency services, we are not required, unless otherwise provided for in this contract, to reimburse out-of-network providers at more than ninety percent (90%) of the Medicaid rate in effect on the date of service to providers with whom we have made a minimum of three documented attempts to contract.

60	**Provide a general system description that details how each component of the DBPM's health information system will support the major functional areas of the DBP. Include a systems diagram that highlights each system component, including subcontractor components, and the interfacing or supporting systems used to ensure compliance with RFP requirements. Describe how the DBPM's system will share information between Nebraska's systems and its own system to avoid duplication of effort. Identify any requirements that cannot be met without custom modifications or updates to the DBPM's systems. If modifications or updates or updates are required, describe them and the DBPM's plan for completion prior to program operations.**

[redacted]

[redacted]

61	**Provide a description of how the DBPM will comply with applicable Federal (including but not limited to HIPAA) standards for information exchange, and ensure adequate system access management and information accessibility. Affirm the DBPM's use of HIPAA-compliant files and transaction standards. Include the process for resolving discrepancies between member eligibility files and the DBPM's internal membership records, including differences in members' addresses.**

[redacted]

Use of HIPAA-Compliant Files and Transaction Standards

DentalTrac™ currently complies with all requirements associated with HIPAA. We have designed and implemented a complete set of controls to govern the accuracy and completeness of our receipt and transmission of data. Our EDI subsystem is fully compliant to HIPAA ASC X12 5010 standards as well as other industry standards. Refer to the table to the right for a list of currently supported file format standards.

All of our HIPAA ASC X12N transaction files are **fully compliant to HIPAA 5010** requirements. We support the full set of HIPAA 5010 transaction files and the ICD-10 code set.

Supported File Format Standards	
HIPAA ASC X12 270/271	Health Care Eligibility Benefit Inquiry and Response
HIPAA ASC X12 276/277	Health Care Claim Status Request and Response
HIPAA ASC X12 277CA	Health Care Claims Acknowledgement
HIPAA ASC X12 277U	Health Care Claims Status Response
HIPAA ASC X12 278	Health Care Services - Request for Review and Response; Health Care Services Notification and Acknowledgment
HIPAA ASC X12 820	Payroll Deducted and Other Group Premium Payment for Insurance Products
HIPAA ASC X12 834	Benefit Enrollment and Maintenance
HIPAA ASC X12 835	Health Care Claim Payment/Advice
HIPAA ASC X12 837D	Health Care Claim: Professional, Institutional, and Dental, including coordination of benefits (COB) and subrogation claims
HIPAA ASC X12 997	Functional Acknowledgement
HIPAA ASC X12 999	Functional Acknowledgement
NSF	National Standard Format
HL7	Health Level Seven
XML	Extensible Markup Language
UDF	User Defined File

62	**Describe the DBPM's approach to monitoring system availability issues and the resolution process. Provide a description of the DBPM's system help desk. Include the DBPM's process for ensuring that recurring problems, not specific to system unavailability, are identified and reported to DBPM management within one business day of recognition and are promptly corrected.**

63	**Provide a description of the DBPM's eligibility and enrollment database. Include a description of how the DBPM will:** • **Complete updates within the timeframes specified in the contract.** • **Identify members across multiple populations and systems.** • **Monitor, track, and resolve any discrepancies between the enrollment files and the DBPM's system (e.g., duplication of records and information mismatches).**

Eligibility and Enrollment Database

DentalTrac™'s comprehensive eligibility and enrollment module uses a sophisticated **business rules engine to process benefit and enrollment data transmissions** and to determine eligibility and benefits of members. Our system accepts HIPAA-format and proprietary member enrollment files transmitted daily by trading partners. DentalTrac™'s sophisticated EDI subsystem also allows us to accept eligibility and enrollment data in virtually any data format provided. We are able to process data files with fixed or varying layouts, file formats, and delivery methods.

Currently, we receive and process eligibility and enrollment data files from twelve different trading partners, most using HIPAA ASC X12N 834 file format and the rest using proprietary file formats. Our EDI subsystem and our Automated Communications Module (ACM) are responsible for automatically retrieving data files from our trading partners, applying all validation and business rules applicable to each trading partner and program administration. Scheduling the retrieval of data files from our trading partners can be configured with granularity down to a one-minute interval.

In 2015, the MCNA EDI module processed over 85 million enrollment transactions for almost 3 million members with an average turnaround time of 19.7 hours from the time the transaction file was received.

Upon processing eligibility and enrollment files, DentalTrac™ follows business rules that trigger multiple validation checks during the process as well as execute the necessary steps to satisfy contractual compliance. During the validation points, DentalTrac™ generates integrity checksums and reports that confirm the electronically transmitted data file was not altered in any way during processing.

Our Enrollment Coordinator works with the Member Services Department to ensure the accuracy and timeliness of member enrollment information. The Coordinator can manually update plan-approved changes to a member's eligibility record in real-time, **ensuring members always obtain the services to which they are entitled**. DentalTrac™'s extensive logging capabilities maintain an audit trail for all current and retroactive changes to enrollment data, whether those changes arise from manual updates or from processing an electronic transmission. Our Member Services Representatives also have functionality available to them to capture additional information from our members, which may not always be available in the eligibility and enrollment files. Additionally, member address changes and

telephone number changes will be transmitted to MLTC within the required time frame and in the format required.

DentalTrac™ leverages its uniform data dictionary to enforce referential integrity checks when loading and processing eligibility and enrollment files. Members are assigned a unique member number that persists across changes in demographics and changes in eligibility benefits and categories. Member eligibility is managed through non-overlapping dated eligibility spans which are linked to the member's record. All information in the eligibility and enrollment files provided by MLTC will be stored within DentalTrac™ and linked to the member's profile for referential and reporting purposes.

DentalTrac™'s business rules and data integrity validations allow MCNA to automatically identify potential duplicates by comparing key identifying criteria such as name, address, date of birth, social security number, and Medicaid ID. When potentially duplicate records are identified, DentalTrac™ uses advanced heuristics to determine the certainty level of duplication and will automatically merge the records when the certainty level exceeds business-defined thresholds. When these thresholds are not met, an exception report is generated and reviewed by our Enrollment Coordinators to identify the true nature of the duplication and to determine the need to merge the duplicate records. Once duplicate records are merged, all history associated with the member profiles are linked for transparency. Eliminating duplication allows us to administer members' benefits more efficiently and report information back to MLTC more accurately.

MCNA's Enrollment Manager (EM) will work directly with MLTC 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 are processed **within 24 hours from the time of receipt**
- Reconciling the enrollment data and resolving discrepancies
- Reviewing enrollments and disenrollments to identify potential issues, and ensuring each member's eligibility status is accurate
- Notifying MLTC **within 6 hours of file receipt** if any issues are identified during processing

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, pre-authorizations, complaints, grievances, 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.

Please see **Attachment 63-1** for a flowchart that 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 MLTC.

64	**Provide a description of the DBPM's information security management functions. Include a description of proposed access restrictions for various hierarchical levels, controls for managing information integrity, audit trails, and physical safeguards of data processing facilities.**

[redacted]

[redacted]

[redacted]

[redacted]

65	**Describe the DBPM's business continuity, contingency, and recovery planning. Attach a copy of the DBPM's plan, or summarize how the plan addresses the following aspects of emergency preparedness and disaster recovery:** • **Operational and system redundancy in place to reduce the risk of down-time.** • **System and operational back-up sites.** • **Contingency and recovery planning including resumption of operations.** • **Prioritized business functions for resumption of operations and responsible key personnel.** • **Employee and supplier preparedness, including a plan for training and communication to employees and suppliers and identified responsibilities of key personnel, in the event communications are unavailable.** • **Approach to provider preparedness for continuity of member care and assurance of payment for services rendered in good faith.** • **Testing approach and regular schedule to improve and update the plan over time.**

Overview of MCNA's Business Continuity and Disaster Recovery

MCNA maintains a detailed plan governing all disaster recovery and continuity of operations activities we will undertake before, during, and after a catastrophic event. This detailed plan, named the **Disaster Recovery and Business Continuity (DR/BC) Plan,** has been audited and approved by an independent firm meeting the American Institute of Certified Public Accountants standards as presented in our Service Organization Control (SOC) 2 Type 2 Report.

[redacted]

[redacted]

[redacted]

[redacted]

66	**Describe the DBPM's strategies for ensuring its claim processing is ready at the time of contract implementation, to ensure timely accurate claims processing. Include the DBPM's strategy for identifying problem areas, and how the DBPM will ensure rapid response.**

MCNA's record of successful implementations has been flawless throughout our transitions for Medicaid and CHIP programs in Texas, Louisiana, Florida, and Iowa. 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 Nebraska covered services and plan benefits as part of this RFP along with any additional documentation provided by MLTC. 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.

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 Nebraska 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 MLTC. 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.

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 MLTC. **These edits are already implemented in a Nebraska dedicated environment of our management information system in preparation for the Readiness Review process that includes a live demonstration of our auto-adjudication logic and claims processing functionality.**

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 MLTC 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 MLTC and its MMIS.

MCNA's extensive experience in Medicaid 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 MLTC to ensure a smooth and successful implementation.** Our testing encompasses all aspects and required linkages within the DentalTrac™ system to ensure the following components are operational and integrated into the claims management process:

- 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 including Fee Schedule/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 have designed custom dashboards to continuously monitor 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.

All processes and metrics will be audited to identify problems or deficiencies. Our claims and implementation teams will develop corrective action plans on a continuous basis to ensure a rapid response to any identified problems. This commitment to quality and our thorough approach to testing prior to and during Readiness Review will ensure that DentalTrac™ is ready at the time of implementation and **will meet and exceed all claims requirements** including the timeliness standards set forth in the RFP. Please refer to **Attachment 78-1** for our draft implementation plan which includes a high level overview of claims processing tasks.

67	**Describe the DBPM's methodology for ensuring that claims payment accuracy standards will be achieved. At a minimum, address:** • **The process for auditing claims samples.** • **Documentation of the results of these audits.** • **The processes for implementing any necessary corrective actions resulting from the audit.**

MCNA's Process for Auditing Claims

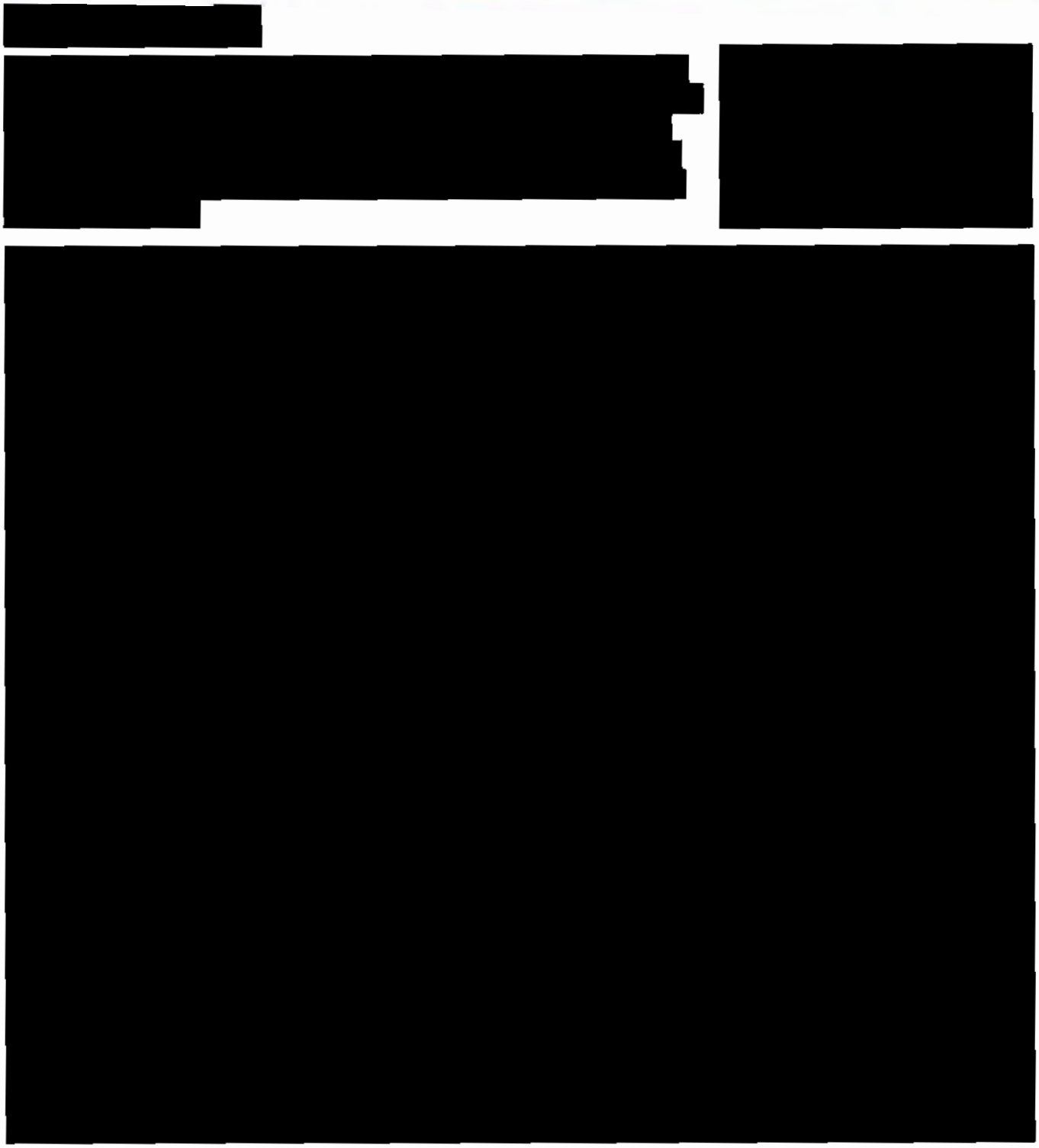
MCNA's auditing process is focused on ensuring that Medicaid is the payer of last resort, and that all dollars allocated to the Medicaid and CHIP programs are used to benefit our members through appropriate coverage of dental care services. Our commitment to continuous process improvement permeates throughout our organization. Our comprehensive auditing policies and procedures address elements that ensure compliance with all internal key performance metrics and regulatory requirements. MCNA commits to ensuring compliance with all requirements of this RFP including the provision of written documentation of all audit results to Nebraska on a monthly basis and submission of the required Claims Payment Accuracy Report.

Our **Compliance Audit Team** (CAT) is responsible for auditing MCNA's claims process, and reports directly to our Chief Compliance and Privacy Officer, Mayre Thompson. Mayre, a former Program Analyst for the Bureau of Managed Care at the Florida Agency for Health Care Administration, reports results of the claims process audits 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.

The audit efforts implemented by the CAT staff provide a comprehensive and well-rounded evaluation of our claims management system and claims staff ensuring compliance with all contractual obligations and adherence to policies and procedures.

Sampling Methodology

Our MIS applies its algorithms to develop a stratified universe of claims processed during the review period. This universe encompasses the entire population of electronic and paper claims processed or paid on initial submission. A statistically-valid, random sample of all processed or paid claims on initial submission in each month is captured and stratified by provider and financial type.



68	**Describe in detail how the DBPM will verify that services were actually provided including:** • **Minimum sampling criteria to ensure a representative sample.** • **How results of monitoring will be reported to the State quarterly.**

Verification of Services Billed

As part of our Fraud, Waste, and Abuse Program, MCNA has a process in place for verifying with members whether services billed by providers were received in accordance with 42 CFR §455.20 and §433.116(e). On a monthly basis, our Special Investigations Unit (SIU) runs a random sampling algorithm to select a predetermined percentage of members who have received a service for which MCNA recently paid a claim. The paid claims sample will be a minimum of two percent (2%) of claims per month. The claim payment date can be no more than 30 days prior to the sample selection date to ensure that the verification is conducted within 45 days of the claim paid date in accordance with the requirements of this RFP. The minimum sampling methodology ensures that all general and specialty dentists and all claim types are proportionally represented. If MCNA believes that a particular service or provider type could be more prone to fraud, waste, or abuse, that provider type or service may be oversampled.

Survey Process

MCNA uses the sample to verify that the services billed were actually received by the members. We conduct the surveys using two methods: (1) mail and (2) outbound calls.

Each member in the mail sample group receives a notice in easily understood language that specifies:

- The description of the service furnished.
- The name of the provider furnishing the service.
- The date on which the service was furnished.
- The amount of payment made for the service.

The notice asks the member to notify MCNA if they did not receive the services listed or if the services they received differ from those listed. Please see below a sample letter that MCNA uses to verify service delivery.

The remaining members of the sample are contacted telephonically to confirm service delivery and validate the services that were rendered. MCNA's dedicated outbound call unit, the Care Connections Team, makes outbound calls to the sample members and notates the responses in each member's profile within DentalTrac™. Likewise, the following scenarios may also warrant attempting to contact a member by phone to ascertain whether the billed services were rendered:

- Excessive visits or services
- Questionable services
- Recurring billing patterns

MCNA will refer any member whose response indicates that services may not have been received to MLTC and to the SIU team for additional review within three (3) business days. Our SIU also requests dental records for any discrepancies identified during the verification process.

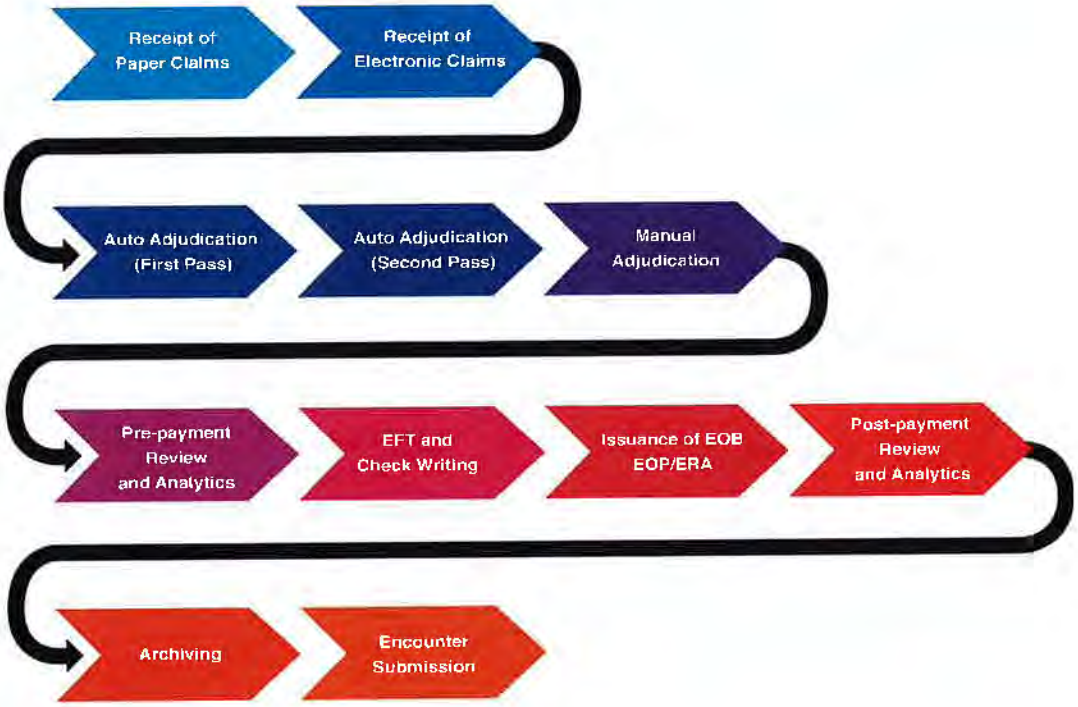
We track complaints received from members and resolve the complaints according to our grievance system process. The resolution may include referral to MLTC. MCNA will use the feedback received through complaints to modify or enhance the verification of services process.

MCNA will report the total number of service verification surveys sent out to members, the total number of surveys completed, the total number of services requested for validation, the number of services validated, and an analysis of interventions related to complaints or other issues, in accordance with the reporting requirements outlined in Attachment 5 to the RFP.

69	**Describe the DBPM's approach for ensuring encounter data is submitted accurately and timely to MLTC, consistent with required formats. Include in the response how the DBPM proposes to monitor data completeness and manage the non-submission of encounter data by a provider or subcontractor.**

MCNA has over a decade of experience processing Medicaid and CHIP dental claims and encounters, and successfully submitting encounter data to the states we serve. Complete and accurate encounter data begins with a comprehensive claims payment approach. Understanding claims processing and adjudication requires extensive knowledge of program benefits, proper standards of care, provider practice patterns, and member needs and behaviors. 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. Our claims management system functionality is in production today managing all of our lines of business, including dental managed care programs in Texas, Louisiana, Florida, and Iowa, where we have met or exceeded the performance requirements specified in this RFP.

The DentalTrac™ Claims module is designed specifically to operate public sector programs such as the Nebraska Medicaid Dental Benefit Program. DentalTrac™ enables us to deliver exceptional service levels across all of our claims capability core competencies and integrated components, including:



Our claims management system supports all modern claims capabilities, including electronic data interchanges (EDI), HIPAA transactions, and an MLTC-compliant claims adjudication and encounter submission process. Our highly trained claims and EDI management team is able to operate efficiently and reliably against the strictest guidelines without compromising quality or performance metrics.

Encounter processing controls initiate when a paper claim is received in our mail room or an EDI file is available from the clearinghouses, and continue to function until the remittance advice is issued to the provider. Our claims management system converts paper claims to electronic ASC X12N 837D files utilizing advanced Optical Character Recognition (OCR) technologies with over 99.5% accuracy. This ensures that all applicable edits, business rules, and validations implemented on electronic claims files are also applied to all paper claims. Claims submitted by providers are a critical component of provider reimbursement and proper administration of program benefits, and will ultimately be reported to MLTC as encounter data. Every paper claim submitted is time stamped, digitized, and logged by the mail room upon receipt. MCNA ensures that every inbound paper claim is accounted for through regular productivity and auditing reports.

Our dedicated EDI Department works with our 75 trading partners, dental providers, and other internal MCNA departments to ensure the seamless processing of all electronic claim and encounter submissions supporting our well-established, industry standard transaction files and protocols. Our EDI Department is available to assist our providers with any submission issues, including claims rejections for various reasons including invalid file formats, inability to identify the submitter, and unknown billing provider. EDI staff are also responsible for enforcing our encounter policies and procedures to guarantee that all encounter data is processed according to the specifications in this RFP.

MCNA is fully compliant with all state and federal requirements regarding transaction standards. All encounters are submitted electronically in the standard HIPAA transaction format and maintain integrity with all reference data sources, including member and provider records. We understand that should HIPAA standards evolve in the future, MCNA will coordinate the timing of the transition with MLTC, and make any system or process changes necessary to comply.

[redacted]

DentalTrac™ complies with industry-accepted clean claim standards for all encounter data, including submission of complete and accurate data for all fields required on standard billing forms or electronic claim formats. This supports the proper adjudication of a claim, enabling MLTC to perform comprehensive financial reporting and utilization analysis. In the event a provider submits a claim that is denied due to lack of sufficient or accurate data required for proper adjudication, MCNA will submit to MLTC all available data in relation to that claim without alteration or omission.

MCNA understands the importance of proper management of claims and encounter data. MCNA will transmit to MLTC complete encounter data and change history, including line-level detail, to enable all services submitted in a single claim to be easily ascertained. Although MCNA does not pay providers on a capitated basis, we understand that should we enter into a capitated reimbursement arrangement, we must contractually require submission of all utilization or encounter data to the same standards of completeness and accuracy, including pricing information, as required for proper adjudication of FFS claims. MCNA will make every effort to enforce this provision in order to ensure that MLTC receives accurate and complete encounter data.

We will submit encounter data no less than monthly on a date designated by MLTC. Additionally, within two (2) business days of the end of a payment cycle (the last cycle of the week if multiple payments are made within the week), MCNA will generate encounter data files for that payment cycle from our DentalTrac™ system.

All incoming data including, but not limited to, eligibility/enrollment, providers, claims, service authorizations, grievances, complaints and appeals, financial transactions, CDT codes, health assessment forms, and radiograph data are logged and monitored following established procedures and quality control processes, allowing us to confirm the completeness and accuracy of all transmissions. MCNA will collect and submit to MLTC complete and accurate data on member characteristics, provider characteristics, and services furnished to members through an encounter data

system, per the State's specifications. Controls implemented at the inbound point are used to verify that resulting transactions are complete.

Additionally, MCNA will reconcile all encounter data submitted to the State to control totals and to our MLR reports. The reconciliation will be provided to MLTC with each MLR report submission as specified in Attachment 5 of this RFP. MCNA submits encounter data that meets or exceeds MLTC quality standards, ensuring accurate, complete information for program administration. Our Texas, Louisiana, Florida, and Iowa encounter data submissions exceed the MLTC standard of 95%.

70	**Provide an example of dashboards that the DBPM will use to track DBPM performance for DBPM leadership and the QAPI Committee.**

Meeting Performance Standards

Our commitment to meet the performance standards set forth in this RFP begins with highly trained personnel who oversee each operational area of MCNA. Our team will be trained on all Nebraska program components, including eligible populations, covered services and limitations, and all service level goals and requirements. Our training protocols are designed to mirror Nebraska requirements and ensure all employees understand the goals related to their role.

Monitoring performance is critical to ensuring that all performance standards are met. Based on our experience in providing high quality dental benefits to the nearly 3,500,000 members we serve, MCNA has developed a proven approach to success. We maintain a "dashboard" of key performance indicators (KPIs) for every state we serve. Relevant metrics for all operational departments are tracked and trended. Operational data is measured in comparison to contractual performance standards. Clinical performance indicator data is compared to national benchmarks reported by the National Committee for Quality Assurance (NCQA), the American Dental Association's Dental Quality Alliance (DQA), and external quality review organizations (EQROs) contracted by the state agencies we serve.

MCNA's Quality Improvement (QI) Department continuously monitors plan operations to identify areas for improvement. Each of our plans has a dedicated Key Performance Indicator Dashboard that tracks contract performance across a spectrum of measures.

The KPI dashboard allows for the rapid identification and escalation by our supervisory staff of any performance standard issues affecting our plans. Each department monitors their operational performance on a daily, weekly, monthly, quarterly, and annual basis. The results of operations and our rate of success meeting the standards are reported to MCNA's Quality Improvement Committee (QIC) on a quarterly basis. Feedback generated through the dashboard will be incorporated into our Quality Improvement Program (QI Program) which is further described in Questions 41-47 of this response.

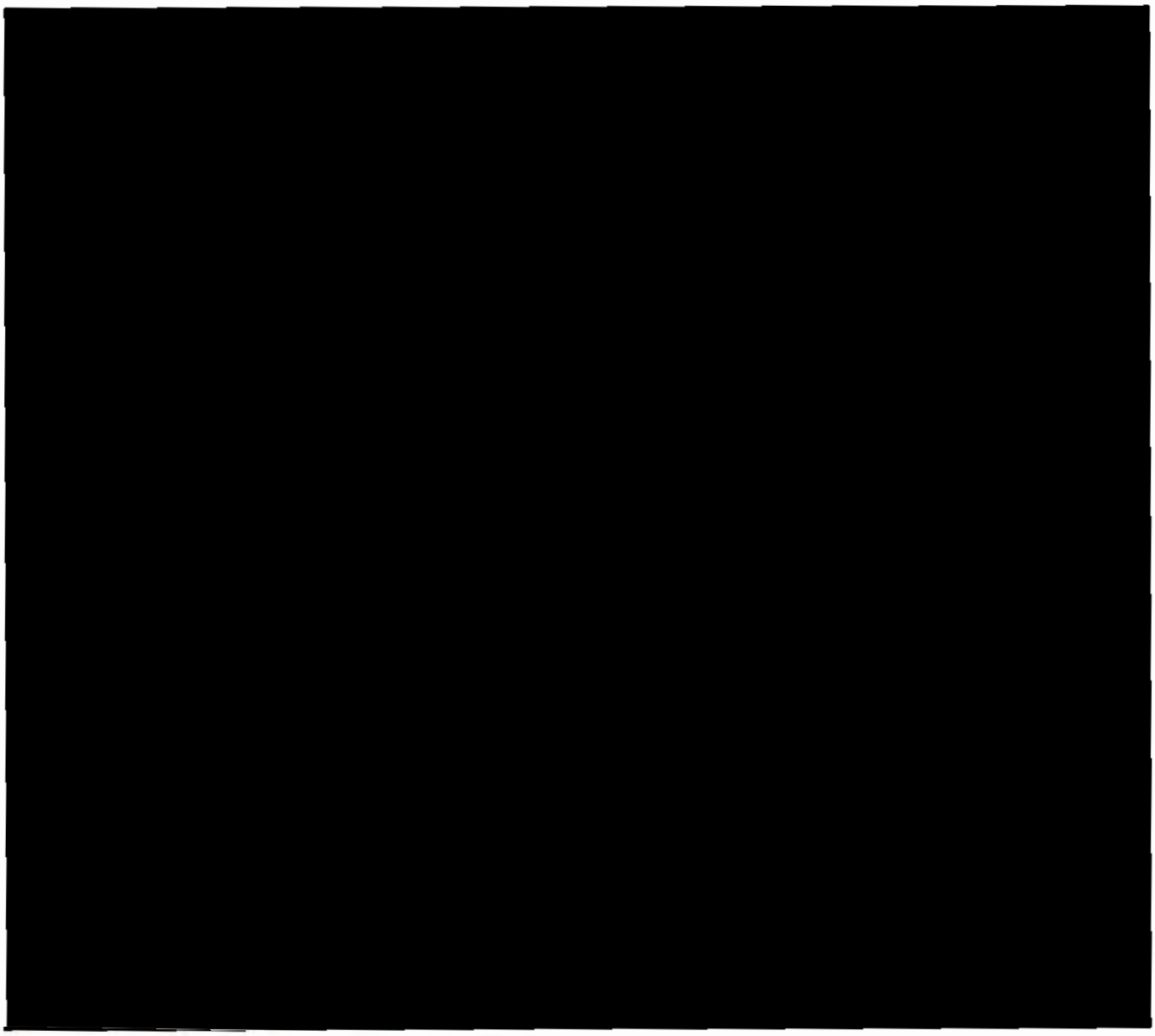
We will develop a KPI reporting dashboard to provide MLTC leadership with easily accessible results related to access and quality of care, as well as program cost-effectiveness. The dashboard must be operational within six months after the contract start date, and we understand that access to this dashboard will be determined in consultation with MLTC. We acknowledge that MLTC reserves the right to require MCNA to participate in an alternative reporting and dashboard system at its discretion. The dashboards will be updated within the timelines specified by MLTC, and will include the following statistics:

- Member enrollment
- Call center statistics
- Status of credentialing applications
- Performance measures

- Care management
- Pending grievances and appeals
- Pending claims
- Financial status
- Any other issues as identified by MLTC

MCNA understands that MLTC has the right to modify, add, or delete dashboard requirements throughout the contract term, and we will update our processes, policies and procedures, and the KPI dashboard to reflect any changes.

Below is a dashboard developed for Nebraska using the performance standards set forth in this RFP. Additional statistics will be added through collaborative discussion with MLTC.



71	**Provide examples of the following reports:** • **Member Grievance System** • **Performance Improvement Projects** **How will the DBPM use required reports in its day to day management and operations?**

Utilizing Required Reports to Manage and Enhance Operations

MCNA utilizes the required reports listed in Attachment 5 of the RFP to ensure continuous quality improvement across all operational areas of our organization.

Member Grievance System Reporting

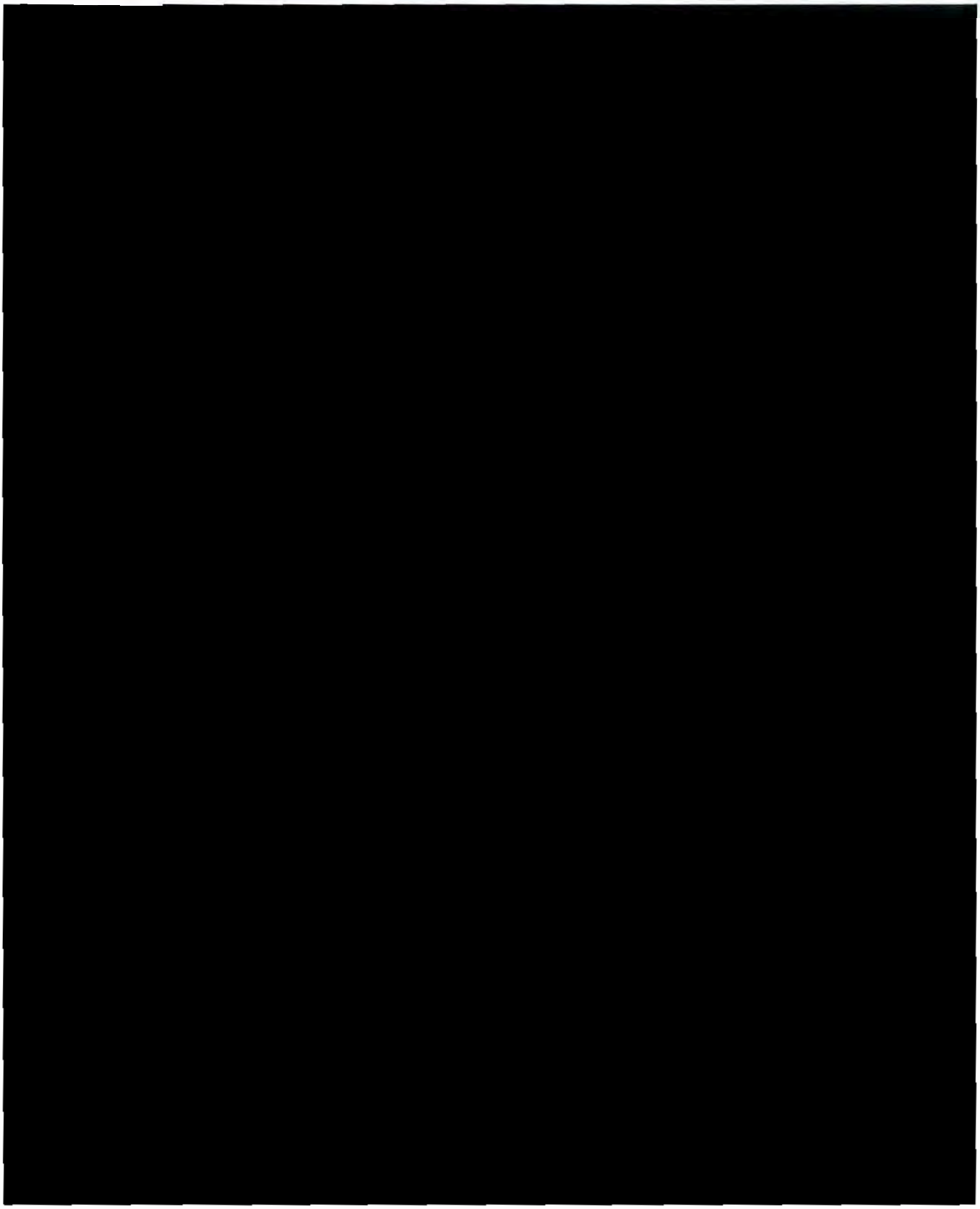
Complaint, grievance, appeal, and State fair hearing data is reviewed by departmental staff, the Quality Improvement Committee, the Utilization Review Committee, and the Grievances and Appeals Committee to track trends, identify patterns, and develop interventions, as needed. The Grievance Manager (GM) will be responsible for running reports on the member grievance system and will utilize these reports in day-to- day management of the member grievance process and the member appeals process. The Quality Improvement Committee (QIC) will review all inquiry, complaint, grievance, appeal, and state fair hearing summaries on a quarterly basis to identify issues requiring follow-up or

additional intervention. The GM will utilize the required Nebraska Member Grievance System Reports in the table below to capture and report all required data elements.

Required Member Grievance System Reports		
Report Name	**Description of Report**	**Frequency**
Grievances	Summary of new grievances, resolved grievances, and status of unresolved grievances.	Monthly for the first six months and quarterly thereafter.
Appeals	Summary of new appeals, completed appeals, and status of each ongoing appeal.	Monthly for the first six months and quarterly thereafter.
Expedited Appeals	Summary of new expedited appeals, completed expedited appeals, and status of each ongoing expedited appeal.	Monthly for the first six months and quarterly thereafter.
State Fair Hearings	Summary of new state fair hearings, concluded state fair hearings, and status of each ongoing state fair hearing.	Monthly for the first six months and quarterly thereafter.

Grievance data is categorized according to the reason for the complaint, grievance, or appeal. This enables MCNA to identify patterns and trends that could indicate the existence of an overall operational issue that must be addressed. [redacted]

[redacted]



Based on any identified trends or patterns, MCNA's operational areas respond with targeted interventions to address the issue at the root cause of the grievances. This could be anything from additional member or provider education, or identifying the need to take corrective action with respect to a provider who has been found to have issues with the quality of care they provide to our members. Additional monitoring is continued until the trend declines and the issue has been fully resolved.

Please see below an example of the Member Grievance System Reporting that MCNA provides to the Louisiana Department of Health on a monthly basis for their Medicaid and CHIP programs.

Grievance, Appeal and Fair Hearing Log Dental Report

	A	B	C	D	E
1	**Grievance, Appeal and Fair Hearing Log Dental Report**				
2	II. Review Activities				
3			Grievances	Appeals	State Fair Hearings
4		Number of grievances received and reviewed:			
5		Number of grievances resolved:			
6		Number of grievances in pending status:			
7		Average Length of time to complete each grievance(Days)			
8		Number of Appeals received and reviewed:			
9		Number of Appeals withdrawn:			
10		Number of Appeals resolved:			
11		Number of appeals considered invalid:			
12		Number of Dental Plan appeals reveresed in member's favor:			
13		Number of plan appeals in pending status:			
14		Average Length of time to complete each appeal			
15		Number of State Fair Hearing received :			
16		Number of State Fair Hearing level appeals withdrawn:			
17		Number of State Fair Hearings considered invalid or dismissed:			
18		Number of State Fair Hearings in pending status:			
19		Average length of time to complete each State Fair Hearing:			
20		Number of overturned decisions at State Fair Hearing Level:			
21		Number of upheld decisions at State Fair Hearing Level :			
22		Percentage of appeals overturned at the State Fair Hearing level:			
23	In Dental Plan level appeals where the decision was reversed in the member's favor, what were the most common reasons?				
24					
25					
26	In State Fair Hearing cases where the decision was overturned in the member's favor, what were the most common reasons?				
27					
28					
29	List the top 5 reasons that were most commonly the subject of grievances/appeals:				
30					
31					
32					
33					
34					
35		Additional Information Required for Annual Report Submission			
36			Grievances	Appeals	State Fair Hearings
37		Number still pending at the end of Contract Year ___:			
38		Percentage of appeals reversed in Contract Year ___:			

Grievance Log Dental Report

Grievance Log Dental Report

(1) Date Grievance Received	(2) Medicaid ID of Member	(3) Individual & Relationship to Person Filing Grievance (Member, Authorized Rep. or Provider)	(4) Reason for Grievance (Use Number Code from Grievance	(5) Grievance Reason Narrative	(6) Date Grievance Completed	(7) Number of Days to Resolve	(8) Details of resolution

Appeal Log Dental Report

Appeal Log Dental Report

(1) Date Appeal Received	(2) Medicaid ID of Member	(3) Individual & Relationship to Person Filing Appeal (Member, Authorized Rep. or Provider)	(4) Type of Service Denied (Be Specific)	(5) Reason For Appeal (Use Number Code from Appeal Reason Summary)	(6) Appeal Narrative	(7) Date Appeal Completed	(8) Number of days to Resolve	(9) Determination (Upheld, Reversed)	(10) Explain Reason Appeal Was Upheld or Reversed or Withdrawn

State Fair Hearing Log Dental Report

State Fair Hearing Log Dental Report

(1) Date Request Received	(2) Medicaid ID of Member	(3) Individual & Relationship to Person Requesting State Fair Hearing (Member, Authorized Rep. or Provider)	(4) Type of Service Denied (Be Specific)	(5) Reason for State Fair Hearing (Use Number Code from State Fair Hearing	(6) State Fair Hearing Reason Narrative	(7) Date Hearing Was Completed	(8) Number of Days to Resolve	(9) Determination (Upheld, Terminated or Overturned)	(10) Explain Reason State Fair Hearing Was Upheld, Overturned Order Terminating

Grievance Appeal and Fair Hearing Log - Reason Summary

Grievance Appeal and Fair Hearing Log - Reason Summary

Reason Number Code	Reason	Number of Grievances	Number of Appeals	Number of State Fair Hearings
1	Quality of Care			
2	Accessibility of office			
3	Attitude/Service of staff			
4	Quality of office, building			
5	Timeliness			
6	Benefit Limitations/Exclusions			
7	Billing and Financial Issues			
8	Clinical Criteria Not Met - Durable Medical Equipment			
9	Clinical Criteria Not Met - Inpatient Admissions			
10	Clinical Criteria Not Met - Medical Procedure			
11	Prior or Post Authorization			
12	Lack of Information from Provider			
13	Level of Care Dispute			
14	Pharmacy			
15	Not a State Plan Services			
16	Other (Must provide description in narrative column of Summary Reports)			
	TOTALS			
	DO NOT ADD OR CHANGE REASON CODES			

Performance Improvement Project Reporting

Performance Improvement Projects (PIPs) will be managed internally within our Quality Improvement (QI) Department and led by the Vice President of Dental Management and Quality Improvement. Results of PIPs are tracked internally on an ongoing basis, and reported to the QIC. The QI Department will utilize the required Nebraska Performance Improvement Project Report in the table below to capture and report all required data elements to MLTC about our required clinical and administrative PIPs.

Required Performance Improvement Projects Report		
Report Name	**Description of Report**	**Frequency**
Performance Improvement Projects	Data summarizing annual results of each new and ongoing PIP.	Annually

MCNA continuously monitors performance on a variety of care and service indicators for our members. We identify opportunities for improvement by comparing our performance with national benchmarks and to our own performance over time. Per the RFP requirements, MCNA will implement quality improvement projects in both clinical care and non-clinical services such as system or service initiatives. [redacted]

[redacted]

The QI Department continually evaluates data and feedback from members and providers to identify challenges and barriers. The interventions are developed to address the specific issues associated with each PIP goal. Improvement in PIP measures will be demonstrated through ongoing measurement and analysis of intervention effectiveness.

At least quarterly, the results of PIPs will be reported to the QIC for review and discussion. The QIC reviews the progress of each PIP and ongoing results of each PIP measurement. The committee discusses these results and recommends or approves additional interventions, as needed.

[redacted]

Annually, the QI team will report on the results of PIPs as part of the annual QI Program Evaluation. The QI Program Evaluation is presented to the QIC and then to MCNA's Board of Directors. All required reporting will be provided to MLTC in a timely manner.

Please see below an example of the Performance Improvement Project report that MCNA provides to the Texas Health and Human Services Commission on an annual basis.

Performance Improvement Project Report [Page 1 of 4]

MANUAL	CHAPTER	PAGE
HHSC UNIFORM MANAGED CARE MANUAL	10.2.9	1 of 4
CHAPTER TITLE	EFFECTIVE DATE	
Performance Improvement Project Progress Report Template	April 1, 2016	
	Version 2.3	

Performance Improvement Project (PIP) Progress Report Template

This is the template to be used for submitting each PIP Progress Report.

For each PIP Progress report, document the completion of each step. Refer to the instructions in UMCM Chapter 10.2.8 for detailed information on each area.

Double click on the check boxes and select "Checked" in the properties dialog box to make a selection. Enter narrative in the box below the activity description.

Demographic Information	
MCO:	
Project Leader:	**Title:**
Telephone Number:	**E-mail Address:**
PIP Topic/Name:	
Date PIP Initiated:	**Date PIP Progress Report Submitted:**

Program(s) Included in PIP (check all that apply)
☐ CHIP ☐ STAR ☐ STAR+PLUS ☐ STAR Kids ☐ STAR Health ☐ CHIP Dental ☐ Medicaid Dental

Collaborative PIP
Is this PIP a collaborative PIP? ☐ **Yes** ☐ **No** **If yes, provide the MCOs or DSRIP collaborators.**
(Enter names here.)

Requested Documentation Submitted (only required if changes have been made since the previous submission)

Page 1

Performance Improvement Project Report [Page 2 of 4]

MANUAL	CHAPTER	PAGE
HHSC UNIFORM MANAGED CARE MANUAL	**10.2.9**	**2 of 4**
CHAPTER TITLE	EFFECTIVE DATE	
Performance Improvement Project Progress Report Template	April 1, 2016	
	Version 2.3	

☐ Revised PIP Plan with track changes (revisions should include all recommendations made by Texas' EQRO)

☐ Revised PIP Plan clean version

Previous PIP Evaluation Recommendation(s)	
Please address the previous PIP recommendation(s). Describe how each recommendation was incorporated into the PIP and actions taken to meet the recommendation(s).	
Previous Recommendation(s)	**Actions taken to meet recommendation(s)**
(Enter response here.)	(Enter response here.)

1. PIP Performance Measure(s)/Indicator(s)			
List the quantifiable measures. Provide baseline and re-measurement rates for each measure. Add sections and re-measurements for additional measures as needed. **Use the most current data available for all measures – baseline measures and re-measurements.**			
Quantifiable Measure # 1:	(Enter measure description here.)		
Baseline numerator, denominator, rate, and dates:	N:	Rate:	Start:
	D:		End:
Re-measurement 1 numerator, denominator, rate, and dates:	N:	Rate:	Start:
	D:		End:
Re-measurement 2 numerator, denominator, rate, and dates:	N:	Rate:	Start:
	D:		End:
Quantifiable Measure # 2:	(Enter measure description here.)		

Page 2

Performance Improvement Project Report [Page 3 of 4]

MANUAL	CHAPTER	PAGE
HHSC UNIFORM MANAGED CARE MANUAL	10.2.9	3 of 4
CHAPTER TITLE	EFFECTIVE DATE	
Performance Improvement Project Progress Report Template	April 1, 2016	
	Version 2.3	

Baseline numerator, denominator, rate, and dates:	N:	Rate:	Start:
	D:		End:
Re-measurement 1 numerator, denominator, rate, and dates:	N:	Rate:	Start:
	D:		End:
Re-measurement 2 numerator, denominator, rate, and dates:	N:	Rate:	Start:
	D:		End:
Quantifiable Measure # 3:	(Enter measure description here.)		
Baseline numerator, denominator, and rate:	N:	Rate:	Start:
	D:		End:
Re-measurement 1 numerator, denominator, rate, and dates:	N:	Rate:	Start:
	D:		End:
Re-measurement 2 numerator, denominator, rate, and dates:	N:	Rate:	Start:
	D:		End:

2. Major Achievements and Challenges to Date
Use the space below to provide a brief description of the major achievements to date in meeting the goals of this PIP.
(Enter response here.)
Use the space below to provide a brief description of the challenges encountered with this PIP, how they were addressed, and any additional comments related to progress status.
(Enter response here.)

3. Status of Planned Interventions

Performance Improvement Project Report [Page 4 of 4]

MANUAL	CHAPTER	PAGE
HHSC UNIFORM MANAGED CARE MANUAL	10.2.9	4 of 4
CHAPTER TITLE	EFFECTIVE DATE	
Performance Improvement Project Progress Report Template	April 1, 2016	
	Version 2.3	

Describe the status of PIP interventions below by filling out the table provided. The interventions listed below are from Activity 7B in your approved PIP Plan submission (v2.2). Please indicate the type of intervention using the check boxes at the start of each intervention description. Add rows for additional interventions as needed.

PIP Interventions Use intervention titles from 7B in your approved PIP Plan Template (Chapter 10.2.5 of the Uniform Managed Care Manual).	**Status of Interventions** Report the intermediate results based on tracking and monitoring efforts for each intervention. Please be specific and report all results for all interventions.		**Modifications** Indicate whether or not modifications of an intervention were necessary. If the intervention was modified describe the modifications; include a description of the barriers encountered that resulted in the need for a modification.	**Provider Engagement** Describe how providers were engaged in the implementation of the interventions. Report the feedback received from providers who were involved in this intervention. If interventions were modified based on provider feedback, describe the modifications in detail.
Intervention Title: Date of Implementation: Did the date of implementation change from original PIP Plan? ☐ Yes ☐ No If yes, address change in "Modifications". Intervention level: ☐ Member ☐ Provider ☐ System (Include a description here only if the intervention has been modified.)	Number of members/ providers Targeted: Reached:	Percentage of members/ providers Targeted: % Reached: %	Were modifications made? ☐ Yes ☐ No (If yes, enter response here.)	(Enter response here.)
	(Describe additional tracking and monitoring results here.)			

Page 4

72	**Provide a detailed description of the DBPM's approach to implementing the necessary functionality to support FFS claims processing.**

MCNA has been managing Medicaid and CHIP programs for over a decade. As a pioneering advocate for the transition of fee-for-service (FFS) dental programs to full at-risk managed care dental programs, we bring a proven approach and excellent track record to Nebraska Medicaid to ensure the successful operation and smooth transition of the FFS program.

We understand MLTC is in the process of replacing its Medicaid Management Information System (MMIS) and would like to enter into a services agreement for the processing of remaining FFS claims. We understand MLTC will provide the per unique claim initial rate, and payment for FFS dental claims management services will be paid separately from managed care capitation payments. [redacted]

We understand and agree to maintain the same functionality for FFS dental claims that is required for managed care claims as described in Section IV.R – Claims Management of this RFP. The extensive functionality of our robust management information system (MIS), DentalTrac™, allows us to handle an unlimited number of products and lines of business while maintaining the highest levels of program integrity and confidentiality.

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 was the first dental insurance company to receive full claims processing accreditation from URAC.** This ensures that our highly trained claims management team is able to operate efficiently and reliably in accordance with the strictest national guidelines and benchmarks without compromising quality or performance metrics.

ACCREDITED
Claims Processing
Expires 10/01/2017

The DentalTrac™ Claims module is designed specifically to operate public sector programs such as the Nebraska Medicaid Dental Benefits Program. DentalTrac™ supports all modern claims capabilities, including electronic data interchanges (EDI), HIPAA transactions, and an MLTC compliant claims adjudication process. We offer Nebraska Medicaid a **comprehensive turnkey solution** to claims processing, including fee-for-service, 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 into all aspects of our operations to deliver continuous and self-improving quality outcomes.

Our approach to implementing the functionality necessary to support the processing of FFS claims will incorporate the same governance, objectives, and fiscal responsibility that we commit to the processing of at-risk claims for Nebraska Medicaid. DentalTrac™'s ability to handle the most complex implementations and demanding claims processing needs is exemplified throughout this RFP. Our

excellent track record in claims processing efficiency, provider management, and commitment to improving the oral health outcomes of our members is the result of the dedication and passion that permeates our organization. These characteristics have fueled MCNA's successful transitions of Medicaid and CHIP programs in Texas, Louisiana, Florida, and Iowa, including the seamless operation of FFS programs in these states.

At MCNA, we engage our Program Management Office (PMO) for all projects in order to ensure flawless implementation through a dedicated team. With the knowledge that varied core strengths are needed in order to ensure successful implementation, the PMO is comprised of subject matter experts within our company. For additional information about our PMO approach, please see our response to question 78 of this RFP.

Our PMO will coordinate with all critical MCNA business units and Nebraska Medicaid stakeholders to ensure that project-specific key resources are aligned and in place for a successful implementation. The PMO will apply our proven methodologies using our structured approach to success and ensuring alignment with the long-term operational support and objectives Nebraska Medicaid requires.

The expertise and knowledge inherent throughout our organization ensures that MCNA operates in a cohesive manner without the "silo" effect you find in other organizations. Our claims management system is an essential component of our fully-integrated, proprietary, and enterprise-wide management information system (MIS), DentalTrac™. Our experienced claims management staff ensure accurate, prompt payment of claims while maintaining a high degree of provider satisfaction. **MCNA's team will approach our implementation of FFS dental claims processing utilizing each of these resources in the same manner as our approach for the managed care dental program.**

MCNA will coordinate with MLTC to define the project management and reporting standards that will be followed during the implementation of the FFS program. These standards will include the establishment of communication protocols for MLTC and MCNA staff, contacts with other MLTC contractors, schedules for key activities and milestones, a comprehensive plan for exchanging information, and the finalization of parameters for the project deliverables. Our PMO will be responsible for enabling smooth collaboration between MCNA's representatives from internal business units, business analysts, reporting analysts, EDI teams, and our operations team and the MLTC stakeholders responsible for this project during the pre-implementation and throughout its operation.

Our PMO uses a SMART approach to project management, and our program implementation follows a clearly defined roadmap of activities that result in successful implementations:

- **Initiating**
  - Determine scope
  - Compile requirement documents
  - Appoint subject matter experts
  - Identify stakeholders
  - Complete project charter
  - Obtain PMO approval
- **Planning and Design**

  - Appoint project team
  - Complete project plan
  - Complete design requirements
  - Create risk plan
  - Develop acceptance criteria
  - Complete training plan
- **Executing**
  - Initiate project kickoff
  - Assign tasks to project team
  - Initiate development and configuration activities
  - Complete sprints
  - Review and adjust tasks
  - Update project status
- **Monitoring and Controlling**
  - Change Management
    - Identify needs and set expectations
    - Adjust tasks to meet goals
    - Confirm objectives are met
    - Implement solution
  - Agile Risk Management
    - Identify what risks are present
    - Assess the severity
    - Take action to circumvent
    - Confirm action towards risk
- **Closing**
- **Validate and test results**
- **Review results with stakeholders**
- **Complete user acceptance testing**
- **Receive sign-off from stakeholders**
- **Complete training**
- **Close all plans and documents**

One of the first tasks we complete is the compilation of all requirements. This process will ensure that all stakeholders understand the problem and agree on the scope, responsibilities, and measures of success for the program. Our PMO crafts requirements in a concise, clear, measurable, testable, and traceable form. During this phase, we will be able to identify any technology enhancements that may be required to meet MLTC's requirements, goals, and objectives for the FFS program. Our PMO will also coordinate with our operations teams to ensure proper training of program operations and full compliance with program requirements.

DentalTrac™'s **leading edge technology** is the platform that supports our operations. Its comprehensive, flexible, scalable, industry-compliant, production-proven, and enterprise-wide platform offers a rich set of fully-integrated modules that allows MCNA to comprehensively meet the needs of MLTC. DentalTrac™ supports all requirements for both the fee-for-service and managed care dental

programs set forth in this RFP, including but not limited to, claims processing, claims re-pricing, third-party liability, fraud analytics, capitation, network management, enrollment administration, prior authorization and referral management, care management, customer service, and electronic data interchange.

We have extensive experience working with multiple vendors to successfully achieve our clients' goals and exceed their expectations. The flexibility built into the core of DentalTrac™ allows us to easily interface with any number of vendors meeting any interfacing requirements "out-of-the-box", including configurable, program benefits design, claim edits, payment rules, claim adjudication, and electronic payments. We do this without the need for substantial effort to customize our MIS. DentalTrac™'s business intelligence module and extensive reporting capabilities provide real-time insights into program operations 24x7x365. These are values we will bring to MLTC to ensure the success of both the FFS and managed care components of the Nebraska Medicaid program.

Reimbursement for FFS Payments

As the claims broker, we will make payments for all FFS dental claims to providers. We agree to submit to MLTC a reconciliation report of all funds expended and received with any remaining balance to be reimbursed for FFS payments. We understand that we may submit a funding request to MLTC on a weekly basis to cover the cost of FFS dental claims payments. We will submit the required report with each funding request to justify the request.

Implementation Timeframe

MCNA acknowledges that the anticipated implementation of the DBPM FFS claims processing functionality will occur during the second year of the contract. MLTC will identify the date for DBPM FFS claims services to begin and MCNA will coordinate with MLTC throughout years one (1) and two (2) of the contract. Please refer to our response to Question 77 for further information on the time that it will take for MCNA to be ready to pay FFS claims.

Functionality

MCNA has been managing claims processing and administration for Medicaid and CHIP dental programs for over a decade. Our proprietary management information system, DentalTrac™, is a robust and flexible platform designed to meet the most demanding state and federal requirements in the administration of public sector dental benefit programs. As a fully HIPAA-compliant system, DentalTrac™ has allowed MCNA to operate all aspects of dental benefits administration in both managed care programs and fee-for-service programs, successfully interfacing with over 75 trading partners. DentalTrac™ exchanges data involving encounters, enrollment updates, eligibility inquiries, providers, claims, and payment acknowledgments. Our systems will interoperate where needed with MLTC systems and will conform to appropriate standards and specifications set by MLTC and by the industry.

MCNA will maintain the functionality necessary to process claims for services requiring unique provider and member reimbursement methodologies that differ from standard processing protocols. We confirm that our claims processing system is capable of handling retroactive member eligibility and processing claims accordingly, and that FFS claims will be processed even if the billing provider is not contracted with MCNA. Our highly capable MIS is ready to handle the needs and requirements of MLTC and will accommodate all future requirements imposed by MLTC or other state and federal entities. System and operational changes will be made within sixty (60) days of notification by MLTC. We understand that the recoupment of erroneous payments made to providers is solely our responsibility as the claims broker. Additionally, we understand MLTC will not reimburse us for uncollected recoupments for claims paid in error.

DentalTrac™'s unique Client Management module is designed to provide our clients and MLTC secure access to our MIS. We will configure our Client Management module to allow MLTC secure access to our FFS dental claims processing system in order to view claims and all information related to FFS claims processing. MLTC's access to DentalTrac™ will only be granted to authorized personnel and MLTC must provide such access requests in writing.

Users who are granted access will be required to adhere to multi-step authentication protocols that further complement the security already built into the core of DentalTrac™. MCNA's end-user training team will provide initial training to MLTC staff who support this scope of work. Our training team is also responsible for preparing and maintaining training materials on the use of our MIS, including video tutorials, all of which will be available to MLTC staff. Additionally, should MLTC staff need further support after training, our dedicated help desk team will be available 24x7x365 to provide assistance and guided access in order to answer specific questions.

Claims Processing

MCNA's claims processing approach is centered around our best-in-class claims capability core competencies and integrated components (CCIC) model. Our CCICs include:

- Transactional processing
- Service delivery

- Quality assurance
- Information management

As a fully **HIPAA and ICD-10 compliant** claims management system, DentalTrac™ supports all HIPAA approved code sets and industry standard taxonomies and code sets. These include National Provider Identifier (NPI), place of service codes, diagnosis codes, procedure codes (CDT and others), and Claim Adjudication Reason Codes (CARCs). Our system accepts and correctly processes International Classification of Diseases, 10th revision, (ICD-10) diagnosis codes on any claims sent in by any network provider in all current markets.

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Service Authorization Procedures

MCNA's Utilization Management Department provides comprehensive program management for the appropriate application of clinical and administrative guidelines that meet the requirements of this RFP. We will develop and administer prior authorization procedures for services paid under the FFS program in accordance with Nebraska Medicaid policy and the requirements of Section IV.N – Utilization Management in this RFP.

DentalTrac™'s Utilization Management module leverages the same flexibility and scalability as our Claims Administration module and is the system of record for all dental prior authorization data and referrals within our MIS. Our Dental Clinical Reviewers base their clinical decisions on carefully crafted clinical criteria that is applied to all member and authorization data before making any determination. We acknowledge that we will pay or deny FFS claims in accordance with FFS authorization policies set forth in 471 NAC Chapter 6, or as prescribed by MLTC.

Payments to Providers

DentalTrac™'s capability to manage unlimited lines of business allows us to establish the clean separation of data and controls while leveraging economies of scale. This capability will allow MCNA to maintain a separate Line of Business (LOB) configuration for the FFS dental claims and the managed care dental claims. Providers will be setup and configured in each distinct LOB with unique business rules and requirements for participation. While providers may share demographics, FEIN, NPI, and other credentialing information across LOBs, DentalTrac™'s ability to support multiple LOBs will allow us to define criteria, rules, and requirements unique to a specific LOB in order to accommodate the needs of the FFS or the managed care dental program. This includes defining requirements for provider participation and reimbursement fee schedules. We will process and pay FFS provider claims on schedule and in compliance with the fee schedule rates set by MLTC, including supplemental payments for covered services rendered by the University of Nebraska Medical Center College of Dentistry.

Remittance Advice

Claims that are determined to be payable are batched and paid **automatically during our payment cycles**. As part of our implementation process, transition plan, and ongoing relationships with our Nebraska providers and MLTC, we will promote full understanding of all programmatic operating procedures documented in our provider manual, and all contractual requirements through **extensive training sessions, bulletins, newsletters, educational videos, and other reference materials to help our providers**. Our payment cycles and all provider materials will adhere to MLTC requirements, and we will obtain MLTC's approval before they are communicated to providers.

We ensure our providers understand the reimbursement options we make available to them. We also **allow our providers to choose** to receive a paper or electronic Remittance Advice (RA) or Explanation of Payments (EOP) 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 EFTs because they receive payment more efficiently and securely, and the electronic format facilitates easier reconciliation for office staff. Upon processing claims payments, DentalTrac™ automatically generates RAs, Explanations of Benefits (EOBs), and notices of adverse actions to members for denied claims. Every aspect of the claims processing lifecycle can be customized to meet the specific needs of MLTC with regard to the FFS program. In Louisiana and Texas, 82.3% and 73.2% of MCNA providers, respectively, are paid by EFT.

Providers have access to our Provider Portal where they can check the status of claims, prior authorizations, referrals, and many other features in real time. DentalTrac™ posts the RAs, EOBs, and other notices associated with claims payments that have been processed to our Member and Provider Portals, where members and providers have access to them at all times. Our RAs meet the requirements specified in Section IV.R – Claims Management of this RFP and reflect payments or denials to providers. Providers who participate with MCNA in multiple lines of business (Medicaid Managed Care and the FFS program) will receive a separate RA for each participating line of business. Each RA will clearly identify the claims processed under each line of business for ease of understanding. Our RAs or EOPs are well organized and contain all elements required in this RFP.

Claims that do not meet the auto-adjudication 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 processing are deemed "unclean" and remain pended. In such cases the provider is notified with detailed information, including but not limited to, the date received for the rejected or denied batch, the date of denial or rejection, and the reason for the rejection or denial in writing. This notification is sent using our HIPAA 835 Remittance Advice, via our online and paper Explanations of Payment (EOPs), and in real time through our web-based Provider Portal. Resubmission of a claim with the necessary information or documentation shall constitute a new claim for purposes of establishing the time frame for claims processing.

In compliance with 42 CFR §455.18 and §455.19, the following statement will be included on each RA sent to providers: *"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 material fact, may be prosecuted under applicable federal and/or state laws."*

Third Party Liability (TPL)

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 Nebraska 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 MLTC requirements to assure that liable third parties are billed whenever their responsibilities for payment exist.

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 MLTC. We will develop and maintain a process to identify and capture information regarding other insurance sources (TPL) for FFS members. Information regarding TPL will be maintained in the member file and utilized during claims payment to ensure that Medicaid is the payer of last resort.

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) process, 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 efforts in order to avoid causing them unnecessary aggravation. These payment recoveries will be returned to the State in full immediately upon receipt.

We will expend the same level of effort on the recovery and cost avoidance of casualty claims for FFS dental claims as is expended on managed care claims. We will ensure that all denials of FFS claims for TPL coverage will comply with MLTC policies and applicable law, and understand that MLTC will retain responsibility for all estate recovery activities.

Member Services

MCNA acknowledges and commits to providing member services call center activities to all eligible FFS members in the same manner as is required for managed care members, as outlined in Section IV.G – Member Services and Education of this RFP. MCNA's Member Services Department is cross-trained to handle our multiple lines of business, ensuring that our staff is properly trained to handle the needs of the Nebraska FFS and managed care dental members. We also understand and agree to use MLTC's interface to verify FFS member eligibility.

Provider Services

MCNA offers dedicated toll-free lines to our providers and will establish a dedicated provider hotline for those providers who render services to FFS members, including FFS providers who are not contracted with MCNA. Our call centers are staffed with live agents Monday through Friday, 7:00 a.m. to 7:00 p.m. CST, excluding state-approved holidays. MCNA's Provider Hotline meets all the requirements specified in Section IV.J – Provider Services of this RFP. Our Provider Hotline staff are cross-trained to handle multiple lines of business and are capable of assisting providers regarding a multitude of issues, including:

- Member eligibility verifications
- Member assignments
- Provider portal assistance

- Claims status and reconsiderations
- Claims payments
- Prior authorization and referral procedures
- Filing complaints, grievances, and appeals
- Covered services and fee schedule inquiries
- Electronic Data Interchange (EDI) assistance

MCNA's Provider Hotline team coordinates EDI-specific calls with our dedicated EDI team, which is available to support providers with questions about EDI exchanges and the establishment of trading partner agreements.

We currently make provider notifications, bulletins, newsletters, frequently asked questions, and other pertinent information available on our website and our Provider Portal. We will ensure that all providers participating in the FFS dental program receive the appropriate training to be able to easily access these resources. Our convenient Provider Portal is available 24x7x365 and allows providers to complete all of the actions available through our Provider Hotline.

Paid Claims Sampling

As the claims broker, we agree to adhere to the same paid claims sampling requirements for FFS claims as is required for Nebraska Medicaid dental managed care claims, as outlined in Section IV.R – Claims Management of this RFP. Refer to our response to Question 67 for further information on our claims sampling and audit process.

Claims Dispute Management

As the claims broker, we agree to adhere to the same claims dispute management requirements for FFS claims as required for Nebraska Medicaid dental managed care claims, as outlined in Section IV.R – Claims Management of this RFP. We understand FFS claims must be disputed through the MLTC fair hearing process. We agree to support MLTC in claims disputes by providing all required documentation and subject matter representation in the manner specified by MLTC.

Claims Payment Accuracy

As the claims broker, we agree to adhere to the same claims payment accuracy requirements for FFS claims as required for the Nebraska Medicaid dental managed care claims, as outlined in Section IV.R – Claims Management of this RFP. Refer to our response to Question 67 for further information on our claims payment accuracy methodology.

Claims Data

DentalTrac™ currently complies with all requirements associated with HIPAA standards for electronic exchange, privacy and security requirements (45 CFR §162 and §164), as well as Nebraska state laws. We have designed and implemented a comprehensive set of controls to govern the accuracy and completeness of our receipt and transmission of data. Our EDI subsystem is fully compliant with HIPAA ASC X12 standards as well as other industry standards. Please refer to the table to the right for a list of currently supported file format standards.

Supported File Format Standards	
HIPAA ASC X12 270/271	Health Care Eligibility Benefit Inquiry and Response
HIPAA ASC X12 276/277	Health Care Claim Status Request and Response
HIPAA ASC X12 277CA	Health Care Claims Acknowledgement
HIPAA ASC X12 277U	Health Care Claims Status Response
HIPAA ASC X12 278	Health Care Services - Request for Review and Response; Health Care Services Notification and Acknowledgment
HIPAA ASC X12 820	Payroll Deducted and Other Group Premium Payment for Insurance Products
HIPAA ASC X12 834	Benefit Enrollment and Maintenance
HIPAA ASC X12 835	Health Care Claim Payment/Advice
HIPAA ASC X12 837D	Health Care Claim: Professional, Institutional, and Dental, including coordination of benefits (COB) and subrogation claims
HIPAA ASC X12 997	Functional Acknowledgement
HIPAA ASC X12 999	Functional Acknowledgement
NSF	National Standard Format
HL7	Health Level Seven
XML	Extensible Markup Language
UDF	User Defined File

MCNA agrees to submit all FFS dental claims data (including adjustments and recoupments) a minimum of monthly on a date designated by MLTC. We will ensure that all claims data is identified as FFS and has the appropriate account code on the claim.

Audit Requirements

As the claims broker, we will adhere to all audit requirements for managing FFS claims as required for the Nebraska Medicaid dental managed care claims, as outlined in Section IV.R – Claims Management of this RFP. We agree to support MLTC by providing claims payment explanations as requested.

73	**Describe the level of effort necessary to support Nebraska program and policy changes, including but not limited to new covered services, prior authorization requirements, or additional populations.**

MCNA knows the successful implementation and ongoing operation of the Nebraska fee-for-service (FFS) Dental Benefit Program requires a flexible work plan, well-defined milestones and expectations, robust communication, ample financial and manpower resources, and strong operational and leadership teams. We recognize that during the transition and operation of the FFS program there may be policy changes, including but not limited to, new covered services, prior authorization requirements, or additional populations. As such, our dedicated Program Management Office (PMO) team coordinates these changes with all internal and external stakeholders to facilitate the engagement of all documentation, risk assessments, setting and tracking of milestones, communication plans, and resources as appropriate to ensure MCNA's prompt and accurate response to changes in order to meet any required deadlines.

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74	**Describe how the DBPM will maintain a distinction between FFS and managed care processing rules, claims transactions, providers, members and prior authorizations within the system.**

DentalTrac™'s scalable, enterprise-grade design allows MCNA to manage an unlimited number of lines of business within our system and to establish a clean separation of data and controls while leveraging economies of scale. This capability will allow MCNA to maintain a separate Line of Business (LOB) configuration for the FFS dental claims and the managed care dental claims. DentalTrac™ allows us to configure each line of business as a completely independent entity within our MIS or as an entity with shared resources across other lines of business. For the Nebraska FFS program, we will configure the FFS LOB as a completely independent entity that will not share any data or configuration profiles with the Nebraska managed care dental program. The diagram below represents how unique lines of business lie at the core of DentalTrac™'s architecture, providing the type of extensive flexibility necessary to meet the needs of the most demanding program designs and requirements.

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75	**Provide an explanation of the DBPM's plan and approach for business operations to support the FFS volume vs. the risk-based volume. Will the plan have separate or joint business operations units for some or all processes?**

MCNA's has over a decade of experience in managing multiple lines of business on our single, proprietary management information system (MIS), DentalTrac™. MCNA Insurance Company (the bidder) is licensed in 13 states and our affiliate third party administrator, Managed Care of North America, Inc., is licensed in 12 states. Together, we administer the dental benefits of nearly 3,500,000 members. Our state-of-the-art MIS maintains all claim and encounter data, pre-authorization data, provider enrollment detail, member eligibility, and complaints, grievances, and appeals data in a fully integrated platform. The scalability of DentalTrac™ allows us to handle hundreds of thousands of transactions per second while providing exceptional service to an unlimited number of clients and partners. Our approach to supporting MLTC's fee-for-service (FFS) dental program includes the full integration of our enterprise-wide MIS and MCNA's committed and talented staff.

MCNA will configure DentalTrac™ to handle the FFS volume and the risk-based volume of operations as two (2) distinct lines of businesses. Please refer to our response to Question 74 for further information on DentalTrac™'s ability to manage multiple lines of business. As the claims broker, we will treat the FFS program as if we were contracting with a client separate from the managed care dental program, and we will maintain streamlined channels of communication with MLTC.

MCNA's diverse and culturally sensitive staff is continuously cross-trained on all of our lines of business, creating a unique and positive experience for our clients, providers, and members, especially in markets where we are contracted for multiple lines of businesses. Cross-training our employees allows MCNA to deliver MLTC, providers, and members a superior quality of service, streamlined operations, and contractual compliance.

Our approach to FFS program operation begins with the design and implementation phase. Coordinated by our Program Management Office (PMO), our Project Management team gathers and documents information about the scope of the project and all stakeholder expectations. We will design a customized plan to ensure all expectations are met and exceeded from day one of operations. This process adheres to all aspects of our implementation plan for the managed care dental program as described in our response to Question 78.

During this phase, our PMO will coordinate with all operational units within the company to develop a staffing plan for any additional staff necessary to handle the operation. As the claims broker, we will hire additional staff in all key operational areas that will be dedicated to each line of business for the Nebraska Medicaid Program. This dedicated staff will be supported by the rest of MCNA's staff in order to leverage the benefits described earlier. The primary operational areas assigned to this dedicated staff will be:

- Provider registration and enrollment
- Provider Hotline
- Member Hotline
- Claims processing, including adjustments and TPL/COB
- Utilization management, including prior authorization and referrals
- Data capture
- Grievances and appeals

MCNA will develop a functional operational structure for each Nebraska Medicaid line of business that meets the core requirements specified in this RFP, including but not limited to, claims processing, provider services, member services, and utilization management. Each dedicated staff member will be fully trained on the functional areas of the contract respective of their assigned tasks and responsibilities.

Our Compliance Department will oversee the development of specific policies and procedures for each line of business and integrate them into MCNA's ongoing compliance monitoring process. Our Director of Training and Quality Assurance will oversee the development of training materials for each line of business that will adhere to our policies and procedures and comply with all contract requirements. All staff will complete a rigorous training program that incorporates the same quality training processes we have successfully applied during our previous implementations for Medicaid, CHIP, and Medicare contracts across the nation.

MCNA houses all materials produced by the Compliance Department, the Training and Quality Assurance Department, and each other operational department within our corporate intranet and our digital learning management system. All of these materials are accessible to authorized employees on a 24x7x365 basis. Employees will be required to successfully complete training and obtain a certificate of completion before being assigned to their work areas to begin handling a new line of business. Every employee will also be required to complete training programs on an annual basis as well as immediately upon the issuance of policy changes that may affect the operation of the programs.

Additionally, all member and provider materials produced by MCNA will be posted in our Member and Provider Portals, respectively, and we will adhere to MLTC's requirements for their distribution. This includes providing appropriate notice to our members and providers about the availability of new materials within the time frames required by MLTC and this RFP.

76	**Provide an explanation of the significant risks associated with the implementation and ongoing operation of claims broker services, and provide mitigation strategies for those risks.**

Risk Assessment and Mitigation

Proper risk management and mitigation is one of the cornerstones of project management at MCNA. The MCNA Project Management Office (PMO) consistently monitors for all issues and risks that may arise during the implementation process. The PMO uses a formal review and resolution process to prevent risks from being overlooked and possibly causing disruption to the project.

With an eye toward industry standards and best practices, our 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:

- Impact 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 options are considered:

- Try to avoid the risk. When avoidance is possible, MCNA applies all efforts to circumnavigate the threat or disruption.
- Mitigate the risk and diminish its impact on the project.

- Accept "as is" if there is no viable resolution. At MCNA, this is usually the last course of action. Our Project Managers and Subject Matter Experts have extensive knowledge about risk avoidance and mitigation.

4. Review

MCNA utilizes a regular review of the Risk Register (described below) 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 we maintain all lines of open communication with the stakeholders.

Documenting and Classifying Risk

MCNA utilizes tools and processes to manage risks for all projects. Documenting risk in a 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 each ranked as 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 possible causes. The risk may be identified through a multitude of sources 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

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 Potential 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

The 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	• 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	• Decomposition • Add another analysis phase • Detailed specifications • Early review of functionality • Add more time to the project schedule

Risk Factor 3	Project Decision-Making		
Low	Medium	High	Mitigation Ideas
One sponsor and One decision- maker	Sponsoring/ Decision making committee	No Clear Sponsor/ Decision-maker	• 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	• 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)	• 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	• 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 information	Mandate from an external source	• 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. We will incorporate the following processes for risk management into operational activities throughout the life of the MLTC contract: planning, identification, analysis, monitoring, and control. MCNA recognizes that new risks can be identified at any time during the contract term and our processes may need to be updated accordingly. Our objective is to decrease the probability and impact of developments that could adversely affect the project.

MCNA has over a decade of experience managing Medicaid programs of various sizes and an impeccable track record of successful implementations under the most demanding time frames. Since 2009, we have operated a regionally based claims payment team located in the State of Nebraska. This unit has been under the oversight and direction of our Nebraska Executive Director, Dr. Holly Portwood.

We are confident that our proven strategies for identifying and mitigating risks will enable MLTC to transition the FFS program seamlessly from the existing MMIS to MCNA.

MCNA's implementation team will work closely with our PMO to identify potential risks before the contract is initiated. When a risk is identified, it will first be assessed to ascertain the probability of its occurrence and the degree of its impact to the schedule, scope, cost, and quality of the project. After this initial assessment, the risk will be prioritized. Certain risk events may impact only one project area while others have the potential to impact the project in multiple categories. The probability of occurrence, number of categories impacted, and the degree (High, Medium, or Low) to which a risk may impact the project will be the basis for assigning the risk priority. All identifiable risks will be entered into our Risk Register. As part of documenting a risk, two other important items will be addressed:

- Mitigation strategies that will be implemented by MCNA to lessen the probability of the risk event occurring
- A contingency plan or a series of activities that will take place either prior to or during the event occurrence

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

Implementation Timeline		
Risk Identification	**Risk Mitigation and Plan**	**Monitoring and Tracking**
Systems integration	• Coordination with vendors • Standardization of file exchange formats • Coordination of user acceptance testing	• Document on Risk Register • Regular implementation meetings • Review of UAT results
Continuity of operations	• Identify data files available for transfer • Identify benefits by member aid category and provider type • Exchange member claims and utilization history • Exchange participating provider registry • Transfer existing toll free numbers and support channels	• Document on Risk Register • Regular implementation meetings • Review of UAT results • Monitor operation of toll free numbers and other support channels
Benefit design	• Coordination of user acceptance testing of benefit design and claim edits • Coordination of user acceptance testing of prior authorization and referral edits	• Document on Risk Register • Regular implementation meetings • Review of UAT results
Provider reimbursement	• Establish reimbursement fee schedules • Define claims lifecycle policies	• Document on Risk Register • Regular implementation meetings
TPL/COB	• Establish interfaces • Identify historical patterns • Coordinate with HMOs	• Document on Risk Register • Regular implementation meetings

Delays in building and/or configuring and testing the information systems within your organization's Span of Control required to implement the FFS program		
Risk Identification	**Risk Mitigation and Plan**	**Monitoring and Tracking**
Delayed delivery of hardware	• Establish relationships with hardware vendors • Maintain an abundant supply of hardware at corporate office location to be shipped "on demand"	• Infrastructure Team monitors procurement process and communicates updates to PM • Document on Risk Register
Delayed delivery of applications	• 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	• 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
Delayed delivery of data from MLTC to MCNA	• Identify root cause with MLTC • 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 MLTC daily on mitigation activity	• 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

Member & Provider Transition		
Risk Identification	**Risk Mitigation and Plan**	**Monitoring and Tracking**
Improper submission of claims (confusion)	• Increase outreach efforts • Enhance educational strategies • Distribute informational and training materials • Promote participation in Provider Portal • Enhance branding of each line of business • Coordinate with clearinghouses • Partner with MLTC on education and participation • Insert communication materials in remittance advices and notices	• Monitor provider complaints • Analyze claim submission patterns • Monitor claim volumes • Document on Risk Register • Monitor call center volumes • Monitor timeliness of claims submissions • Monitor website visit behavior
Improper submission of grievances and appeals (confusion)	• Increase outreach efforts • Enhance educational strategies • Distribute informational and training materials • Promote participation in Provider Portal • Enhance branding of each line of business	• Monitor provider complaints • Evaluate provider satisfaction surveys • Monitor claim resubmissions • Monitor member complaints • Monitor call center volumes • Document on Risk Register
Provider registration	• Enhance educational strategies • Distribute informational and training materials • Coordinate with MLTC on data transfers	• Monitor provider complaints • Monitor call center volumes • Monitor claim rejections • Document on Risk Register
Coordination of Care	• Prior authorization data transfer • Claim and Utilization data transfer • Review members with special needs • Identify members receiving ongoing treatments	• Monitor claim denials • Monitor provider complaints • Monitor member complaints • Monitor call center volumes • Document on Risk Register

Delays in Enrollment Processing During the Implementation of the FFS program		
Risk Identification	**Risk Mitigation and Plan**	**Monitoring and Tracking**
Failure to load enrollment files from MLTC in a timely manner	• Identify and fix root cause of failure • Enter member file manually • Review denied claims and reprocess those affected by eligibility file • Verify eligibility using MLTC system • Update MLTC daily on mitigation activity	• EDI team reviews daily / weekly / monthly logs • Monitor Provider and Member Complaints log • Document on Risk Register
Inability to open or process enrollment file	• Request replacement file or alternate file format from MLTC • Identify and fix root cause • Update MLTC daily on mitigation activity	• EDI team reviews daily / weekly / monthly logs • System processing error logs reviewed daily • Document on Risk Register
Corrupted file provided	• Request replacement file or alternate file format from MLTC • Identify and fix root cause • Update MLTC daily on mitigation activity	• EDI team reviews daily / weekly / monthly logs • System processing error logs reviewed daily • Document on Risk Register
SFTP server not accessible or reachable	• Review access credentials • Attempt FTP access • Check to ensure SFTP is not offline • Check internal network and Internet connectivity • Update MLTC daily on mitigation activity	• 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	• Alert Infrastructure team for resolution • Reach out to host maintainer, if applicable • Update MLTC daily on mitigation activity	• System alerts monitored by NOC are escalated to Development and EDI teams • Document on Risk Register

Enrollment file not received	• Verify with MLTC • Review expected delivery date of file • Check connectivity • Check authorization credentials	• 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 Claims Processing During the Implementation of the FFS program		
Risk Identification	**Risk Mitigation and Plan**	**Monitoring and Tracking**
Failure to load historical claims and utilization data file	• Identify and fix root cause of failure • Review denied claims and reprocess those affected by missing data file • Verify history using MLTC system • Update MLTC daily on mitigation activity	• EDI team reviews daily / weekly / monthly logs • Monitor provider and member complaints • Document on Risk Register
Inability to open or process historical claims and utilization data file	• Request replacement file or alternate file format from MLTC • Identify and fix root cause • Update MLTC daily on mitigation activity	• EDI team reviews daily / weekly / monthly logs • System processing error logs reviewed daily • Document on Risk Register
Corrupted file provided	• Request replacement file or alternate file format from MLTC • Identify and fix root cause • Update MLTC daily on mitigation activity	• EDI team reviews daily / weekly / monthly logs • System processing error logs reviewed daily • Document on Risk Register
SFTP server not accessible or reachable	• Review access credentials • Attempt FTP access • Check to ensure SFTP is not offline • Check internal network and Internet connectivity • Update MLTC daily on mitigation activity	• 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	• Alert Infrastructure team for resolution • Reach out to host maintainer, if applicable • Update MLTC daily on mitigation activity	• System alerts monitored by NOC are escalated to Development and EDI teams • Document on Risk Register

Improper claim denials	• Review claim edits • Review fee schedules • Review provider load and registration • Review denied claims and reprocess those affected • Update MLTC daily on mitigation activity	• Configuration team reviews claim edits, benefit design, and fee schedules • System processing error logs reviewed daily • Document on Risk Register
Failure to generate remittance advices	• Identify and fix root cause of failure • Notify providers of delay and provide payment information in Portal • Update MLTC daily on mitigation activity	• Configuration team reviews error logs • EDI team monitors translations • Mailroom monitors print jobs • Document on Risk Register
Failure to generate weekly expense report and funding request	• Identify and fix root cause of failure • Fund weekly expenses until report and request are generated • Reconcile funds covered by MCNA and MLTC • Update MLTC daily on mitigation activity	• Reporting team reviews error logs • Encounter team reviews encounter processing • Finance team reviews operational expenses and general funding • Document on Risk Register
Failure to issue EFT or paper checks	• Identify and fix root cause of failure • Issue payments using alternative methodology • Notify providers of delay • Update MLTC daily on mitigation activity	• Systems team to review communication and printing technology • EDI team to review data exchange with third party printing and payment processing vendors • Document on Risk Register

Delays in the Publication of Marketing, Educational, and Related Materials and/or the Delivery of these Materials to MLTC and/or its agents, Members, and Providers		
Risk Identification	**Risk Mitigation and Plan**	**Monitoring and Tracking**
Delay with developing member or provider materials	• 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	• List all materials in Project Plan • Daily conference calls and meetings with Communications Committee • Document on Risk Register
Printing vendor behind schedule	• 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 MLTC daily on mitigation activity	• 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	• Identify alternate distribution vendor • Project Lead meets with Distribution vendor liaison • Post notices on websites and Portals • Update MLTC daily on mitigation activity	• 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	• 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	• Project Charter review • Daily Project Plan review • Weekly / bi-weekly checkpoint calls • Document on Risk Register
Narrowed implementation timeline	• Assign more resources to accomplish tasks and deliverables • Compare work completed against remaining tasks and adjust number of hours required to complete implementation • Update MLTC daily on mitigation activity	• Daily Project Plan review • Weekly / bi-weekly checkpoint calls • Document on Risk Register
Call center problems	• 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 MLTC daily on mitigation activity	• 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	• Review project charter, contract and SLA for clarification • Update MLTC daily on mitigation activity	• Project Plan review • Checkpoint call discussion • PMO project status review • Document on Risk Register
Incomplete deliverables / tasks	• Assign additional resources • Re-schedule existing resource hours	• Checkpoint call discussion • PMO project status review • Project Plan review • Document on Risk Register

Miscommunication on deliverables	• Schedule weekly checkpoint meetings with stakeholders • Periodically review contract and Project Charter to ensure on target approach	• Checkpoint call discussion • Project contract and charter review • Document on Risk Register
Natural disaster causes office closure	• Transfer operations to other center (Florida or Texas) • Update MLTC daily on mitigation activity	• National weather monitoring systems • Monitor State / County / City alerts • Document on Risk Register

77	**Provide a timeline for implementation of claims broker functionality, including the number of months that it will take to pay FFS claims.**

Throughout the past decade while administering Medicaid and CHIP dental benefits, MCNA has successfully managed the implementation of over 60 dental program lines of business across the nation exclusively through organic growth. We have provisioned each one of these dental programs as independent lines of business (LOBs) with unique characteristics as either fee-for-service or managed dental care. The vast amount of experience accumulated by MCNA's management team throughout these implementations inspires us to raise the bar for each new program implementation that we manage.

Our leadership team, Program Management Office (PMO), and implementation and operations teams are comprised of highly qualified professionals with a range of complementary multi-disciplinary expertise. These professionals operate in unison, forming a highly resilient team focused on MCNA's mission to deliver value to our clients and providers by delivering access, quality, and service excellence that improves the oral health outcomes of our members. We can only achieve this by maintaining our long-standing tradition of impeccable and effective implementations and ongoing operations for every LOB that we manage. Please refer to the answer to Question 78 of this RFP for additional information about our implementation and transition approach.

Our implementation methodologies have been tested by the most rigorous and demanding projects. We will demonstrate our expertise to Nebraska's Medicaid dental benefits program through our commitment to excellence and the delivery of a responsive, high quality implementation plan designed specifically for the unique transitioning of the claims broker function.

Our proven approach is characterized by three main pillars. It begins with effective communication, which is crucial to meeting all goals and expectations. We ensure all stakeholders are fully aware of every objective, milestone, and task associated with the plan.

We will provide a detailed and complete overview of all implementation and go-live activities, all aspects of which will be carefully coordinated with MLTC. MCNA's implementation team will be ready to meet face-to-face with MLTC during all planning meetings, milestone review meetings, or at any time requested by MLTC. Additionally, regular weekly checkpoints will be established to ensure the proper progress reports are delivered to all stakeholders throughout the lifecycle of the implementation.

We regard our relationship with MLTC as a true partnership, and are confident that our open and honest communications approach will build and maintain the highest levels of confidence between us. After implementation is complete, MCNA will continue to hold weekly meetings with the MLTC to monitor the performance of the program. MCNA may recommend, or MLTC may request, that the frequency of these post-implementation meetings be adjusted in order to assist all stakeholders in resolving concerns or proactively addressing potential issues.

The second pillar of our successful implementation approach is risk management and full transparency. The moment our PMO initiates the planning process, the details of every activity are documented along with the assigned resources, responsibilities, duration, expected outcomes, and other associated elements. This level of detailed documentation allows us to ensure that every task is properly accounted for and completed in a satisfactory manner. It also allows for effective identification of possible problem areas, which MCNA is prepared to address through our risk mitigation plan.

Our commitment to transparency means that MCNA will communicate status updates to MLTC whether a task is on track, unexpected results are experienced, or dependencies on third parties impede progress. If a problem is identified, MCNA will communicate full details upon discovery and throughout the resolution process during project checkpoint meetings or upon request. Our approach to risk management ensures that each project is analyzed from multiple perspectives to eliminate any gap that could jeopardize the success of the project. Please refer to the answer to Question 76 of this RFP for further information about our risk management approach.

The third pillar of our implementation approach is the delivery of anticipated results. We remain fully accountable for every task within the implementation of our programs, whether planned or made necessary by unforeseen circumstances, and will maintain that accountability throughout our partnership with MLTC. We will provide MLTC a complete matrix of contract deliverables, assigned resources, risk analyses, test cases, and results and maintain it as a live document throughout the implementation process.

Our team of professionals are driven to provide value and deliver service excellence to our clients, providers, and members. We accomplish this through our time-tested, successful implementation methodologies. The project team begins with a thorough review of all requirements and expectations to achieve the level of understanding necessary to develop an implementation plan. We accomplish this by stress testing every aspect of our systems, configuration settings, interfaces, processes, and staff until complete satisfaction with our abilities is achieved.

At the end of each successful implementation, our team conducts a retrospective analysis of our performance and notes any areas of opportunity to support of our continuous quality improvement and process refinement goals. All such testing will be carefully coordinated with MLTC and any other external vendor or system required to transition from the current MMIS to a FFS dental program operated by MCNA.

Please see the high-level overview of MCNA's anticipated timeline for the transition and implementation of the claims broker functionality. Our start and end date timeframes assume maximum length of time for all tasks. We welcome the opportunity to work with MLTC for the successful implementation of this program and to demonstrate our ability to provide unparalleled FFS dental program operations. Once MLTC determines the operational start date of the FFS dental program, MCNA will determine and coordinate all necessary resources and provide a more detailed timeline of the project.

[redacted]

[redacted]

[redacted]

78	**Provide a preliminary implementation plan that describes the DBPM's plan to comply with all the major areas of the contract including:** • **Member services** • **Network development and management** • **Provider education** • **Quality management, including credentialing** • **Utilization management** • **Transition and care coordination** • **Information systems management** • **Claims management** • **Grievances and appeals**

[redacted]

[redacted]

MCNA recognizes the success of any dental managed care program is dependent on the development of a comprehensive network of providers in addition to understanding the specific needs of the state. Our vast experience building networks in multiple states demonstrates our commitment to ensure our members can quickly and easily access the care they need.

Readiness Review Approach

The cornerstone to MCNA's readiness approach is the development and adherence to a detailed implementation plan. Our plan for Nebraska will include a task list, staff responsibilities, timelines, and processes that we will use to ensure services begin on the contract effective date. If awarded a contract, we are committed to implement the program in the time frames described in the plan.

[redacted]

Project Work Plan

Flawless implementations are critical to ensuring client success. The work plan submitted with this RFP outlines the key activities necessary to successfully assume DBPM operations. It includes the establishment of MCNA's Nebraska Project Implementation Team and the identification of the project office toolset to be utilized to manage the DBPM implementation project. Our team utilizes our PMO to enable continuous information flow and monitoring of deliverables.

MCNA's project plan includes key milestones and activities needed in order to be ready to assume plan operations on July 1, 2017. All timeframes including those for network development are included along with an estimate of person hours for the identified tasks. Finally, the plan takes into account dependencies and MLTC related components. **Please refer to Attachment 78-1 for MCNA's preliminary implementation plan for the Nebraska DBPM.**

MCNA's Project Management Methodology

MCNA knows a successful implementation of the Nebraska 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 Nebraska has been developed based on our experience with similar transitions in Texas, Louisiana, Florida, Kentucky, and Iowa.

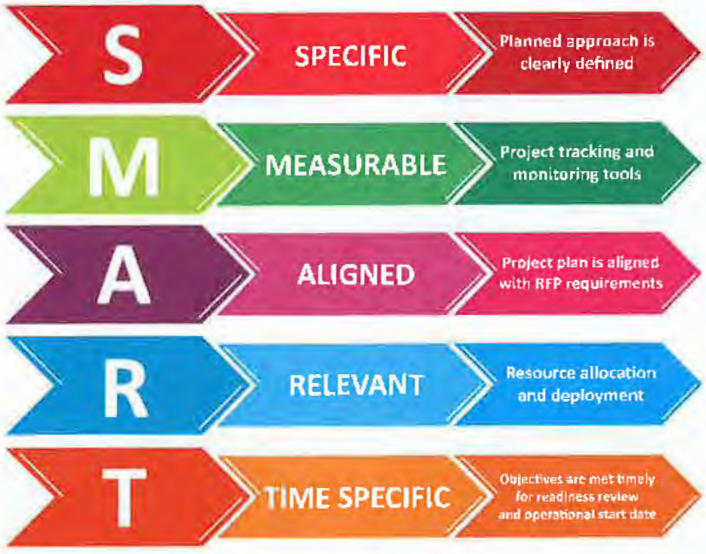
MCNA recognizes that the transition phase will include all activities that must be completed successfully prior to MCNA's operational start date, including all Readiness Review activities, and that MLTC will conduct Readiness Reviews to determine whether MCNA has implemented all systems and processes necessary to begin serving Nebraska enrollees. In compliance with CMS requirements regarding a readiness review which must be completed within 90 days of go-live, MCNA agrees to satisfy all requirements, including any remediation measures, by June 1, 2017, thirty (30) days prior to go-live.

During the Contract Start-Up and Planning phase, MCNA will work with MLTC to define the project management and reporting standards to be followed. These standards will include the establishment of communication protocols for MLTC and MCNA staff, contacts with other MLTC 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 MLTC throughout the process, including post implementation, are the hallmarks of MCNA's turnkey approach to DBPM operations. MLTC 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 other activities needed to ensure the requirements described in the RFP are carried out to the satisfaction of MLTC, are outlined in the plan.

All member and provider educational materials such as Member Handbooks, Provider Directories, and Provider Manuals will be submitted to MLTC for approval prior to distribution. Our provider orientation and training sessions, seminars, and webinars will follow a MLTC approved schedule. Finally, we will work with MLTC, 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.

Program Management Office (PMO)

In anticipation of the RFP award announcement, MCNA has organized our program management office (PMO) under the leadership and direction of MCNA's Chief Information and Security Officer, Daniel Salama, in order to be fully prepared for our pre- and post-contract work plan development activities with MLTC. Our PMO enables 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.

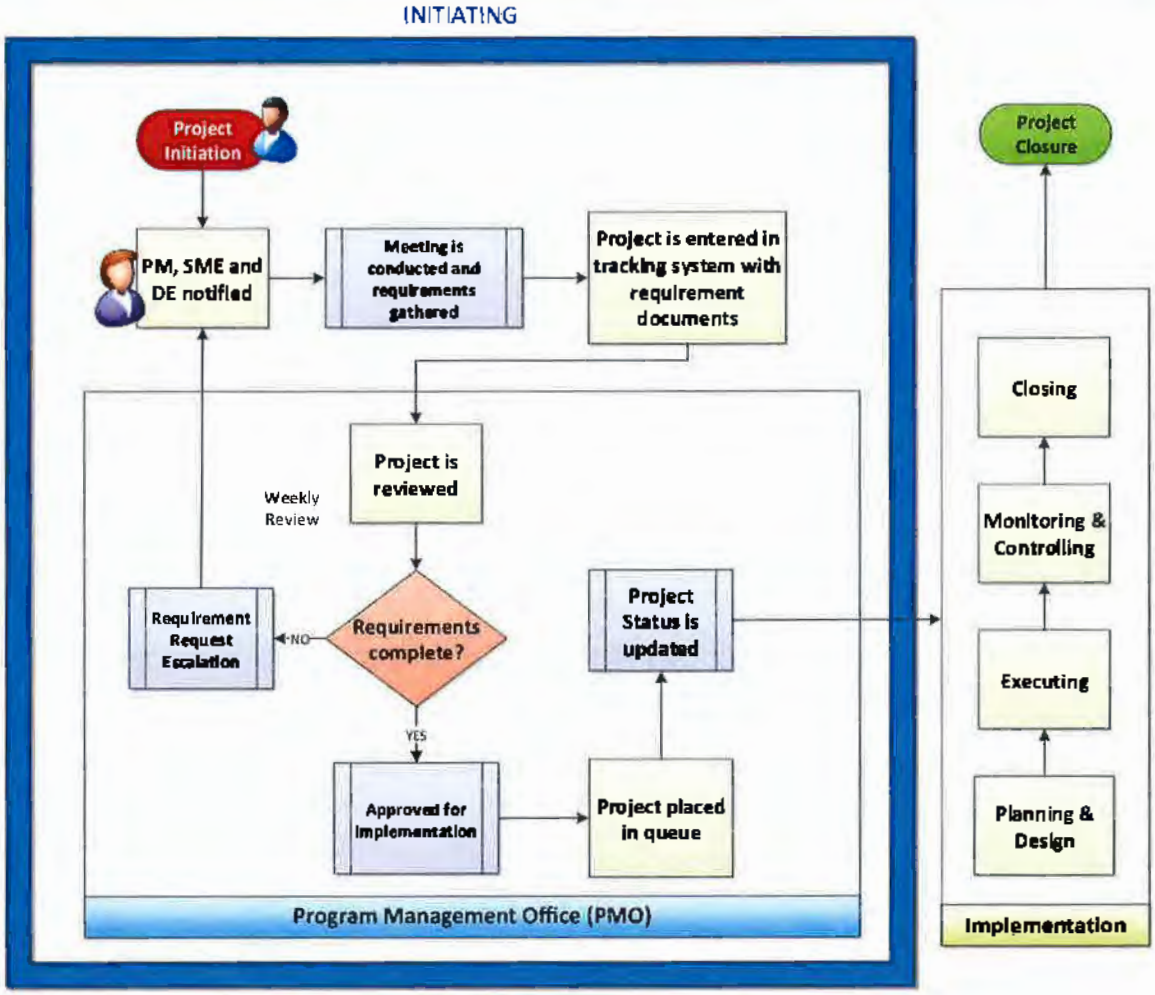
At MCNA, the PMO is engaged for all projects in order to ensure flawless implementation through a dedicated team. With the knowledge that versatile and varied core strengths are needed in order to ensure successful implementation, the PMO is comprised of:

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

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

Each PMO 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. Their proven project management skills are complemented by a combined healthcare implementation experience level in excess of 100 years.

The following diagram shows a summary of the activities flow and administration within our PMO.



MCNA strives to be a lean company and constantly improves the efficiency of its processes and methodologies. 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:

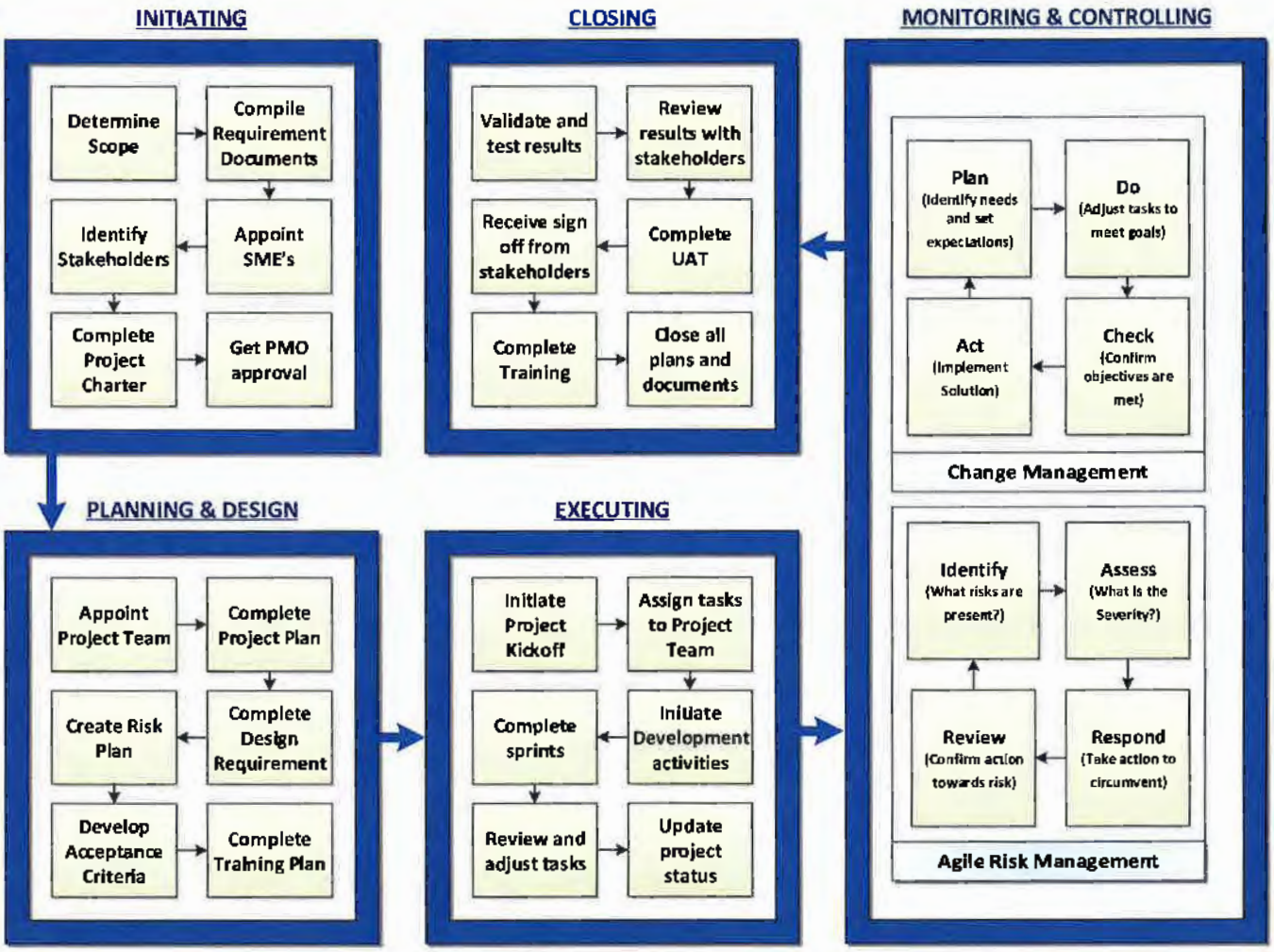
- Assignment of the right balance of SMEs, PMs and DEs as part of the overall project team
- Allocation of Operational Process Assets (OPA's) and contract to project team
- Kickoff meeting for contract and Service Level Agreement (SLA) review
- Development of Project Plan through Microsoft Project® with critical milestones
- Weekly implementation meetings with MLTC staff and MCNA project team
- Development of Project Charter, Action Log and Risk Register
- Formal communication of plan and project update sharing with MLTC 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, 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 needed to implement solutions or approaches 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 the delivery stage, and contributes to analyzing and responding to RFPs and their implementations. The PMO's 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 PMs provide an updated Project Plan, Action Plan and Risk Register for review by the implementation team, which may include MLTC 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's PMO goes 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. To ensure "scope creep" does not occur when new or additional project demands are made known, MCNA continuously monitors project parameters. Scope creep 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 project team is well versed in the mitigation strategies and processes that can be used to circumvent escalation. During the course of the implementation, the project 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.

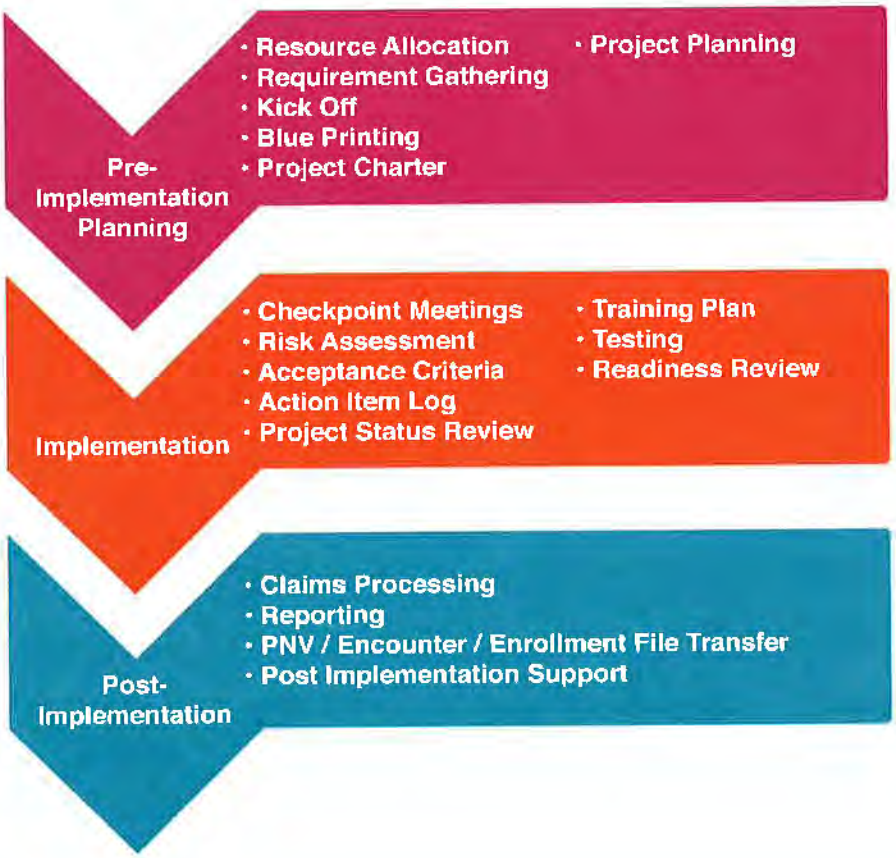
The bi-weekly PMO reviews not only focus on the project path, but also the effectiveness of the project team at keeping the implementation activities on track. Any additional resource allocation, key decision resolution, change management activities, fiscal requirements and project adjustments are also 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 MLTC 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 Implementation Champion. Daniel's experience with large-scale transitions and implementations coupled with his extensive knowledge of information technologies makes him the best and most logical choice to lead the PMO 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 MLTC. These team members will be solely dedicated to the furtherance of the project and will complement 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 project PMO to assess its resource allocation needs 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 contribute their expertise and skills.

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 Operational Process Assets (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 compilation of all activities pertaining to the implementation.

The development of the Project Charter is a Risk Management strategy that reduces the need for Change Management. Unexpected challenges are inevitable with any project, but MCNA's experience has taught us that a robust Charter allows both the stakeholder and the project team to understand the project requirements thoroughly, and vet solutions prior to issues arising as the project reaches 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 MLTC 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 definition is drafted and 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 of the Action Log is to prevent the project plan from being overloaded with tasks that are not critical for the implementation, yet must be maintained along with a log of all activities required for the project 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 July 1, 2017. 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).

Reporting

MCNA has a dedicated team of Reporting Analysts who develop and maintain over 500 complex reports which are utilized 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 MLTC and MCNA. Our team members are able to generate and receive files in a multitude of formats, including customized formats requested or utilized by MLTC. This flexibility puts us ahead of our competition and we are able to work with MLTC 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 implementation 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 MLTC

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 MLTC 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 MLTC 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 review and 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 Management Information System (MIS) 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.

[redacted]

Deliverables as Listed in Attachment 12 – Policies, Procedures, and Plans

Provider Contract Template

Submit provider contract template as described in Section IV.I - Provider Network.

MCNA is pleased to submit our Provider Contract Template as described in Section IV.I - Provider Network as **Attachment 24-1**.

Network Development Plan

Submit plan for developing an adequate provider network within the timeframe described in Section IV.I - Provider Network.

MCNA is pleased to submit our plan for developing an adequate provider network within the timeframe described in Section IV.I - Provider Network as **Attachment 24-2**.

Key Staff Resumes

As possible, submit resumes of proposed key staff as described in Section IV.V - Transition and Implementation.

MCNA is pleased to submit our Key Staff Resumes as described in Section IV.V - Transition and Implementation as **Attachment I-1**.

Preliminary Implementation Plan

Submit preliminary implementation plan as described in Section IV.V - Transition and Implementation.

MCNA is pleased to submit our Preliminary Implementation Plan as described in Section IV.V - Transition and Implementation as **Attachment 78-1**.

Draft Member Handbook

Submit a draft copy of the member handbook as described in Section IV.G – Member Services and Education.

MCNA is pleased to submit a draft copy of our member handbook as described in Section IV.G - Member Services and Education as **Attachment 16-1**.

FP 5427 Z1: Medicaid Dental Benefit Program

ance Company for the Nebraska Department of Health and Human Services

NTS

Attachment Addenda-1
MLTC Addenda

AdministrativeServices

Byron L. Diamond
Director

Pete Ricketts, Governor

ADDENDUM ONE
REVISED SCHEDULE OF EVENTS

Date: October 17, 2016

To: All Bidders

From: Michelle Thompson/Teresa Fleming, Buyers
AS Materiel State Purchasing Bureau

RE: Addendum for Request for Proposal Number 5427Z1
to be opened October 25, 2016 at 2:00 p.m. Central Time

	ACTIVITY	DATE/TIME
5.	State responds to written questions through Request for Proposal "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html	~~October 17, 2016~~ TBD
6.	Proposal opening Location: State Purchasing Bureau 1526 K Street, Suite 130 Lincoln, NE 68508	October 25, 2016 2:00 PM Central Time
7.	Review for conformance of mandatory requirements	October 26 - 28, 2016
8.	Evaluation period	October 31 – November 15, 2016
9.	"Oral Interviews/Presentations and/or Demonstrations" (if required)	TBD
10.	Post "Letter of Intent to Contract" to Internet at: http://das.nebraska.gov/materiel/purchasing.html	November 21, 2016
11.	Contract finalization period	November 22, 2016 – January 3, 2017
12.	Contract award	January 3, 2017
13.	Contractor start date	July 1, 2017

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal.

AdministrativeServices

Byron L. Diamond
Director

Pete Ricketts, Governor

ADDENDUM TWO
REVISED SCHEDULE OF EVENTS

Date: October 19, 2016

To: All Bidders

From: Michelle Thompson/Teresa Fleming, Buyers
AS Materiel State Purchasing Bureau

RE: Addendum for Request for Proposal Number 5427Z1
to be opened ~~October 25, 2016~~ October 31, 2016 at 2:00 p.m. Central Time

	ACTIVITY	DATE/TIME
5.	State responds to written questions through Request for Proposal "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html	~~October 17, 2016~~ TBD
6.	Proposal opening Location: State Purchasing Bureau 1526 K Street, Suite 130 Lincoln, NE 68508	~~October 25, 2016~~ October 31, 2016 2:00 PM Central Time
7.	Review for conformance of mandatory requirements	~~October 26 - 28, 2016~~ November 1 – 3, 2016
8.	Evaluation period	~~October 31 – November 15, 2016~~ November 4 – 18, 2016
9.	"Oral Interviews/Presentations and/or Demonstrations" (if required)	TBD
10.	Post "Letter of Intent to Contract" to Internet at: http://das.nebraska.gov/materiel/purchasing.html	~~November 21, 2016~~ November 23, 2016

	ACTIVITY	DATE/TIME
11.	Contract finalization period	~~November 22, 2016 – January 3, 2017~~ November 28, 2016 – January 3, 2017
12.	Contract award	January 3, 2017
13.	Contractor start date	July 1, 2017

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal.

AdministrativeServices

Byron L. Diamond
Director

Pete Ricketts, Governor

ADDENDUM THREE
QUESTIONS and ANSWERS

Date: October 21, 2016

To: All Bidders

From: Michelle Thompson/Teresa Fleming, Buyers
AS Materiel State Purchasing Bureau

RE: Addendum for Request for Proposal Number 5427 Z1
to be opened October 31, 2016 at 2:00 p.m. Central Time

Questions and Answers

Following are the questions submitted and answers provided for the above mentioned Request for Proposal. The questions and answers are to be considered as part of the Request for Proposal. It is the Bidder's responsibility to check the State Purchasing Bureau website for all addenda or amendments.

Question Number	RFP Section Reference	RFP Page Number	Question	State Response
1.	Glossary of Terms	xiii	Appears to be a very broad definition of subcontractors, covering any entity that does any work related to the contract, example, a company that simply assembles creditialing information for DentaQuest to review to make creditialing decisions. Is that the intent?	A subcontractor is any organization or person who provides a function or service outside the scope of a provider agreement.
2.	Project Desctition and Scope of Work	Page 140 j-Subcontractors	There are several detailed requirements, such as page 140 tracking hours, in which we do not do for most of our subcontractorsIn the cases it does not apply, is it okay to put "not applicable" in these circumstances?	The intent is for the bidder to provide i -iv for any and all subcontractors. If "not applicable" is the appropriate response, provide as such.
3.	Attachment 7, 8 and 14	Attachment 7, 8 and 14	Will you be providing a narrative that identifies the specific data assumptions and methodologies behind the specific payment rates for each age band?	Please review the PowerPoint presented during the Pre-Proposal Conference for the specific assumptions within the rate development. MLTC will provide a data book when the rates are updated in the Spring of 2017. The PowerPoint can be found at the following website: http://das.nebraska.gov/materiel/purchasing/5427/5427.html. And the direct link to the PowerPoint is: http://das.nebraska.gov/materiel/purchasing/5427/Optumas%20Dental%20Rate%20Presentation.pptx
4.	Attachment 7	Attachment 7	What Fee Schedules were used during the experience period as well as any fee schedule changes during the experience period and expected during contract year?	The underlying reimbursement for the rate development is Medicaid FFS. The only fee schedule change was for the repricing of the UNMC provider services at the average of the top 5 Commercial Dental Providers in Nebraska.

5.	Attachment 7 and 14	Attachment 7 and 14	Will you be providing membership growth or decline as well as providing monthly membership in relation to FY 2014, FY 2015 and future expectations?	Due to the fluctuation in the monthly membership, the annual membership provided in Attachment 7 is a more accurate data point to use in your own calculation of risk as it relates to the capitation rates offered in the RFP. The projected membership has not been fully defined as it related to the upcoming biennium budget.
6.	Attachment 7, 8 and 14	Attachment 7, 8 and 14	Will you be providing the member access rates (Current) and Expected?	The access rate assumed within the rate development is consistent with the access rate that was present within FFS during the base data time period of FY14-FY15. The State's actuaries will not be providing any additional information surrounding expected access.
7.	Attachment 7, 8 and 14	Attachment 7, 8 and 14	What assumptions were used for Trending?	Please see Slide 9 and 10 of the FY18 Rates PowerPoint that was presented during the Pre-Proposal Conference for the trend assumptions. The PowerPoint can be found at the following website: http://das.nebraska.gov/materiel/purchasing/5427/5427.html. And the direct link to the PowerPoint is: http://das.nebraska.gov/materiel/purchasing/5427/Optumas%20Dental%20Rate%20Presentation.pptx
8.	Attachment 7 and 14	Attachment 7 and 14	Will you be providing Claim Lag data for the FY 2014 and FY 2015?	Since the IBNR adjustment shown on Slide 7 of the Optumas Dental Rate Presentation (please find link in the response to Question 7) is "de minimis" no further information will be provided.
9.	Attachment 7, 8 and 14	Attachment 7, 8 and 14	Will you be providing the assumptions for Coordinated care savings or Managed care savings?	There are no assumptions for coordinated care savings or managed care savings. Those savings are dependent upon how the DBPM manages the program. The State

				does not anticipate savings, but requires the DBPM to manage a more efficient and sustainable program.
10.	Attachment 7	Attachment 7	Will you be providing DCode level experience/utilization?	Yes, please see Attachment 16.
11.	Attachment 7, 8 and 14	Attachment 7, 8 and 14	Will you be providing any program changes assumed in the rating?	All adjustments, including policy adjustments was shared during the Pre-proposal Conference (please find link in the response to Question 7).
12.	Attachment 7, 8 and 14	Attachment 7, 8 and 14	Confirmation that "Net Medical Rate" only includes claim cost.	Confirmed.
13.	Attachment 7, 8 and 14	Attachment 7, 8 and 14	Confirmation that "Loaded Rate" excludes ACA/HIPF Taxes.	Since the program is new during FY18, the ACA/HIPF tax does not apply during the first contract year.
14.		Page viii	**"Auto assignment"** states that an enrollee, who does not select a dental home within a predetermined length of time during enrollment activities is automatically assigned to a dental home." How does automatic assignment work?	The DBPM will develop an algorithm that MLTC must approve. The algorithm may account for previous member-provider relations, familial relations, provider location, etc.
15.			Can dentists through the DBM get assistance with reasonably priced language interpretation so they are in compliance with OCR 1557 Rule? Language line is approximately $4.95/minute. Can this be added to the contract?	This will not be required of the DBPM. The DBPM could propose this as a value-add service.
16.			What is the total cost of the contract? We couldn't find it listed. If you do the math, it appears to be in the range of $55 million. Why is not just stated?	The total cost of the contract is dependent on the final capitation rates and the membership mix for each month of the contract.
17.			Can you require that the dentist portal include the ability to access the amount of	The bidder should provide a response that meets the requirements of the RFP.

			the $1,000 cap that has been spent for an adult patient? Otherwise, the dentist has no way of knowing what was spent in another clinic and could go over the cap.	
18.		Page 38	"*Providers may not bill members any amount greater than would be owed if the DBPM provided the services directly (i.e., no balance billing by providers is permitted).*" With a $1,000 cap on adult benefit, how will non-covered services be handled? How will covered services once the member reaches the annual maximum be handled? Are these determinations being left to the DBPM?	The DBPM may provide value-added services above what Medicaid currently covers. There are no planned changes to the policy related to Non-covered services.
19.		Page 40	"*The Dental Director must be currently licensed as a Doctor of Dentistry ("dentist") with no restrictions or other licensure limitations.*" – The Dental Director should be licensed in the state of Nebraska.	Please see Addendum Four, #3.
20.		Page 48	*Value added services: Minimizing the occurrences of missed appointments through member incentives, technology-based appointment reminders, member education, or other mechanisms identified by the DBPM.* Consider that case management services also be included specifically in this sentence.	Case management is not precluded as a proposed value-added service.
21.	**8(e)(ii)**	Page 8	discusses minimizing the occurrences of missed appointments through member incentives, technology-based appointment reminders, member education, or other mechanisms identified by the DBPM. Is there a mechanism that requires the DBM to track missed/late cancelled appointments to help the Provider?	No. MLTC identified that as a priority for potential value-added services, but the DBPM will have the discretion to decide which value-added services it would like to propose. Please see Section IV.E.8.d.

22.		Page 57	Notice to Members of Provider Termination mentions "When timely notice from the provider is received, the notice to the member must be provided within fifteen (15) calendar days of the receipt of the termination notice from the provider." Timely notice is not defined. Include standard protocol that a dentist may to discontinue seeing a patient as long as patient is provided 30 days of emergency care while in transition of finding a new dental home.	Please see Addendum Four, #4.
23.			Can MLTC require the dentist portal to include what dental services the patient has received in the last 12 months to avoid duplicating services and billing? For example, dentist #1 could place a sealant, but in 6 months it falls off. Dentist #2, not knowing that the sealant was placed, billed, and lost, places another sealant and bills for it. Now dentist #2 is in violation of the rule that sealants can only be billed out every 2 years.	Please see response to Question 17.
24.		Page 64/65	*For the first year of the contract period, the DBPM must accept into its network any dental provider participating in the Medicaid program provided the dental provider is licensed and in enrolled with DHHS and accepts the terms and conditions of the contract offered to them by the DBPM. This provision also does not interfere with measures established by the DBPM to control costs and quality consistent with its responsibilities under this contract nor does it preclude the DBPM from using different reimbursement amounts for different*	The DBPM and provider will negotiate reimbursement through the contracting process but are required to reimburse no less than the published Medicaid fee-for-service rate in effect on July 1, 2016 for the first year of the contract.

			specialties or for different practitioners in the same specialty [42 CFR §438.12(b)(1)]. Note this opens the door to the DBPM negotiating rates with individual providers just like the commercial sector. Some dentists may experience lowering reimbursement rates especially after the first year. It sounds like the DBPM can pay a differentiated rates for dentists in network for good reason (under provider incentives). Good reason might be one dentist in the whole community/county being in network or a lack of specialists and one specialist is seeing a disproportionate amount of patients/members. Are we understanding this correctly?	
25.		Page 68	*Credentialing and Re-credentialing of Providers and Clinical Staff* – The contract does not appear to stipulate how quickly credentialing should be accomplished. This is a problem in some states that takes up to 6 months to credential a new provider and this becomes an issue. 30 days is preferred.	Please see Addendum Four, #8.
26.		Page 74	The DBPM must develop, establish, and maintain a provider advisory committee to create network development and management strategies and procedures. Include the requirement that the DBPM should share the *Reporting Dashboard* (page 125) with the advisory committee.	The Reporting Dashboard is an internal tool to ensure accountability. While MLTC or the DBPM may share the dashboard with external stakeholders, MLTC will not include that requirement in the RFP.
27.		Page 77	*QAPI Committee*: The RFP asks the DBPM to describe how they will get provider input into any QAPI plan. Include a representative from the NDA on the QAPI Committee.	Per Section IV.M.2.a.i-iii of the RFP establishes the minimum QAPI Committee membership. The bidder should provide a response that meets the requirements of the RFP.

28.		Page 82	*The DBPM must submit an electronic copy of the UM policies and procedures to MLTC for written approval within thirty (30) calendar days from the date of award, annually thereafter, and prior to any revisions*. The NDA requests that state to share this for input or request the state include a requirement in the contract that the DBPM needs to seek input on these from the NDA.	The bidder must meet all of the requirements of this RFP. The bidder should provide a response that meets the requirements of the RFP.
29.		Page 99	*For the first year of the contract, the DBPM rate of reimbursement must be no less than the published Medicaid fee-for-service rate in effect on July 1, 2016, unless MLTC has granted an exception for a provider-initiated alternative payment arrangement.*" Can MLTC stipulate that the FFS fee schedule is the floor always rather than just the first year?	No, the DBPM and the providers should negotiate and contract alternative payment methods rather than only rely upon the fee schedule.
30.			Will the provider manual be available to dentists before they are asked to sign the provider contract?	MLTC will require the DBPM to submit for approval to MLTC its provider manual within thirty (30) days after contract award. Providers are free to contract with the DBPM before or after receiving the Provider Manual.

31.		Page 111	*MLTC reserves the right to review any claim paid by the DBPM or its designee. The DBPM has the right to collect or recoup any overpayments identified by the DBPM from providers of service in accordance with existing laws or regulations. However, if an overpayment is identified by the State or its designee one year or later from the date of payment, the DBPM will collect and remit the overpayment to MLTC. In the event the DBPM does not collect mispayments from the provider within 30 calendar days of notification of the overpayment, the DBPM must refund the overpayment to MLTC. Failure by the DBPM to collect an overpayment from a provider does not relieve the DBPM from remitting the identified overpayment to MLTC.*" Nowhere in the contract does it say how far back the DBPM can go to claim overpayments. Neb.Rev.Stat. § 68-974 states that all recovery audit contractors retained by the department when conducting a recovery audit shall review claims within two years from the date of the payment. Does this two year lookback period apply to the DBPM? If not, include a two year lookback limitation.	The bidder must meet all of the requirements of this RFP. MLTC cannot limit the timeframe associated with any audit the Medicaid program is subject to.
32.			Would you mind clarifying Form A Bidder Contact Sheet? Do you have a specific order or location you would like this included in the response?	Bidders should complete Form A, Bidder Contact Sheet and include with their proposal response. The State does not have a specific order or

				location. The sections of the proposal response should be separated by an identified tab.
33.	Section IV.C.2	Page 35	Will a certificate of authority to conduct the business of accident and health insurance issued by the Nebraska Department of Insurance to a foreign (Texas) insurer satisfy the licensure requirements of this RFP?	No, the contractor will be required to obtain a certificate of authority from the State of Nebraska before go live.
34.	Section II.P	Page 6	According to the Nebraska Secretary of State's Office, and Chapter 21 Section 20,168 (4) The Requirements of the Business Corporation Act shall not be applicable to foreign or alien insurers, which are subject to the requirements of Chapter 44. Please confirm that a foreign insurer authorized to transact the business of accident and health insurance by the Nebraska Department of Insurance will not be required to submit a Secretary of State certification with their bid, pursuant to Section II.P of the RFP.	The State is looking into this and will provide a response at a later date.
35.	Section D Staffing Requirements 2.c	Page 38	Is the replacement of key staff approved by state prior to job offer? Is this also required for initial hires?	MLTC must approve initial and replacement hires of key staff prior to the key staff starting.
36.	Section D Staffing Requirements	Page 42	What will Dental QA and Government Quality be doing, separation of responsibilities?	MLTC requires the DBPM to employ a staff member dedicated to the daily business of quality management and improvement. MLTC's role in quality assurance is to review and audit the DBPM's quality measures and initiatives.

37.	Section E Core Medicaid Dental Benefits	Page 45	How often are the state benefit grid (from website) updated with CDT codes?	The program reviews the yearly release of any new code updates from the ADA around November or December for the following year. MLTC implements or makes needed additions or revisions to the codes and fee schedule for a January 1 release. MLTC also reviews and adds or revises the fee schedule during our fiscal year with a release date of each July 1.
38.	Section E Core Medicaid Dental Benefits	Page 45	Will we have access to the incumbent's current clinical guidelines?	This is a new program and there is no incumbent. Nebraska Medicaid's clinical guidelines can be found in the Medicaid & Long-Term Care Rules and Regulations.
39	Section H Grievance and Appeals	Page 59	Is there a time period when a member cannot file a grievance, i.e. 180 days after date of service or occurrence?	The DBPM must establish their grievance system that meets all relevant Federal and State regulatory requirements.
40.	Section H Grievance and Appeals 4.d.ii	Page 61	Requirement of only 1 level of appeal-does it then required to go to a Fair Hearing?	Per 42 CFR 438.402, the DBPM may have only one level of appeal for enrollees.
41.	Section H Grievance and Appeals 7.a	Page 63	Are all Fair Hearings telephonic? Are there any requirements to present in person?	Fair hearings are held in the DHHS Hearing Office in the State Office Building in Lincoln. The parties are permitted to appear in person or by telephone.
42.	Section H Grievance and Appeals 7.a	Page 65	Will we be provided the number of grievances, appeals, Fair Hearings historically?	The Fair Hearing Office opens appeals as directed by the Divisions. They opened 2 Medical Assistance Dental appeals in 2016 and 10 in 2015. In addition, they opened 99 Recovery Audit Contractor appeals in 2015, all of which appear to

				involve dental providers. It is estimated that a number of appeals opened as Medical Assistance Payment appeals involved dental providers, but they do not track those appeals by provider type.
43.	Section I Provider Network Requirements	Page 64	Will the State consider Letters of Intent or Letters of Agreements as acceptable for the necessary network coverage requirements?	Letters of Intent and Letters of Agreement are not required as part of the proposal. MLTC will determine network adequacy by the provider enrollment file, as well as data and analysis attesting to the sufficiency of the DBPM's network.
44.	Section I Provider Network Requirements 1.f	Page 65	Can the Plan terminate providers "without cause"	No, except when the provider does not act on re-validation. In this case, the plan may terminate.
45.	Section I Provider Network Requirements 1.h.v	Page 65	Is the methodology of the access surveys determined by the dental plan?	Yes, but the DBPM must submit the survey for MLTC's approval.
46.	Section I Provider Network Requirements 5.c	Page 66	We do not currently contract and list prosthodontists, will this be required for NB?	No. Contracts are not required but the services must be available.

47.	Section I Provider Network Requirements 5.e	Page 67	Is the dental plan able to interpret this requirement, and have a mechanism to require some requirements for specialty referrals, or are all specialty referrals to be "self-directed"?	The DBPM will submit their proposed process for MLTC approval during contract finalization.
48.	Section V Proposal Instructions A	Page 138	Where would the State prefer the Scope of Work response to be included within the Technical Proposal?	The State does not have a specific order. The sections of the proposal response should be separated by an identified tab.
49.	Attachment 4 Dental Access Standards		Will the State be providing a census?	Yes, please see Attachment 17. This is a census based on CFS service areas, which can be found here: http://dhhs.ne.gov/children_family_services/Documents/SvcAreaMap-NEW.pdf
50.	Attachment 14 - COA-level Rate Development	Page 3	There is an UNMC % adjustment applied to the base data. Can you please provide additional detail on what this adjustment accounts for and how it was calculated?	The State provided their actuary with the UNMC provider IDs. The State's actuary used that information to identify the UNMC claims inherent in the FFS data, and repriced the claims to an enhanced fee schedule provided by the State. This enhanced fee schedule reflects the average reimbursement of the top 5 Commercial Dental Providers in Nebraska.
51.	Attachment 1		Are there any limitations on the levels of Incentive Bonuses or Activities that improve health care quality that can be included as Net Qualified Medical Expense?	The definition for activities that improve quality is consistent with the Medicaid Managed Care Final Rule released by CMS. As such, there is no predefined maximum associated with these types of services.

52.	Attachment 1		Please define what is considered to be "related-party medical margin"	Related-party medical margin is any margin built into sub-capitation arrangements between a parent and subsidiary company, to the extent they exist.
53.	Attachment 1		Is the 2% Hold Back included in the calculation of "revenue earned" described in Section 3 of the MLR Calculation description? If so, is an adjustment allowed in the event a porion of the holdback is not ultimately "earned" by the DBPM?	The MLR calculation will include the portion of the hold back that is ultimately earned by the DBPM.
54.	Attachment 7		Please describe what, if any, adjustments have been made to the base experience data presented in the data book. Were any claims excluded and, if yes, why? Was there any repricing of historical claims to reflect payment at 100% of the dental fee schedule?	No dental claims were excluded. All claims are reimbursed at a 100% dental fee schedule so claims were not repriced.
55.	Attachment 7		Can the state provide the mapping used to align dental service codes with the CoS descriptions contained in the data book?	Please see Attachment 18.
56.	Attachment 7		Please describe the methodology used to categorize members in specific age cells. Is cell determined based on age at a point in time or does a member change cells within a SFY on their birthdate?	The rating cohorts are based on the member's age at the time the claim was incurred within the rate development. Operationally, a member's age cohort will be determined on a monthly basis when capitation payments are made.
57.	Attachment 7		Does the state anticipate any significant shifts in the projected population distribution relative to what was seen in the base experience period(s)? If yes, please describe.	MLTC does not anticipate shifts in the population distribution relative to the base data.

58.	Attachment 7		Please confirm that the Units column reflects the sum of actual service units submitted for each claims and does not represent visits or encounters.	Confirmed.
59.	Attachment 8		Please confirm that there are no planned adjustments to the capitation rates shown in this exhibit. It is assumed rates will be paid as shown with no adjustments for risk, region, gender differences in a particular DCO's membership distribution.	The rates will be updated in the Spring of 2017 to incorporate more recent base data and any new policy changes that may be in effect during the FY18 contract period.
60.	Attachment 13		Please provide a file containing projected membership by each county within the state	Due to counties having populations small enough to potentially identify individuals enrolled in Medicaid, MLTC cannot provide that information. However, please see the response to Question 49.
61.	Attachment 14		Please provided further detail around the UNMC Repricing factors applied in the rate development. What is the purpose of this adjustment? How were the SFY14 and SFY15 Adjustments estimated?	Please see response to Question 50. There was no estimated adjustments because MLTC had actual data.
62.	Attachment 14		What is the rationale for the 50/50 blending of SFY14 and 15 claims experience? I would expect greater weight would be assigned to the more recent data.	During the rate development process the FY14 data is trended forward one year to FY15 in order to place both years of data on the same basis prior to blending. There were no significant reasons that led MLTC to believe the FY15 base data more accurately represents the expected experience for the FY18 contract period, thus an equal blend of FY14 and FY15 was used when developing the final rates.

63.	Attachment 14		Please describe the process for determining the 2.0% Utilization Trend assumed in the rate development. Any detailed analysis supporting this estimate would be appreciated.	MLTC reviewed historical FFS data to help inform the aggregate PMPM trend across all services. This aggregate PMPM trend was uniformly distributed between the utilization and unit cost components of the trend assumption. These trend assumptions will be refined at the more detailed category of service level when the FY18 rates are updated in the Spring of 2017.
64.	Attachment 14		Please describe the process for determining the Unit Cost Trend assumed in the rate development. Are there any known changes to the state fee schedule included in this estimate? Any detailed analysis supporting this estimate would be appreciated.	See the response to Question 63.
65.	Attachment 14		Please confirm that the rate development assumes the annual trends shown in this exhibit will be compounded annually across a 36 month period. Additionally, please confirm that the annualized trends are EXACTLY as they appear in the exhibit (i.e. rounded to the nearest tenth of a percent) and that the 36 month compounding is NOT rounded in the calculation.	Confirmed. The FY14 base data was trended for 12 months in order to place both years of data on the same basis prior to blending. The two years were then blended together and trended from the midpoint of the FY15 time period (12/30/2014) to the midpoint of the FY18 time period (12/30/2017). The trends shown during the Pre-proposal Conference are the exact trends used in the rate development. However, please note that trends are applied at the COA and COS level of detail. As such, the trends shown on the "COA Rate Development" exhibit will be the effective COA trends across all services.

66.	RFP Document P.2.k	97	Can the state provide the certification document referenced in P.2.k on page 97? The rate development has been provided in Attachment 14 but the accompanying narrative would be helpful in better understanding the specific components of the development.	MLTC will provide a databook when the rates are updated in the Spring of 2017.
67.	RFP Document P.7.	101	Please provide further detail around the supplemental payments DBPM's are required to "pass through" to UNMC providers. Is it the intention of this program to be revenue neutral to the DBPM or does over/under utlization risk exist? Additionally, what is meant by the statement "these payments are calculated into the captiation rate on a quarterly basis"? This would imply the capitation rates shown in Attachment 8 will be modified multiple times per year???	The UNMC supplemental payment is a per member per month amount that is calculated based on utilization of service provided by the UNMC providers. The intention is to be revenue neutral. The UNMC supplemental payment is calculated quarterly and does not impact capitation rates.
68.	RFP Document R.12.a	112	Has the states actuary assumed a certain level of expected Third Party Liability payments in their rate development and, if so, what is the projected amount? This question is meant to include COB dollars as well.	The dollars underlying the rate development are the Medicaid paid amounts inherent in the FFS data. As such, MLTC is assuming that the TPL recovered in the contract period will resemble the level of TPL inherent in the base data.
69.	Section IV.C.3 Accreditation	35	Section IV.C.3, page 35, requires that the DBPM obtain Health Plan Accreditation through NCQA. Per our understanding of NCQA accreditation requirements, the DBPM would not qualify to apply for Health Plan Accreditation through NCQA. The DBPM could apply for NCQA Certification for the functions of Utilization Management	MLTC will accept URAC for accreditation.

			and/or Credentialing. Additionally URAC offers a comprehensive Dental Benefit Plan Accreditation. Can the State please clarify the requirement around NCQA? Is the requirement meant to reference NCQA Certification in Utilization Management and/or Credentialing? Additionally, would the State consider URAC accreditation in lieu of NCQA certification as the URAC accreditation is more comprehensive than NCQA certification.	
70.	IV.G Member Services and Education	51	Describe proposed member education content and materials and "attach examples" used with Medicaid or CHIP populations in other states. Describe innovative methods the DBPM has used for member education. Describe how the DBPM will provide equitable member education throughout the State. "Provide examples" and descriptions of how member education will be used to improve service coordination including: - The use of technological tools, including social media and mobile technology. - Partnership with community-based organizations for education and outreach. **Please confirm requested examples are not included in the page limit.**	MLTC confirms that requested examples are not included in the page limit.
71.	RFP Dental Management Document	4	Would the state please confirm that all attachments can be placed behind a tab for attachments behind the technical narrative?	This formatting is acceptable to the State.

72.	RFP Dental Management Document	4	Will the State please confirm that Calibri 11pt. Font with 1 inch margins on all sides is acceptable for all required responses?	This formatting is acceptable to the State.
73.	RFP Dental Management Document	4	Please confirm that a 10pt. font is acceptable for all tables and figures.	This formatting is acceptable to the State.
74.	Attachment 11 - Proposal Statements and IV.L Care Coordination Question 40	9	"Describe how the DBPM will assist members to identify and gain access to community resources that provide services the Medicaid program does not cover." Is the State solely referring to the identification and access to dental resources the Medicaid program does not cover?	MLTC requires the DBPM to direct members to community resources that broadly help improve health outcomes.
75.	SPB RFP Revised: 01/29/2016 page 41	41	Can the State please clarify that question #1. should be "dental health services" and not "physical and behavioral health services"? Tribal Network Liaison* The Tribal Network Liaison is responsible for: 1. Planning and working with Provider Services staff to expand and enhance physical and behavioral health services for American Indian members. 2. Serving as the single point of contact with tribal entities and all DBPM staff on American Indian issues and concerns. 3. Advocating for American Indian members with case management and member services staff.	Please see Addendum Four, #9.
76.	R. Claims Management, 6. Paid Claims Sampling, a.	107	Does the State require the provision of EOBs for all Medicaid recipients?	MLTC does not require this but the DBPM must have a method to verify services.

77.	R. Claims Management, 6. Paid Claims Sampling, c.	107	Regarding the language,"The service verification surveys may be conducted at any point after a claim has been paid, but no more than 45 calendar days after the date of payment. This sampling may be performed by mail, telephonically, or in person (e.g., during case management on-site visits)." Please provide additional detail regarding expectations for conducting service verification surveys, i.e., what should these surveys contain? and is the expectation that this process is conducted as part of credentialing and/or UM?	The DBPM will submit for MLTC's approval their proposed surveys. While this process may be used for credentialing or utilization management, the primary purpose is to ensure the DBPM and MLTC comply with Federal law regarding claims payment, processing, and verification that beneficiaries received billed for services. The bidder should provide a response that meets the requirements of the RFP.
78.	R. Claims Management, 6. Paid Claims Sampling, c.	107	Regarding the language, " Concurrent review will be allowed when tied back to a successfully adjudicated claim." Is the State's expecation that the plan conducts concurrent reviews for dental services?	Yes.
79.	Attachment 11	p.2, Q18	Question 18 requests "an overview of the proposed member website, including how it will satisfy requirements in this RFP." The Scope does not mention a member website; will the state please provide additional detail regarding the requirements for a "member website" and "member portal."	Please see Addendum Four.
80.	Attachment 11	p.2, Q17	Question 17 requests written material and references the "appropriate reading level" for all member materials. Please provide the appropriate grade reading level for the state of Nebraska.	The DBPM must write all member materials in a style and reading level that will accommodate the reading skill of the members. In general, the writing should be at no higher than a 6.9 grade level, as determined by the Flesch–Kincaid Readability Test.

81.	Attachment 12	p.1	Will the state provide additional detail regarding requirements for the draft copy of a Member Handbook? Section IV.G; is the Member Handbook also called Member Orientation as referenced in IV.G.4.a?	Yes. Please see Addendum Four, #5.
82.	Covered Benefits	43	Is transportation the responsibility of the member's health plan?	No
83.	Covered Benefits	43	Is the facility component of an emergency room visit the the responsibility of the member's health plan?	Yes, the DBPM will not be responsible for outpatient or inpatient hospital claims.
84.	Covered Benefits	43	Is the facility component of dental services performed in a hospital setting (in patient or outpatient) the responsibility of the member's health plan?	Yes, please see the response to Question 83.
85.	Provider Network Requirements	64	Can the state provide a file of their existing provider network, including name, address and phone numbers?	Please see Attachment 19. The spreadsheet provides the following: Provider Number, Business Name, Title Code, Provider Type Code, Practice Type Code, Address, City, Pay to Name, Pay to Name Address, Pay to Name City. MLTC looked at paid dental claims on MLTC's claims history database, and found there were two Provider Types who bill on dental claims: • Dentists (DDS) – Provider Type 40 • Tribal 638 Clinic – Provider Type 26 MLTC also found two different provider types usually listed as the rendering provider: • Dentists (DDS) – Provider Type 40 • Licensed Dental Hygienist – Provider

				Type 42 Furthermore, there were a small number of claims where the rendering provider was a personal care aid (Provide Type 33) or MD (Provider Type 01) or DO (Provider Type 02). MLTC did not consider them for this listing. The attached spreadsheet lists all active providers with a Provider Type of 40, 42, or 26 There can be multiple entries for the same provider/person if: • The provider has multiple Medicaid Provider IDs (normally to bill with multiple locations) • The provider has multiple NPIs attached to a single Medicaid Provider ID • The provider has multiple Taxonomy codes attached to a single Medicaid Provider ID
86.	III.F.3 "Insurance Coverage Amounts Required"	10	The RFP contains a requirement for Abuse & Molestation Insurance as part of the Commercial General Liability Insurance the bidder is to maintain. Would the State of Nebraska waive this requirement?	Provide all exceptions to Section III. Terms and Conditions under "NOTES/COMMENTS" in the applicable table.
87.	III.F.3 "Insurance Coverage Amounts Required"	10	The RFP contains a limit of $7,000,000 for Commercial Crime Coverage. Would the State of Nebraska accept $2,000,000?	See the response to Question 86.

88.	III.F.3 "Insurance Coverage Amounts Required"	10	The RFP contains a limit of $15,000,000 for Cyber Liability Coverage. Would the State of Nebraska accept $10,000,000?	See the response to Question 86.
89.	III.F.4 "Evidence of Coverage"	11	Several of the coverage limits contained in III.F.3 would require an adjustment to the bidder's current insurance limits which would come at a cost to the bidder. The RFP states in III.F.4: "The Contractor should furnish the State, <u>with their proposal response</u>, a certificate of insurance coverage complying with the above requirements ." Is this a mandatory requirement? May the bidder provide a certificate of insurance coverage evidencing required coverage after the intent to award decision?	The Certificate of Insurance is not a mandatory requirement of the RFP. Bidders may provide a Certificate of Insurance in their proposal response. The awarded bidder must provide a certificate of insurance coverage after the intent to award.
90.	IV.I.1 "Provider Network Requirements"	64 (78)	Is Bidder expected to build a network of Providers on a contracted Provider Agreement or Letter of Intent basis before we submit our bid? Or will we show in the RFP how we will build the Medicaid network if awarded?	No. MLTC requires the DBPM to provide a description of how the bidder will build their Medicaid network if awarded.
91.	Attachment 8 – Dental Rates	Attachment 8	Is the Total Loaded Rate ($19.94) the full-risk price for all 5-years until December 31, 2022? Or is it only for Fiscal-Year 2018?	These rates are only applicable for the SFY18 contract period.

			FY2018 Rate Summary Age Band | FY15 MMs | Net Medical Rate | NML | Loaded Rate 0-1 | 295,534 | $ 1.63 | 9.0% | $ 1.80 2-5 | 467,090 | $ 16.71 | 9.0% | $ 18.36 6-18 | 1,191,822 | $ 25.61 | 9.0% | $ 28.13 19-24 | 123,094 | $ 13.20 | 9.0% | $ 14.51 25-54 | 494,494 | $ 16.75 | 9.0% | $ 18.40 55-64 | 123,876 | $ 15.45 | 9.0% | $ 16.97 65+ | 218,284 | $ 10.40 | 9.0% | $ 11.43 **Total | 2,914,194 | $ 18.15 | 9.0% | $ 19.94**	
92.	IV.4.2 "Key Staff Positions"	39-40 (53-54)	May we contact the current Nebraska Dental Director, Dr. Charles Craft?	No, that would be a violation of the RFP; **Section II. D. Communication with State Staff and Evaluators**.
93.	IV.4.2 "Key Staff Positions"	39-40 (53-54)	Is Bidder expected to hire a Dental Director before the RFP is awarded? Or can we identify a candidate, and upon award of the contract, hire that person before go-live?	MLTC does not expect the DBPM to hire a Dental Director before MLTC awards the contract. Please see Section IV.D.2 of the RFP to find MLTC's requirements regarding the hiring key staff.
94.	IV.4.2 "Key Staff Positions"	39-40 (53-54)	What specifically is/was Dr. Craft's job description? Do his responsibilities require him to be present in the office M-F, 9a-5p?	Dr. Craft is employed by the DHHS, Division of Public Health. He is not a member of MLTC's staff. MLTC does not have that information.
95.	II.P "Secretary of State/ Tax Commissioner"	6 (20)	Bidder is registered with the Secretary of State. We cannot find anything about registering with the Tax Commissioner. What are the requirements here?	The Secretary of State and the Tax Commissioner do not have separate requirements.

96.	Att. 11 #58 Section IV.O	13, of Attachment 11	Question 58 refers to RFP Section IV.O, however the body of the question "Describe the DBPM's method and process for capturing TPL and payment information from its claims system. Explain how the DBPM will use this information". Seems to be referring to Section IV.R of the main document. Can you confirm?	Yes, MLTC confirms. Please see Addendum Four, #14.
97.	Att. 15	BAA	Does the Business Associate Agreement which is contained in Attachment 15 need to be signed by the offerer and included in the proposal or whether the State and the successful bidder sign the BAA during the contract finalization period.	The State will require the awarded contractor to sign a Business Associate Agreement (BAA). The bidder is not required to submit the signed BAA as part of the proposal response.
98.	Att. 11 "Proposal Statements and Questions" #3	Att. 11, p.1	Question No. 3 states: "Describe the approach the DBPM will take to ensure compliance with all relevant provisions of Part 438 of Chapter 42 of the CFR, Title 471, 477, and 482 NAC." There is no page limit to the bidder's response. There are several hundred pages of regulations contained within the above cited sections. Bidder respectfully requests that the State explain if bidders are to address in general terms their compliance "approach" and how, in general, they will ensure compliance with Part 438 of Chapter 42 of the CFR, Title 471, 477, and 482 NAC or whether the State requests a detailed explanation of how the bidder will "ensure compliance with all relevant provisions" of these sections.	Bidders should describe their general approach to compliance regarding the cited regulations; however, the State did not put a limitation on the depth of detail the bidder may provide. The bidder should provide a response that meets the requirements of the RFP.

99.	I. Scope of the Request for Proposal, A. Schedule of Events	Page 1	a. Will any extensions be considered or granted to the bid deadline of October 25, 2016? b. Will any alternative effective dates (other than July 1, 2017) be considered? c. What activities will be completed in the contract finalization period? i. What process will be used for this activity?	a. See Addendum Two – Revised Schedule of Events. b. The State anticipates to go-live with this program on July 1st. c. The contract finalization period is the time allowed to negotiate terms and conditions, process a compliant Certificate of Insurance, Performance Bond, and Certificate of Good Standing. . i. this process will be facilitated by the State Purchasing Bureau.
100.	II Procurement Procedures, B. General Information.	Page 2	a. Will any other forms of contract be considered besides a fixed price contract?	No.
101.	II Procurement Procedures, C. Customer Service.	Page 2	a. With respect to development of enhancements, please define what the State envisions as the needed enhancements? i. How will success be defined? ii. How will success be measured? b. What are the customer service industry's best practices and processes? i. How are these determined? ii. What measurable criteria is the State considering?	Section II, C. Customer Service on page 2 refers to Customer as the State of Nebraska. This requirement is an overarching requirement of the Contractor in relation to the State.
102.	III. Terms and Conditions.	Page 7	a. Does the following sentence mean that if the Bidder requires a contract deviation that the bidder will not be considered? *"The State of Nebraska will not*	The State will not substitute the contractor's contract for the State's contract. The State will negotiate terms, but not to the point that our contract does not exist.

			consider proposals that or terms for those of the State of Nebraska's." b. It appears that the Terms and Conditions section indicates the Bidder must accept the Terms and Conditions as written with no modifications. The State may then consider additional elements from the Bidder but only if the Bidder agrees to the Terms and Conditions as stated first. Is this a correct interpretation?	a. "The State of Nebraska will not consider proposals that **propose the substitution of the bidder's contract, agreements, or terms** for those of the State of Nebraska's." The State will not replace its terms and conditions for the bidder's contract, agreements or terms. b. "Bidders are expected to closely read the Terms and Conditions and provide a binding signature of intent to comply with the Terms and Conditions; provided, however, a bidder may indicate any exceptions to the Terms and Conditions by (1) clearly identifying the term or condition by subsection, and (2) including an explanation for the bidder's inability to comply with such term or condition which includes a statement recommending terms and conditions the bidder would find acceptable." The bidder may either "Accept", "Reject" or "Reject & Provide Alternative within RFP Response". The State will negotiate Terms and Conditions with the awarded bidder during the contract finalization period.

103.	III. Terms and Conditions. A. General.	Page 7	a.	Please define and/or direct us to the rules of contract interpretation as established in the State of Nebraska?	Case law statutes
104.	F. Insurance Requirements.	Page 9	a.	What is the State turnaround time for approval?	Once a compliant Certificate of Insurance is received by the awarded bidder; the approval will be determined in a couple of business days.
105.	L. State of Nebraska Personnel Recruitment Prohibition.	Page 13	a.	Are there any circumstances under which this prohibition could be altered? For example, the expertise of State employees currently engaged in delivering the Medicaid Dental services could be of value to the plan members and in the best interests of the members to continue to engage rather than lose due to the transition.	See the response to Question 86.
106.	Z. Early Termination.	Page 17	a.	Is the correct interpretation that the Contractor may not terminate the plan before 12/31/22? For any reason?	See the response to Question 86.
107.	8. Merger, Reorganization , and Change of Ownership	Page 36	a.	Does this requirement apply to just the Contractor, or does it also apply to any Subcontractors?	This requirement only applies to the Contractor, although MLTC expects the Contractor to notify MLTC of any material change that would affect members or providers.
108.	2. Key Staff positions	Page 39	a. b.	Does the State have existing job descriptions for each position? Will the State furnish those descriptions to the Bidders?	MLTC only provides the minimum duties and requires that hired staff are qualified. MLTC requires the DBPM to produce the job descriptions.

109.	E1a. General Provisions	Page 43	a. What are considered the prevailing dental community standards? i. How are these determined? ii. What measurable criteria is the State considering?	Prevailing dental community standards are determined by Medicaid's Rules and Regulations and the measurable criteria MLTC is considering can be found in Attachment 6 of the RFP.
110.	F. Fee-For-Service (FFS). 1. DBPM FFS Claim Services.	Page 48	i. Is this an additional service the Contractor is to provide without regard to incremental additional costs to the Contractor? ii. Is there any amount included in the administration fee for the Contractor's general or other administrative expenses? iii. Is there any amount included in the administration fee for Contractor profit margin?	MLTC will not make any additional considerations regarding the additional service of paying fee-for-service claims. Section IV.F.1 DBPM FFS Claim Services of the RFP prescribes payment.
111.	I. Provider Network Requirements.	Page 64	a. Will the state provide a list of all providers (including TIN, location, claim volume, etc.) currently contracted with the State for this Medicaid Dental program. i. If so, when will this list be provided? b. Are there any exception or non-standard payments, or fee schedules, to providers for access or other reasons? i. If so, how are these amounts determined? ii. If so, under what circumstances are these exceptions allowed? iii. If so, how do these amounts	a. Please see Question 85. b. There are only two exceptions to the fee schedule. The UNMC supplemental payment, which calculated in accordance with the following link: http://dhhs.ne.gov/medicaid/Documents/4.19bitem10.pdf The other exception is the encounter rate paid to IHS facilities as determined by Medicare.

			differ from the standard fee schedule set by the MLTC?	
112.	I. Provider Network Requirements. 4. Geographic Standards.	Page 64	a. Will the State make any allowances in the Geographic Standards for current gaps between the existing State provider network and the Geographic Standards? b. How does the State envision the Contractor resolving gaps between access and Geographic Standards when no provider exists in an area that meets the Geographic Standards? c. What is the timeframe in which a Contractor must meet the Geographic Standards when a new member residence is identified that is not within the Geographic Standards?	a. MLTC will not make any allowances for network adequacy gaps. b. MLTC requires the DBPM to develop a provider network availability plan to identify such gaps and describe the remedial action(s) that the DBPM will take to address those gaps. c. MLTC requires the DBPM to have an adequate network, as stated in the RFP, at the contractor start date.
113.	I. Provider Network Requirements. 10. Provider Enrollment in Medicaid.	Page 68	a. Does this requirement only apply to the provider network the Contractor develops for this Medicaid Dental program? b. When a Contractor maintains multiple commercial provider networks, does this requirement mean the Contractor must require providers in those commercial networks to become providers to NE Medicaid Dental?	a. Yes, this requirement only applies to providers who wish to provide Nebraska Medicaid dental benefits. b. No provider is required to become a Nebraska Medicaid provider. However, the DBPM must contract with all providers the DBPM intends to reimburse for providing Medicaid dental services.

114.	P. DBPM Reimbursement.	Page 96	a. If there are any exception or non-standard payments, or fee schedules to providers for access or other reasons, are these amounts included in the determination of the capitation rate? b. Is the intent for the Contractor to agree to any method of determination and/or any assumptions used in the determination of the capitation rate? c. How often during the life of the contract will capitation rates be updated? Annually? Semi-Annually? i. On what date? ii. How far in advance of their effective date/application? d. If the method and/or assumptions for determining the capitation rate changes from time to time, does the Contractor have the ability to approve of these changes? Or is this element "take it or leave it"? e. If the fee schedule for providers is changed by the State (for any reason), will the capitation rate be changed prior to the implementation of the fee schedule changes? f. Have the implications of the requirements of the RFP been factored into the determination of the future capitation rates? i. In other words, if the RFP includes changes, enhancements,	a. There were no adjustments related to reimbursement other than the UNMC adjustment described in the response to Question 50. b. The Contractor should evaluate the proposed capitation rate and the associated actuarial assumptions and determine if the proposed rates are feasible for the Contractor's business model. c. Capitation rates will be updated on an annual basis and will be submitted to CMS no later than April 1st of the preceding contract period (i.e. the SFY19 rates will be submitted to CMS by April 1st, 2018). d. MLTC will provide substantiation and documentation of all aspects of the rate development methodology, however, the State will look to CMS/OACT for approval. The Contractor should evaluate the proposed capitation rate and the associated actuarial assumptions and determine if the proposed rates are feasible for the Contractor's business model. e. Significant changes in fee schedules will prompt a review of existing rates. To the extent that the impact is greater than +/- 1.5%, MLTC will update the rates prior to implementation. f. MLTC has developed the rates consistent with State policy. As such,

			improvements, system changes and other requirements that increase utilization and/or cost compared to current practices and outcomes, have these components been factored into the determination of the future capitation rate? ii. Will such prospective implications be included in the determination? Or will the capitation rate always be "after the fact"? g. Is there any allowance for the Contractor's costs of initial implementation included in the capitation rate? h. Is there any allowance for the Contractor's costs of on-going changes, enhancements, system changes, future implementations, etc. included in the capitation rate?	utilization is assumed to only increase by the secular utilization trend. To the extent MLTC knows ahead of time of the rate implications, MLTC does include them. g. The capitation rates do not include any additional funds for implementation costs. h. MLTC intends to use the DBPM's encounter data for prospective contract periods. As such, any enhancements or system changes that are reflected in the encounter data will be considered in future rate development cycles.
115.	U. Contract Monitoring.	Page 126	a. Is there a maximum limit to the amount of monetary actions, damages, sanctions, penalties, etc. that may be applied under the Contract for any one item? b. Is there an aggregate annual maximum on the amount of monetary actions, damages, sanctions, penalties, etc. that may be applied under the Contract? i. If so, is it limited to the 2%	a. No. b. No. i. No, the 1.5% (please see Addendum Four) holdback constitutes the maximum amount available to the DBPM to earn via the quality performance program. ii. There is no maximum to liquated damages, sanctions, penalties, etc.

			holdback? ii. If not limited to the 2% holdback, what is the maximum? iii. If no maximum, please confirm that the correct interpretation is that there is no limit to the amount of these items that may be levied on the Contractor.	iii. That is the correct interpretation.
116.			I wanted to email you and ask about the NCQA Certification that is required in the dental RFP. Dental plans aren't eligible for HPA through NCQA and wanted to point that out. We have noticed this is a requirement in the RFP? I am not sure if this was just carried over by mistake from the Heritage plan requirements with the health plans?	See response to Question 69.
117	Quality Performance Program Measures – CY1	Attachment 9	Does the performance guarantee **Average Speed to Answer:** Calls to Member/Provider lines must be answered on average within 30 seconds imply the call center will answer 100% of the calls within 30 seconds? Can this be negotiated to fall in-line with standards of 80% of calls answered in 30 seconds?	MLTC does not expect the DBPM call center to answer 100% of the calls within 30 seconds. MLTC does require the average time for the call center to answer a call to be within 30 seconds. MLTC predicates this metric on average call wait-times and it is not negotiable.
118	Section III, OO – Proprietary Information	23	We would like clarification on how the State wishes for Proprietary Information to be marked on Original Proposal? Would it be acceptable to redact the proprietary information on the original RFP,	Yes, it would be acceptable for the bidder to redact the proprietary information on the original RFP and provide a document with the applicable information. Package proprietary information according to

			then, on a separate document named PROPRIETARY, include the information redacted from the original RFP, along with the page number and paragraph where the information would be included?	Section III. OO Proprietary.
119	Section IV, F, -Fee-For-Service (FFS) Dental Claims Management and Processing	48	How many FFS members will there be under the FFS arrangement? How will the State identify FFS members?	Remaining fee-for-service members are yet to be determined. MLTC will identify the FFS members by their eligibility category.
120.	Section IV.F FFS-Claims Management and Processing	Attachment 11, page 16	Please elaborate on what is meant by claim brokering. What is the state looking for specifically with Question 76 and 77? Is the state referring to claim negotiating and financial settlement with providers?	See Section IV.F.1: The State is currently in the process of replacing its aged Medicaid Management Information System (MMIS). As part of this transition, the State is moving toward a model of contracting with risk-bearing entities for the provision of services for nearly all Medicaid members and services. As this transition continues, the State will be responsible for processing fewer FFS claims for fewer members. Rather than procure a standalone claims processing system for these remaining needs, the State intends to enter into a services agreement with the DBPM for the management and processing of remaining FFS dental claims. In addition to the DBPM responsibilities outlined in this RFP, MLTC will pay the DBPM an administrative

				processing fee for each unique adjudicated FFS claim or adjustment on a monthly basis. MLTC will provide the per unique claim initial rate. Payment for FFS dental claims management services will be paid separately from managed care capitation payments.
121.	Terms and Conditions, F 4 Evidence of Coverage		Under the Terms and Conditions, F 4 Evidence of Coverage, it asks we provide a certificate of insurance, but not sure if we are to fax it or include in our response or both. If we do need to fax the form, can you confirm we need fax by the opening date of 10/25? **F. 4. EVIDENCE OF COVERAGE** The Contractor should furnish the State, with their proposal response, a certificate of insurance coverage complying with the above requirements to the attention of the Buyer at 402-471-2089 (fax) Administrative Services State Purchasing Bureau 1526 K Street, Suite 130 Lincoln, NE 68508 These certificates or the cover sheet must reference the RFP number, and the certificates must include the name of the company, policy numbers, effective dates, dates of expiration, and amounts and	See the response to Question 89. The Certificate of Insurance does not need to be faxed before the opening date.

			types of coverage afforded. If the State is damaged by the failure of the Contractor to maintain such insurance, then the Contractor shall be responsible for all reasonable costs properly attributable thereto. Notice of cancellation of any required insurance policy must be submitted to Administrative Services State Purchasing Bureau when issued and a new coverage binder must be submitted immediately to ensure no break in coverage.	
122.	III.FF "Performance Bond"	19-20	The RFP states: "The Contractor will be required to supply a bond executed by a corporation authorized to contract surety in the State of Nebraska, payable to the State of Nebraska, ***which shall be valid for the life of the contract*** to include any renewal and/or extension periods." The contract term is 5 years and there are two potential 1 year extensions after the initial term for a potential 7 year contract. Bidder is unable to obtain a 5 to 7 year bond term but is able to obtain the bond for the first year which will be extended via a continuation certificate/annual bond form every year thereafter, including extensions. Can the State of the Nebraska please advise if it will accept a one year, continuous renewal bond?	Yes, the State of Nebraska will accept a one year, continuous renewable bond.

123.			I refer to RFP 5427 Z1 (Medicaid Dental Benefit Program). The RFP provides for page limitations for responses. As a courtesy to the reader, our format includes a copy of the question before each of our responses. While some questions may be one or two sentences long, other questions are more extensive in length. We would like to confirm that a recitation of the question would not contribute towards our page limitations.	The recitation of the question will not contribute towards the page limitations.

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal.

RFP 5427 Z1
Addendum Four – Additional Revisions to RFP

#	Document	Section	Change From:	Change to:
1	RFP	IV.A.e.iii.a	Two (2) DBPM networks in Cass, Dodge, Douglas, Gage, Lancaster, Otoe, Sarpy, Saunders, Seward, and Washington counties.	Two (2) MCO networks in Cass, Dodge, Douglas, Gage, Lancaster, Otoe, Sarpy, Saunders, Seward, and Washington counties.
2	RFP	IV.A.e.iii.b	Two (2) DBPM networks in Adams, Antelope, Arthur, Banner, Blaine, Boone, Box Butte, Boyd, Brown, Buffalo, Burt, Butler, Cedar, Chase, Cherry, Cheyenne, Clay, Colfax, Cuming, Custer, Dakota, Dawes, Dawson, Deuel, Dixon, Dundy, Fillmore, Franklin, Frontier, Furnas, Garden, Garfield, Gosper, Grant, Greeley, Hall, Hamilton, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Jefferson, Johnson, Kearney, Keith, Keya Paha, Kimball, Knox, Lincoln, Logan, Loup, Madison, McPherson, Merrick, Morrill, Nance, Nemaha, Nuckolls, Pawnee, Perkins, Phelps, Pierce, Platte, Polk, Red Willow, Richardson, Rock, Saline, Scotts Bluff, Sheridan, Sherman, Sioux, Stanton, Thayer, Thomas, Thurston, Valley, Wayne, Webster, Wheeler, and York counties.	Two (2) MCO networks in Adams, Antelope, Arthur, Banner, Blaine, Boone, Box Butte, Boyd, Brown, Buffalo, Burt, Butler, Cedar, Chase, Cherry, Cheyenne, Clay, Colfax, Cuming, Custer, Dakota, Dawes, Dawson, Deuel, Dixon, Dundy, Fillmore, Franklin, Frontier, Furnas, Garden, Garfield, Gosper, Grant, Greeley, Hall, Hamilton, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Jefferson, Johnson, Kearney, Keith, Keya Paha, Kimball, Knox, Lincoln, Logan, Loup, Madison, McPherson, Merrick, Morrill, Nance, Nemaha, Nuckolls, Pawnee, Perkins, Phelps, Pierce, Platte, Polk, Red Willow, Richardson, Rock, Saline, Scotts Bluff, Sheridan, Sherman, Sioux, Stanton, Thayer, Thomas, Thurston, Valley, Wayne, Webster, Wheeler, and York counties.
3	RFP	IV.D.2; Table 1	Add new section	The Dental Director must be licensed to practice in the State of Nebraska.
4	RFP	IV.G.12.c	Add new section	The provider may discontinue seeing their members as long as they provide their members thirty (30) days of emergency care while in transition of finding a new dental home.

5	RFP	IV.G	Add new section	14. Member Handbook a. The DBPM must develop, maintain, and post to the member portal of its website a member handbook in both English and Spanish. In addition to the requirements described in this RFP, the handbook must comply with the requirements in 42 CFR 438.10. b. The draft member handbook must be submitted to MLTC for review and approval a minimum of thirty (30) calendar days after date of award. c. The DBPM must publish the member handbook on its website in the member portal. It must also have hard copies available and inform members how to obtain a hard copy member handbook if they want it. d. At a minimum, the DBPM must review and update the member handbook annually. The DBPM must submit the updated handbook to MLTC for review and approval a minimum of 45 calendar days before it is to be implemented. If the DBPM wishes to make changes to the handbook more frequently than annually, the revised language must still be submitted to MLTC a minimum of 45 calendar days prior to proposed implementation. e. The DBPM's updated member handbook must be made available to all members on an annual basis, through its website. When there is a significant change in the Member Handbook, the DBPM must provide members written notice of the change a minimum of 30 calendar days before the effective date of the change, that they may receive a new hard copy if they want it, and the process for requesting it. f. At a minimum, the member handbook must include: i. A table of contents. ii. A general description of basic features of how the DBPM

				operates and information about the DBPM in particular. iii. A description of the Member Services department, what services it can provide, and how member services representatives (MSRs) may be reached for assistance. The member handbook shall provide the toll-free telephone number, fax number, email address, and mailing address of the Member Services department as well as its hours of operation. iv. A section that stresses the importance of a member notifying Medicaid Eligibility of any change to its family size, mailing address, living arrangement, income, other health insurance, assets, or other situation that might affect ongoing eligibility. v. Member rights/protections and responsibilities, as specified in 42 CFR 438.100 and this RFP. vi. Appropriate and inappropriate behavior when seeing a DBPM provider. This section must include a statement that the member is responsible for protecting his/her ID cards and that misuse of the card, including loaning, selling, or giving it to another person, could result in loss of the member's Medicaid eligibility and/or legal action. vii. Instructions on how to request no-cost multi-lingual interpretation and translation services. This information must be included in all versions of the member handbook. viii. A description of the dental home selection process and the dental home's role as coordinator of services. ix. The member's right to select a different dental home within the DBPM network. x. Any restrictions on the member's freedom of choice of DBPM providers. xi. A description of the purpose of the Medicaid and DBPM ID cards, why both are necessary, and how to use them.

				xii. The amount, duration and scope of benefits available to the member under the contract between the DBPM and MLTC in sufficient detail to ensure that members understand the benefits for which they are eligible. xiii. Procedures for obtaining benefits, including authorization requirements. xiv. The extent to which, and how, members may obtain benefits, including from out-of-network providers. xv. Information about health education and promotion programs, including chronic care management. xvi. Appropriate utilization of services including not using the ED for non-emergent conditions. xvii. How to make, change, and cancel dental appointments and the importance of cancelling or rescheduling an appointment, rather than being a "no show". xviii. Information about a member's right to a free second opinion per 42 CFR 438.206(b)(3) and how to obtain it. xix. The extent to which, and how, after-hours and emergency coverage are provided, including: a) What constitutes an emergency medical condition, emergency services, and post-stabilization services, as defined in 42 CFR 438.114(a) and 42 CFR 422.113(c). b) That prior authorization is not required for emergency services. c) The process and procedures for obtaining emergency services, including use of the 911-telephone system. d) That, subject to provisions of 42 CFR Part 438, the member has a right to use any hospital or other setting for emergency care. xx. The policy about referrals for specialty care and for other benefits not furnished by the member's dental home.

				xxi. How to obtain emergency and non-emergency medical transportation. xxii. Information about the EPSDT program and the importance of children obtaining these services. xxiii. Information about member copayments. The charging of a copayment is at the discretion of the DBPM. If the DBPM chooses to ask its providers to charge copayments, this cost-sharing must be in compliance with 42 CFR 447.50 through 447.57, and cannot exceed the amounts specified at 471 NAC 3-008. xxiv. The importance of notifying the DBPM immediately if the member files a workers' compensation claim, has a pending personal injury or medical malpractice lawsuit, or has been involved in an accident of any kind. xxv. How and where to access any benefits that are available under the Medicaid State Plan that are not covered under the DBPM's contract with MLTC, either because the service is carved out or the DBPM will not provide the service because of a moral or religious objection. xxvi. That the member has the right to refuse to undergo any medical service, diagnosis, or treatment or to accept any health service provided by the DBPM if the member objects (or in the case of a child, if the parent or guardian objects) on religious grounds. xxvii. Member grievance, appeal, and state fair hearing procedures and timeframes, as described in 42 CFR 438.400-424 and this RFP, as follows: a) For grievances and appeals: 1). Definitions of a grievance and an appeal. 2). The right to file a grievance or appeal.

				3). The requirements and timeframes for filing a grievance or appeal. 4). The availability of assistance in the filing process. 5). The toll-free number(s) the member can use to file a grievance or an appeal by telephone. 6). The fact that, when requested by a member, benefits can continue if the member files an appeal within the timeframes specified for filing at 477 NAC 10-001. Pursuant to the same regulation, the member should also be notified that the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member. b) For state fair hearing: 1). Definition of a state fair hearing. 2). The right to request a hearing. 3). The requirements and timeframes for requesting a hearing. 4). The availability of assistance to request a fair hearing. 5). The rules on representation at a hearing. 6). The fact that, when requested by a member, benefits can continue if the member files a request for a state fair hearing within the timeframes specified for filing at 477 NAC 10-001. Pursuant to the same regulation, the member should also be notified that the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member. xxviii. How a member may report suspected provider fraud and abuse, including but not limited to, the DBPM's and MLTC's toll-free telephone

				number and website links created for this purpose. xxix. Any additional information that is available upon request, including but not limited to: a) The structure and operation of the DBPM. b) The DBPM physician incentive plan (42 CFR 438.6). c) The DBPM service utilization policies. d) How to report alleged marketing violations to MLTC. e) Reports of transactions between the DBPM and parties in interest (as defined in section 1318(b) of the Public Health Service Act) provided to the State. xxx. A minimum of once a year, the DBPM must notify members of the option to receive the Member Handbook and the provider directory in either electronic or paper format.

6	RFP	IV.G	Add new section	15. Member Website a. The DBPM must maintain a website that includes a member portal. The member portal must be interactive and accessible using mobile devices, and have the capability for bi-directional communications (i.e., members can submit questions and comments to the DBPM and receive responses). b. The DBPM website must include general and up-to-date information about the Nebraska Medicaid program and the DBPM. All material to be included on the website must be submitted and approved by MLTC in advance of its intended posting. MLTC will review and approve or request changes as quickly as practical but within 30 calendar days of receipt. c. The DBPM must remain compliant with applicable privacy and security requirements (including but not limited to HIPAA) when providing member eligibility or member identification information on its website. d. The DBPM website should, at a minimum, be in compliance with Section 508 of the Americans with Disabilities Act, and meet all standards the Act sets for people with visual impairments and disabilities that make usability a concern. e. The DBPM website must follow all written marketing guidelines included in Section IV G - Member Services and Education. f. Use of proprietary items that would require use of a specific browser or other interface is not allowed. g. The DBPM must provide the following information on its website, and such information must be easy to find, navigate among, and be reasonably understandable to all members:

				i. The most recent version of the member handbook in both English and Spanish. ii. Telephone contact information for the DBPM, including the toll free customer service number prominently displayed and a telecommunications device for the deaf (TDD) number. iii. A searchable list of network providers, with a designation of open or closed panels. This directory must be updated in real time, for changes to the DBPM network. iv. A link to the enrollment broker's website and the enrollment broker's toll free number for questions about enrollment. v. A link to the Medicaid Eligibility website (http://accessnebraska.ne.gov) for questions about Medicaid eligibility. vi. Information about how to file grievances and appeals.

7	RFP	IV.G	Add new section	16. Requirements for Member Materials a. The DBPM must comply with the following requirements for all written member materials, regardless of the means of distribution (for example, printed, web, advertising, and direct mail). b. The DBPM must write all member materials in a style and reading level that will accommodate the reading skill of DBPM members. In general, the writing should be at no higher than a 6.9 grade level, as determined by the Flesch–Kincaid Readability Test. c. MLTC reserves the right to require the DBPM to submit evidence that written member materials were tested against the 6.9 grade reading-level standard. d. The DBPM must distribute member materials to each new member within 30 calendar days of enrollment. One of these documents must describe the DBPM's website, the materials that the members can find on the website and how to obtain written materials if the member does not have access to the website. e. Written material must be available in alternative formats, communication modes, and in an appropriate manner that considers the special needs of those who, for example, have a visual, speech, or hearing impairment; physical or developmental disability; or, limited reading proficiency. f. All members and Medicaid enrollees must be informed that information is available in alternative formats and communication modes, and how to access them. These alternatives must be provided at no expense to each member. g. The DBPM must make its written information available in the prevalent non-English languages in the State. Currently, the prevalent non-English language in

				the State is Spanish. The DBPM must make its written information available in any additional non-English languages identified by MLTC during the duration of the contract. h. All written materials must be clearly legible with a minimum font size of twelve-point, with the exception of member identification (ID) cards, or as otherwise approved by MLTC. i. The quality of materials used for printed materials must be, at a minimum, equal to the materials used for printed materials for the DBPM's commercial plans, if applicable. j. The DBPM's name, mailing address, (physical location, if different), and toll-free telephone number must be prominently displayed on all marketing materials, including the cover of all multi-page materials. k. All multi-page written member materials must notify the member that real-time oral interpretation is available for any language at no expense to them, and how to access those services. l. All written materials related to DBPM enrollment and dental home selection must advise members to verify with their usual providers that they are participating providers in the selected DBPM and are available to see the member. m. Marketing materials must be made available by the DBPM across the State. Materials may be customized for particular locations or populations within the State. n. All marketing activities must provide for equitable distribution of materials without bias toward or against any group. o. Marketing materials must accurately reflect information that is applicable to an average member of the DBPM. p. In all member materials, the DBPM must include the date of issue or revision.

				q. Copies of all member mailings/materials (print and multimedia) must be provided.
8	RFP	IV.I.9	Add new section	g. The DBPM must completely process credentialing applications from the provider within thirty (30) calendar days of receipt of a completed credentialing application. A completed application includes all necessary documentation and attachments. h. "Completely process" means that the DBPM must: i. Review, approve, and load approved providers to its provider files in its system and submit the information in the weekly electronic provider file to MLTC or MLTC's designee, or ii. Deny the application and ensure that the provider is not used by the DBPM. A provider whose application is denied must receive written notification of the decision, with a description of his/her/its appeal rights.
9	RFP	IV.D.2, Table 1	1. Planning and working with Provider Services staff to expand and enhance physical and behavioral health services for American Indian members.	1. Planning and working with Provider Services staff to expand and enhance dental services for American Indian members.
10	RFP	IV.P.5.b	b. Pursuant to Neb. Rev. Stat. §71-831, the DBPM must hold back 2% of the aggregate of all income and revenue earned by the DBPM and related parties under the contract in a separate account. The hold-back constitutes the maximum amount available to the DBPM to earn via the quality performance program.	b. Pursuant to Neb. Rev. Stat. §71-831, the DBPM must hold back 1.5% of the aggregate of all income and revenue earned by the DBPM and related parties under the contract in a separate account. The hold-back constitutes the maximum amount available to the DBPM to earn via the quality performance program.

11	RFP	IV.V.4	The DBPM must have a contracted provider network in place, sufficient in size and composition, to meet MLTC's access standards and the requirements of the covered population ninety (90) calendar days prior to the contract's start date. The DBPM should submit to MLTC a network development plan with its proposal. This plan must be updated upon contract award and bi-weekly until the contract start date. The plan must detail the DBPM's network, including GeoAccess reports, and describe any provider network gaps and the DBPM's remediation plans. Additional requirements regarding network adequacy are included in Section IV.I – Provider Network Requirements of this RFP.	The DBPM must have a contracted provider network in place, sufficient in size and composition, to meet MLTC's access standards and the requirements of the covered population thirty (30) calendar days prior to the contract's start date. The DBPM should submit to MLTC a network development plan with its proposal. This plan must be updated upon contract award and bi-weekly until the contract start date. The plan must detail the DBPM's network, including GeoAccess reports, and describe any provider network gaps and the DBPM's remediation plans. Additional requirements regarding network adequacy are included in Section IV.I – Provider Network Requirements of this RFP.

12	RFP	IV.U.4.iv	iv. Network Performance Requirement Between the date of award and the contract start date, the DBPM must have a contracted provider network in place, sufficient in size and composition to meet the service requirements of its members on the contract start date. The required attestation of network sufficiency must be submitted to MLTC a minimum of ninety (90) calendar days prior to the contract start date. MLTC may assess a penalty of $1,000.00, per calendar day, for each day that the provider network is not adequate to meet the service needs of its members.	iv. Network Performance Requirement Between the date of award and the contract start date, the DBPM must have a contracted provider network in place, sufficient in size and composition to meet the service requirements of its members on the contract start date. The required attestation of network sufficiency must be submitted to MLTC a minimum of thirty (30) calendar days prior to the contract start date. MLTC may assess a penalty of $1,000.00, per calendar day, for each day that the provider network is not adequate to meet the service needs of its members.
13	Attachment 12	Provider Network List	**Description:** Submit list of all network providers via the provider enrollment file as described in Section IV.I - Provider Network. **Due Date:** 90 days prior to contract start date.	**Description:** Submit list of all network providers via the provider enrollment file as described in Section IV.I - Provider Network. **Due Date:** 30 days prior to contract start date.
14	Attachment 11	#58	Section IV.O – Program Integrity	Section IV.R – Claims Management

AdministrativeServices

Byron L. Diamond
Director

Pete Ricketts, Governor

ADDENDUM FIVE
#34 QUESTION and ANSWER

Date: October 25, 2016

To: All Bidders

From: Michelle Thompson/Teresa Fleming, Buyers
AS Materiel State Purchasing Bureau

RE: Addendum for Request for Proposal Number 5427 Z1
to be opened October 31, 2016 at 2:00 p.m. Central Time

Questions and Answers

Following are the questions submitted and answers provided for the above mentioned Request for Proposal. The questions and answers are to be considered as part of the Request for Proposal. It is the Bidder's responsibility to check the State Purchasing Bureau website for all addenda or amendments.

Question Number	RFP Section Reference	RFP Page Number	Question	State Response
34.	Section II.P	Page 6	According to the Nebraska Secretary of State's Office, and Chapter 21 Section 20,168 (4) The Requirements of the Business Corporation Act shall not be applicable to foreign or alien insurers, which are subject to the requirements of Chapter 44. Please confirm that a foreign insurer authorized to transact the business of accident and health insurance by the Nebraska Department of Insurance will not be required to submit a Secretary of State certification with their bid, pursuant to Section II.P of the RFP.	Confirmed, though effective January 1, 2017, Neb. Rev. Stat. 21-20,168(4) is replaced by a materially identical provision found at section 202 (MBCA 14.40) of LB749 (2014). However, the contractor may be required to provide a Certificate of Authority or a Certificate of Good Standing from the Department of Insurance.

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal.

Attachment B-1
Audited Financial Statements

This content has been redacted.

Attachment B-2
Actuarial Opinion

This content has been redacted.

Attachment B-3
Unaudited Financial Statements

This content has been redacted.

Attachment B-4
Banking Reference #1

This content has been redacted.

Attachment B-5
Banking Reference #2

This content has been redacted.

Attachment B-6
Performance Bond Letter

This content has been redacted.

Attachment B-7
Certificate of Insurance

This content has been redacted.

Attachment B-8
SOC 2 Type 2 Report

This content has been redacted.

Jeffrey P. Feingold, DDS, MSD

Founder and Chief Executive Officer

Dr. Feingold established MCNA in 1992 to address a lack of access to quality dental health care and services that affects many low-income children and adults. Under his expert guidance, the company grew from providing discounted dental benefit plans for individuals and groups to administering dental benefits for Medicaid and CHIP programs across the nation. Dr. Feingold continues to lead the company with his inspiring vision of service to those most in need of quality dental care and overseeing its expansion into new markets. His personal and professional experiences are the basis for MCNA's successful member-first philosophy, which has made the company into an industry leading dental benefits administrator.

Experience

President, Chief Executive Officer, and Chairman of the Board (1992 - Present)

MCNA Dental Plans

Provides leadership and oversight for all organizational units, generating a road map for organizational growth and continuing prosperity. Ensures all units fulfill responsibilities in providing levels of service that exceed the expectations of MCNA's contractual partners.

- Responsible for the company's total program management.
- Serves on the Board of Directors as its chair, and works with board members and other stakeholders to develop and implement a strategic vision.
- Directs company's public relations activities according to strategic vision.
- Coordinates with COO to engage in meetings with partner organizations and state and federal regulatory agencies.

President, Chief Executive Officer, and Chairman of the Board (1975 - 2015)

The Dentaland Organization

Founded The Dentaland Organization, which owns and operates a multispecialty group of practices that offers general dentistry services with an emphasis on specialty care.

- Oversaw growth of original practice to seven locations throughout Florida.
- Managed day-to-day operations, brought on key staff members at the appropriate times, and provided comprehensive training so they could assume organizational leadership positions.
- Instilled high level of work ethic within each practice location to ensure patient care met highest standards of quality.
- Initiated progressive adoption of modernizing dental technology across organization to enable practices to increase patient comfort and satisfaction over time.

Faculty Appointments and Board Memberships

- **Florida Atlantic University**
  - Board of Trustees Member
  - Former Vice Chair of the Community and Governmental Relations Committee
  - Former Vice Chairman of Strategic Planning and Development Committee
- **Florida Atlantic University Foundation, Inc.**
  - Former Ex-Officio Member, Foundation Board of Trustees
- **Tulane University Associates**
  - Former Board and Executive Board Member
- **Columbia University Parents Council**
  - Former Vice Chair
- **New York University Stern School of Business**
  - Former Member, Steering Committee
- **New York University School of Dentistry**
  - Former Member, Dean's Advisory Board
- **Dade County Dental Research Center**
  - Former Co-Chair of Departments of Periodontology and Periodontal Prosthesis

Education

- **Fairleigh Dickinson University Dental School**, Master of Science in Dentistry in Periodontology
- **Fairleigh Dickinson University Dental School**, Certificate in Periodontology
- **Eastman Institute for Oral Health**, Internship
- **New York University College of Dentistry**, Doctor of Dental Surgery
- **Tulane University**, Bachelor of Arts

Professional Licenses and Associations

- **Licensed Dentist** by the State of Florida
- **Diplomate**, American Board of Periodontology
- **Member**, American Dental Association
- **Member**, Florida Dental Association
- **Member**, American Academy of Periodontology

References

[redacted] [redacted] [redacted]

Glen S. Feingold

Executive Vice President and Chief Operating Officer

Glen serves as the Chief Operating Officer, utilizing his extensive knowledge of all MCNA processes and procedures garnered during his time fulfilling the responsibilities of many key leadership roles within the company. His base of knowledge allows him to oversee all operational aspects of the company while at the same time effectively interfacing with state and federal regulators to steer MCNA's activities in order to meet external requirements. Glen drives MCNA forward by continually identifying opportunities for growth within both existing and new markets. He provides the motivation to MCNA's leaders to achieve goals in pursuit of that growth.

Experience

Executive Vice President and Chief Operating Officer (2009 - Present)

MCNA Dental Plans

Provides daily guidance to operational units in carrying out all aspects of business processes while ensuring all services to members and providers are contractually compliant and delivered in a timely manner. Sets organizational goals for growth.

- Member of Executive Management Team.
- Oversees all operational aspects of the company and provides executive approval of operational changes and innovations.
- Serves as a member of the Board of Directors.
- Represents MCNA's interests at meetings with state regulatory agencies and other state organizations involved in the management of Medicaid, CHIP, and Medicare dental health benefits.
- Utilizes his intricate knowledge of the dental industry to lead others in support of MCNA's corporate mission, maintaining a commitment to provide Medicaid and CHIP populations with service excellence.
- Provides Board of Directors input into MCNA's Quality Improvement Committee activities and discussions.
- Responsible for MCNA's growth and development strategy, including new market expansion analysis.

Director of Operations (2005 - 2008)

MCNA Dental Plans

Provided daily direction and management for non-clinical company operational activities.

- Member of Quality Improvement Committee.
- Provided oversight of the development of MCNA's enhanced auto-adjudication and claims processing methodology.

Operations Manager (2003 - 2005)

MCNA Dental Plans

Worked directly with departmental leaders to develop and maintain internal policies and procedures guiding the non-clinical operational activities. Provided guidance to departments for process improvement. Provided direct oversight to the following departments:

- Provider Relations
- Network Development
- Claims Management
- Credentialing
- Customer Service
- Human Resources

Education

- **University of Miami School of Business,** Bachelor of Arts in Finance

References

[redacted] [redacted] [redacted]

Philip H. Hunke, DDS, MSD

Plan President

Former President of the American Academy of Pediatric Dentistry (AAPD) and the Texas Academy of Pediatric Dentistry (TAPD), Dr. Philip Hunke, was selected by MCNA to serve as Plan President of MCNA Insurance Company. Dr. Hunke is a graduate of Baylor College of Dentistry and has unparalleled clinical experience serving the children of Medicaid and CHIP programs for over 37 years. He is responsible for the overall development and management of our Louisiana and Texas plans.

Career Highlights

Dr. Hunke served as the President and long-term board member of the American Academy of Pediatric Dentistry, Texas Academy of Pediatric Dentistry, and the Southwestern Society of Pediatric Dentistry. He has been a delegate to the American Dental Association House of Delegates. He served as the Chief of Staff of the Dental Department at the McAllen Medical Center and on the Board of Directors of the Doctors Hospital at Renaissance. Dr. Hunke also serves as MCNA's member representative on the American Dental Association's Dental Quality Alliance.

Experience

Plan President (2010 - Present)

MCNA Insurance Company – Texas and Louisiana

Responsible for overall development and management of MCNA Insurance Company.

- Implements the strategic goals and objectives of the organization.
- Takes the lead for all external initiatives and stakeholder communications.
- Oversees general business operations for the Louisiana, Texas, Iowa, and Idaho plans.
- Serves as a corporate liaison with MCNA Dental Plans.
- Oversees Louisiana Provider Network Recruitment and Management.
- Develops and oversees the MCNA Dental Advisory Committee.

Private Practice (1974 - 2011)

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

Responsible for providing quality care to patients and the daily operations of his practice. Dedicated volunteer time to professional dental organizations.

- Licensed Dentist by the State of Texas.
- Dedicated time to developing important practice guidelines such as the dental home initiative.
- Provided oversight of the business operations of all offices including budgeting, staffing and equipping offices.
- Provided oversight of office staff including paraprofessionals.
- Provided care, treatment, and education to patients.

Original Partner

Doctors Hospital at Renaissance

Original partner and former member of various committees. Served on the Board of Governors, the governing committee, for the 525-bed facility with 18 operating rooms.

- Board of Governors: 2010 - 2012
- Capital Expenditures Committee: 2009 - 2012
- Finance Committee: 2009 - 2012
- Medical Executive Committee, Chief of the Dental State: 2007 - 2008

Chief of Staff for the Dental Department (1975 - 2000)

McAllen Medical Center

Responsible for service on various hospital committees, including the medical executive committee. Retained hospital privileges. Held the office of Chief of Staff for several terms.

- Provided oversight of dental provider credentialing.
- Provided oversight of appropriate staff appointments.

Education

- **Baylor College of Dentistry**, Master of Science in Dentistry
- **Baylor College of Dentistry**, Doctor of Dental Surgery
- **Southern Methodist University**, Bachelor of Arts

Key Contributions to the Dental Field

American Academy of Pediatric Dentistry (AAPD) Clinical Guidelines
Served as President of the American Academy of Pediatric Dentistry providing project leadership and contributing content for the accepted and published clinical guidelines of the AAPD. Clinical guidelines are science- and evidence-based recommendations designed to assist the dental provider in making decisions concerning direct patient care. Adherence to the guidelines increases the probability of a favorable practice outcome and decreases the likelihood of an unfavorable practice outcome.

Centers for Medicare and Medicaid Services (CMS) "Children's Dental Guide"
Served as a content contributor for "Guide to Children's Dental Care in Medicaid" published by CMS in 2004. The guide was developed in conjunction with the American Academy of Pediatric Dentistry. The information in this Guide is based wherever possible on scientific evidence with appropriate citations provided, and on expert opinion where scientific evidence is inconclusive or not available. The Guide is intended to complement, supplement, and expand on policy information contained in CMS' State Medicaid Manual (SMM).

References

[redacted] [redacted] [redacted]

Scott Wieting, DDS

Nebraska Dental Director

MLTC Key Personnel Role: Dental Director

Dr. Scott Wieting, past-President of the Nebraska Dental Association, has been selected to serve as MCNA's Nebraska Dental Director. He is currently the Nebraska Delegate to the American Dental Association, and is a key member of the Nebraska Dental Association Legislative Committee. Dr. Wieting will provide expert oversight of the administrative and utilization management functions of the plan and will be responsible for the oversight and management of MCNA's Clinical Reviewers for the State of Nebraska.

Career Highlights

Dr. Wieting has been an active member of the American Dental Association and the Nebraska Dental Association since graduating from dental school in 1979. His commitment to leadership within the dental community culminated with his service as President of the Nebraska Dental Association in 2013. He takes an active interest in the health of his community through his service as Board Dentist for the Four Corners Board of Health. He is also heavily involved in service with other community organizations, including past service as Board Member and President of the York School Board.

Experience

Nebraska Dental Director (2016 – Present)

MCNA Insurance Company

Provides oversight and management of MCNA Insurance Company's Clinical Reviewers for the State of Nebraska.

- Co-chairs MCNA's Quality Improvement Committee.
- At a minimum, provides utilization review decisions Monday – Friday, 8 am to 5 pm.
- Represents MCNA regarding clinical issues, utilization review, and quality of care issues.
- Oversees compliance with applicable federal and state statutes and regulations.
- Guides the dental service authorization process for Medicaid members.
- Responsible for maintaining current Nebraska utilization review guidelines and criteria.
- Assists with Nebraska provider network recruitment and management.
- Facilitates peer-to-peer discussions between participating providers and MCNA's Clinical Reviewers.

Private Practice/Owner (1979 – Present)

York Dental Arts

Provided oversight and management of a private dental practice.

- Provided comprehensive dental care and preventive services for children and adolescents, including children with special health care needs.
- Conducted oral health exams, which included caries risk assessments.
- Treated patients for dental injuries.
- Presented treatment options and informed consent with patient guardians and caregivers.
- Provided oral health education to patients and parents.
- Developed and implemented office policies and procedures.
- Recruited, hired, and trained office staff.
- Monitored patient satisfaction.
- Practiced and enforced patient safety standards and infection control.
- Ensured patient records were documented appropriately.
- Monitored compliance with HIPAA guidelines and OSHA requirements.

Education

- **University of Nebraska Medical Center College of Dentistry**, Doctor of Dental Surgery

Professional Licenses and Associations

- **Licensed Dentist**, Nebraska State Board of Dentistry
- **Member**, Nebraska Dental Association
  - Past-President
  - Member of Legislative Committee
  - Former Vice President
- **Member**, American Dental Association
  - Nebraska Delegate to ADA
- **Member**, Nebraska Forensic Identification Team
- **Member**, ADA Council on Member Insurance and Retirement Programs
- **Former Member**, Central District Dental Society
  - Past-President
  - Former Delegate
  - Former Trustee

References

Holly Portwood, DDS, MS

Nebraska Executive Director

MLTC Key Personnel Role: Executive Director

Dr. Holly Portwood, a Diplomate of the American Board of Pediatric Dentistry, has been selected to serve as our Nebraska Executive Director. Dr. Portwood earned her Doctor of Dental Surgery degree from the University of Nebraska Medical Center College of Dentistry where she currently serves as an adjunct faculty member. As MCNA's Executive Director, Dr. Portwood will serve as our liaison with MLTC and is responsible for ensuring MCNA's compliance with all contract terms, including securing and coordinating resources necessary to meet contractual goals.

Career Highlights

After earning her DDS, Dr. Portwood pursued her Master of Science degree and Certificate of Pediatric Dentistry from Ohio State University in partnership with Nationwide Children's Hospital. She is the President of the Adams County Dental Society and currently serves as Public Policy Advocate of Nebraska for the American Academy of Pediatric Dentistry. She is a member of the Legislative Council Committee for the Nebraska Dental Association and serves on the boards for Hastings Surgical Center and PAC2 Daycare Facility in Hastings, Nebraska.

Experience

Nebraska Executive Director (2016 – Present)

MCNA Insurance Company

Represents MCNA regarding all matters pertaining to the Contract.

- Serves as member of MCNA's Quality Improvement Committee.
- Ensures compliance with the terms of the Contract, including securing and coordinating the resources necessary for such compliance.
- Receives and responds to all inquiries and requests made by MLTC related to the contract, in the time frames and formats specified by MLTC.
- Attends regular meetings and participates in conference calls with MLTC.
- Promptly resolves any issues related to the contract that are identified by MCNA or MLTC.
- Attends meetings with MLTC representative(s) on a periodic or ad hoc basis to review MCNA's performance and resolve issues.
- Meets with MLTC at the time and place requested by MLTC, if MLTC determines that the MCNA is not in compliance with the requirements of the Contract.
- Attends Nebraska Medicaid Program Integrity meetings with MCNA's Program Integrity Officer and the Nebraska Dental Director to review and discuss investigations, compliance, prevention, and other program integrity-related activities.

- Participates in, and ensures other key staff members participate in, business reviews as requested by MLTC and ensures MCNA is prepared to participate pursuant to an MLTC-developed agenda and/or presentation template.

Pediatric Dentist (2010 – Present)

Pediatric Dental Specialists of Greater Nebraska

Provided comprehensive dental care and preventive services for children and adolescents, including children with special health care needs.

- Conducted oral health exams, which included caries risk assessments.
- Treated patients for dental injuries.
- Presented treatment options and informed consent with patient guardians and caregivers.
- Provided oral health education to patients and parents.
- Practiced and enforced patient safety standards and infection control.
- Ensured patient records were documented appropriately.

Education

- **Ohio State University College of Dentistry in partnership with Nationwide Children's Hospital,** Master of Science in Dentistry and Certificate of Pediatric Dentistry
- **University of Nebraska Medical Center College of Dentistry**, Doctor of Dental Surgery
- **Hastings College**, Bachelor of Arts

Professional Licenses and Associations

- **Licensed Dentist**, Nebraska State Board of Dentistry
- **Diplomate**, American Board of Pediatric Dentistry
- **Member** American Dental Association
- **Member**, Nebraska Dental Association
- **Member and Public Policy Advocate of Nebraska**, American Academy of Pediatric Dentistry
- **Member and Legislative Council Committee**, Nebraska Dental Association
- **President**, Adams County Dental Society
- **Member**, Hall County Dental Society
- **Member**, American Academy of Pediatric Dentistry
- **Member**, American Orthodontic Society

References

Gary Lehn, DDS

Nebraska Associate Dental Director

Dr. Gary Lehn, President of the Nebraska Society of Pediatric Dentistry and Diplomate of the American Board of Pediatric Dentistry, has been selected to serve as MCNA's Associate Dental Director. Dr. Lehn will provide clinical oversight for MCNA's review of claims, pre-authorizations, and referrals for the State of Nebraska in compliance with applicable federal and state statutes and regulations.

Career Highlights

Dr. Lehn attended the University of Nebraska at Omaha and completed his Doctor of Dental Surgery degree at the University of Nebraska Medical Center (UNMC) College of Dentistry, where he graduated with distinction. Following graduation, Dr. Lehn completed his pediatric dental residency at the UNMC College of Dentistry, where he was appointed chief resident and currently serves as an adjunct faculty member. As a member of the UNMC Quality Council, Dr. Lehn helped plan, implement, and monitor a Total Quality Management Program encompassing educational, service, research, and administrative activities in the College of Dentistry.

Experience

Nebraska Associate Dental Director (2016 – Present)

MCNA Insurance Company

Responsible for clinical oversight of the review of claims, pre-authorizations, and referrals for the State of Nebraska in compliance with applicable federal and state statutes and regulations.

- Applies Nebraska utilization review guidelines and criteria.
- Participates in peer-to-peer discussions between participating providers.
- Assists with Nebraska provider network recruitment and management.

Pediatric Dentist (2012 – Present)

Pediatric Dental Specialists of Greater Nebraska

Responsible for providing comprehensive dental care and preventive services for children and adolescents, including children with special health care needs.

- Conducts oral health exams, which included caries risk assessments.
- Treats patients for dental injuries.
- Presents treatment options and informed consent with patient guardians and caregivers.
- Provides oral health education to patients and parents.
- Monitors patient satisfaction.
- Practices and enforces patient safety standards and infection control.
- Ensures patient records were documented appropriately.

Education

- **University of Nebraska Medical Center College of Dentistry**, Doctor of Dental Surgery
- **University of Nebraska at Omaha**, Bachelor of Science

Professional Licenses and Associations

- **Licensed Dentist**, Nebraska State Board of Dentistry
- **Diplomate**, American Board of Pediatric Dentistry
- **President**, Nebraska Society of Pediatric Dentistry
- **Member**, American Academy of Pediatric Dentistry
- **Member**, International Association of Dental Traumatology
- **Member**, American Dental Association
- **Member**, Nebraska Dental Association
- **Adjunct Faculty Member**, Pediatric Dentistry at the University of Nebraska Medical Center College of Dentistry
- **Medical Team**, Hastings Surgery Center
- **Medical Team**, Mary Lanning Memorial HealthCare

References

[redacted] [redacted] [redacted]

Carlos A. Lacasa

Senior Vice President and General Counsel

Carlos Lacasa is a skillful executive whose wide-ranging experience in business administration, corporate law, and the legislature has prepared him well for the challenge of managing MCNA's rapidly expanding operational infrastructure. In 1994, he was elected to the Florida House of Representatives and served as Chair of the House Appropriations Committee, effectively leading the state's budgeting process from 2000 to 2002. He has 25 years of insurance and health care law experience and is a former Chairman of the Board of Citizens Property Insurance Corporation of Florida. As Senior Vice President and General Counsel of MCNA, Carlos is primarily responsible for corporate administration and legal and regulatory affairs. He currently serves as the day-to-day contact for MLTC for the RFP process and once awarded, will proactively work to address MLTC's needs.

Experience

Senior Vice President and General Counsel (2009 - Present)

MCNA Dental Plans

Responsible for operations oversight for all national managed care dental plans including regulatory compliance, budget development, government relations, legal affairs, and Medicaid and CHIP contract management.

- Member of Executive Management Team and Board of Directors.
- Monitors and manages legal affairs of the corporation.
- Monitors and manages agreements with state agencies.
- Member of Quality Improvement Committee.
- Develops and manages budgets for all operating departments.
- Senior lead on all project implementations.
- Provides leadership for Quality Improvement Initiatives and Cultural Diversity objectives across all operating departments.

Vice President and General Counsel (2008)

MD Medicare Choice, Inc.

Responsible for corporate legal representation.

- Negotiated and executed provider network and general administrative contracts.
- Tracked and monitored state and federal compliance with Medicare-related insurance and health care regulations.
- Oversaw compliance with company's reorganization plan.

Of Counsel (1997 - 2008)

Ruden, McClosky, Smith, Schuster & Russell

Member of corporate, health care, and governmental relations practice groups.

- Focused on corporate finance, health care and insurance regulation, public bond finance, and transaction and regulatory law.
- Performed debt restructure, real estate acquisitions and leases, and contracts.
- Drafted employee agreements.
- Served major banking and health care clients in multiple legal venues.

Partner (1991 - 1997)

Armando E. Lacasa, P.A.

Practiced commercial litigation, corporate, and real estate law.

Education

- **Nova Southeastern University,** Juris Doctor
- **University of Miami,** Bachelor of Arts in Political Science and Economics

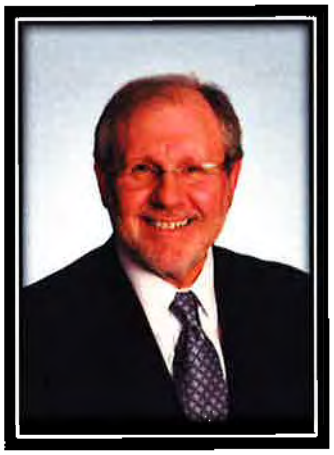
Achievements

- **State of Florida House of Representatives (1994 - 2002)**
  - Chair - House Appropriations Committee (2000 - 2002)
- **Citizens Property Insurance Corporation**
  - Chairman - Board of Governors (2011 - 2013)
  - Member - Board of Governors (2006 - 2011)
- **Florida Taxation and Budget Reform Commission (2007 - 2008)**
  - Miami-Dade Expressway Authority Board (2005 - 2010)
  - Treasurer and Finance Committee Chair (2007 - 2010)
- **University of Florida, Government Relations Advisory Committee (2006 - Present)**
  - Chair (2007 - 2011)
  - Audubon of Florida (2006 - 2010)
  - Board of Governors

References

[redacted] [redacted] [redacted]

Edward A. Strongin, CPA



Chief Financial Officer

MLTC Key Personnel Role: Finance Manager

Ed Strongin has more than 40 years of diversified financial experience. As a Florida licensed Certified Public Accountant, he served as MCNA's outside auditor and financial consultant for almost 20 years. When the opportunity came to join the MCNA organization six years ago, the decision and transition to full-time CFO was an easy one. During his tenure, Ed guided MCNA through its Texas Department of Insurance licensure related to capital and premium-writing requirements and contributed expert analysis in connection with agency capitation rate setting. Mr. Strongin will serve as the Finance Manager for Nebraska. He is responsible for overseeing all financial related supervision of activities implemented by MCNA, including all audit activities, accounting systems, financial reporting, and budgeting.

Experience

Chief Financial Officer (2010 - Present)

MCNA Dental Plans

Responsible for day-to-day planning, implementing, managing and controlling company finance-related activities, including: direct responsibility for all accounting, financial reporting (GAAP and statutory), budgeting and forecasting, strategic planning, taxation, investment management, insurance coverage, asset control/management, participation in deal analysis, structure and negotiations, banking relationships, and institutional financing.

- Member of Executive Management Team.
- Works in tandem with the management team to ensure successful daily operations and develop company's ongoing strategic and financial plans.
- Supervises Accounting, Finance, and Human Resources departments.
- Interfaces regularly with outside auditors, actuaries, bankers, consultants, insurance agents, investment managers, regulators, and reinsurers.

Managing/Administrative Shareholder (1986 - 2010)

Pinchasik, Strongin, Muskat, Stein & Company, P.A., Certified Public Accountants

Responsible for managing daily operations and guiding strategic growth for this South Florida "Top 25" firm. Co-leader of the firm's auditing practice and quality control program, offering clients a full range of financial reporting services, including specific dental healthcare experience serving as principal independent auditor / account supervisor / financial consultant for MCNA Dental, its subsidiaries and affiliated dental provider businesses for a twenty-year period. Oversaw preparation and issuance of certified audit reports for the State of Florida Office of Insurance Regulation.

- **Auditing and Financial Accounting Services**
  - In-depth industry experience with construction contractors, health care and professional service organizations, real estate and retail establishments, and exempt organizations.
- **Forensic Accounting**
  - Calculated and testified to damages, consulted with attorneys about financial accounting and tax matters, assisted attorneys in case preparation, reconstructed income, prepared exhibits to demonstrate various accounting and financial matters.
- **Tax and Business Planning**
  - Assisted clients on sound tax and business strategies to increase cash flow and profits, advised non-U.S. residents and entities on tax issues, tax return preparation, and financing matters.

Education and Certifications

- **University of Miami**, Bachelor of Business Administration
- **Certified Public Accountant**, Florida

Achievements and Memberships

- **Florida Institute of Certified Public Accountants**
- **American Institute of Certified Public Accountants**
- **University of Miami**
  - Former Member – UM Board of Trustees
  - Former President – UM International Alumni Association
  - Former Member – UM Citizens Board
- **University of Miami Iron Arrow Honor Society**
  - Member
- **University of Miami Sports Hall of Fame**
  - Past Treasurer / Executive Board Member
- **South Florida Business Journal**
  - Named "Outstanding CPA in Litigation Support"
- **Miami-Dade County Health Facilities Authority**
  - Current Chairman
- **The Florida Bar**
  - Former Member - Citizens Forum

References

Daniel Salama, BSE

Chief Information Officer

MLTC Key Personnel Role: Business Continuity Planning and Emergency Coordinator, and Information Management and Systems Director

Daniel Salama led his dedicated team of software engineers in creating MCNA's proprietary DentalTrac™ system. He has worked on multiple large-scale projects and will ensure that MCNA delivers a flawless implementation with outstanding results for MLTC. Daniel designed the Internet Service Provider infrastructure and software for 13 countries in Latin America while serving as the Chief Technology Officer of the publicly traded company, IFX Corporation. He has built telephone networks and Internet delivery systems around the world, and designed a software system that saved the Currency Exchange Commission of Venezuela billions of dollars that were being lost due to a flawed verification process and a lack of system controls. Daniel oversees all information systems functions at MCNA. He is responsible for establishing and maintaining connectivity with MLTC information systems and providing necessary and timely data and reports as required. Daniel is also responsible for managing and overseeing our Disaster Recovery and Business Continuity Plan for Nebraska, and will ensure it is maintained and activated appropriately during a disaster situation.

Experience

Chief Information Officer (2004 - Present)

MCNA Dental Plans

Responsible for aligning IT initiatives with business priorities.

- Member of Executive Management Team.
- Led migration to current centralized Information Technology (IT) architecture.
- Develops Information System (IS) plans and programs to improve organization effectiveness.
- Ensures ongoing integration of Information Security with business strategies.
- Enforces mandated HIPAA directives and contract obligations.
- Designs and carries out strategic direction of DentalTrac™, MCNA's proprietary management information system.

Chief Technology Officer (1998 - 2003)

IFX Corporation

Responsible for a $5 million information technology budget and a staff of 40.

- Designed and implemented a $25+ million communications network extending across Latin America.
- Responsible for leading strategic technological planning to achieve business goals.
- Developed and communicated business/technology requirements and alignment plans.

- Worked with executive team, staff, partners, customers, and stakeholders.

Vice President of Information Technology (1995 - 1998)

International Network Corporation of America

Responsible for providing vision and leadership in the implementation of information technology initiatives and development of strategic alliances with multi-national companies in order to deliver customer solutions.

Director of Information Technology (1993 - 1995)

Cardiofoam Corporation

Responsible for overseeing the streamlined operation of the IT and IS department in order to improve operational efficiencies by promoting labor automation.

Robotics Engineer and Project Manager (1993)

IBM Corporation

Responsible for leading a six-person team developing software to run on micro-controlled mechanical arms to be used in the medical industry.

Education

- **Florida Atlantic University**, Bachelor of Science in Computer Engineering
- **Florida Atlantic University**, Bachelor of Science in Chemical Engineering

Certifications

- CCNP, Cisco Certified Network Professional
- CCDP, Cisco Certified Design Professional
- CCSP, Cisco Certified Security Professional
- ISC2 CISSP, ISC2 Certified Information Systems Security Professional
- Oracle Enterprise Linux Certified Administrator
- IAPPM CPD, IAPPM Certified Project Director

References

[redacted] [redacted] [redacted]

Mayre Thompson, MHA

Chief Compliance and Privacy Officer

As a Program Analyst for the Bureau of Managed Care at the Florida Agency for Health Care Administration, Mayre Thompson monitored managed care plans for contract compliance and participated in NCQA, URAC, and AAAHC accreditation surveys. She takes a proactive approach to identifying potential compliance issues and is a member of the Health Care Compliance Association. Mayre currently oversees all of MCNA's regulatory compliance efforts and utilizes her results-oriented approach to ensure that all of MLTC's requirements are met. Mayre also oversees MCNA's URAC Claims Processing and Dental Plan Accreditation processes.

Experience

Chief Compliance and Privacy Officer (2009 - Present)

MCNA Dental Plans

Responsible for all state and federal regulatory compliance, and Medicaid and CHIP contract compliance.

- Member of Executive Management Team.
- Oversees and monitors MCNA's Compliance Program.
- Coordinates and oversees new and ongoing audits, surveys, and reviews.
- Objectively and independently investigates and acts on compliance issues.
- Designs and directs internal investigations and any subsequent corrective measures with all departments, independent contractors, agents, and providers of health and administrative services to MCNA.
- Oversees and monitors all aspects of MCNA's Fraud, Waste, and Abuse Program.
- Responsible for reporting fraud and abuse to external regulatory agencies.
- Establishes methods to improve MCNA's efficiency and quality of services.
- Coordinates internal compliance review and monitoring activities.
- Oversees MCNA's HIPAA Compliance Program.
- Oversees MCNA's grievances and appeals functions.

Chief Compliance Officer (2007 - 2008)

MD MedicareChoice

Responsible for the development and implementation of the Annual Compliance Plan.

- Monitored and audited compliance with all applicable laws, statutes, regulations, and internal policies.
- Developed a functional Compliance department.
- Conducted compliance review of policies and procedures.

- Conducted training on compliance and HIPAA requirements.
- Directed and conducted investigations into compliance issues.
- Reported potential concerns of fraud, waste and abuse.

Program Analyst (2006 - 2007)

Bureau of Managed Health Care - Florida Agency for Health Care Administration

Responsible for compliance contract monitoring.

- Evaluated commercial and Medicaid managed care organizations for contract compliance.
- Functioned as team leader for on-site monitoring when assigned.
- Assisted managed care organizations with desk review and on-site contract compliance issues.
- Conducted risk management, expansion, and renewal surveys.
- Participated in URAC, NCQA, and AAAHC accreditation surveys.
- Reviewed MCO's corrective action plans, policies and procedures, provider contracts, and credentialing.
- Provided professional and technical assistance to the Bureau, the Agency, industry, and regulatory bodies.

OPS Human Service Analyst (2005 - 2006)

Bureau of Contract Management - Florida Agency for Health Care Administration

Responsible for recipient Medicare Buy-In program accounts.

- Determined recipient's eligibility for Medicare Buy-In program.
- Conducted research to determine discrepancies between Medicare and Medicaid records.
- Managed monthly Medicare error reports.
- Maintained knowledge of Title 42 of the Code of Federal Regulations (CFR).

Regulatory Specialist (2000 - 2001)

Florida Department of Health - Division of Medical Quality

Responsible for the Department of Health's licensure renewals.

- Utilized problem-solving skills to resolve licensure renewal issues.
- Researched and maintained state regulations, fees, and continuing education licensure requirements.
- Conducted research regarding license renewal problems.

Education

- **Florida A&M University**, Master of Science in Health Services Administration
- **Florida A&M University**, Bachelor of Science in Health Care Management

References

[redacted] [redacted] [redacted]

Shannon Boggs-Turner, JD

Vice President of Operations

MLTC Key Personnel Role: Operations Manager

Shannon is a proven executive with superb analytical skills and a wealth of experience in the management of both commercial and government sector health plans. As Medicaid Commissioner for the Commonwealth of Kentucky, she received CMS approval for the first Deficit Reduction Act Medicaid Reform Plan in the nation. Her skills in the analysis and implementation of state and federal regulations help to ensure that MCNA's operational focus in Nebraska is compliant with all MLTC requirements.

Experience

Vice President of Operations (2012 - Present)

MCNA Insurance Company

Provides overall direction and guidance to the non-clinical operational activities of the company, with the objective of optimizing business processes, integrating all operational departments, and ensuring client service level agreements are met.

- Member of Executive Management Team.
- Provides daily oversight of non-clinical operational functions including claims processing, quality improvement, utilization management, provider relations, network development, case management, call center operations, and credentialing.
- Represents MCNA with state regulatory agencies and organizations such as the Texas Dental Association, Texas Academy of Pediatric Dentistry, and Texas Academy of General Dentists.
- Decreased Medicaid dental program costs by approximately 25% for the State of Texas through the implementation of managed care using evidence-based utilization management criteria.
- Created the first comprehensive dental pay-for-quality model known as the Stellar Treatment and Recognition Reward (STARR) Program.

Managing Partner (2010 - 2012)

Consulting Strategies Team, LLC

As a founding partner of the firm, delivered consulting services to clients in both public and private sector health care programs.

- Provided full service health care consulting services including grant writing, RFP response preparation, client strategy development, revenue cycle management, contract negotiations, and project management.
- Facilitated client understanding of the impact of the Patient Protection and Affordable Care Act.
- Responsible for generating over $750 million in new revenue for dental services client based on successful RFP responses in 2011.

Executive Vice President (2006 - 2011)

University Health Care, Inc., d/b/a Passport Health Plan

Provided oversight for plan operations and reported directly to the CEO and Board of Directors.

- Oversaw all aspects of daily operations for the Medicaid and Medicare Advantage lines of business for the plan with annual revenues of $1 billion.
- Implemented quality initiatives that led to the consistent national ranking of Passport as one of America's Top 25 Medicaid Managed Care plans by the National Committee for Quality Assurance (NCQA).
- Increased the health plan reserves by nearly $50 million.

Associate Vice President for Health Affairs (2007 - 2010)

University of Louisville

Provided leadership for the operation of health care services for the university and advisory assistance to other associated university health care facilities.

- Helped lead the university's initiative to lower employee health care costs through the implementation of disease state management programs.
- Served as health care policy advisor to the University President.

Medicaid Commissioner (2004 - 2006)

Commonwealth of Kentucky

Oversaw a nearly $5 billion program with direct management of over 150 employees.

- Received approval for the nation's first Deficit Reduction Act based Medicaid Transformation.
- Brought in the state's first pharmacy benefits administrator, procured a new MMIS system, and contracted a Medicaid Administrative Agent to provide disease and case management services.

Compliance Officer and Director of Governmental Relations and Appeals (2001 - 2004)

Bluegrass Family Health

Oversaw compliance program and corporate relationships with governmental regulatory agencies.

- Responsible for all plan compliance with applicable state and federal laws and regulations.
- Implemented all aspects of HIPAA including privacy, security, and transaction code sets.

Education

- **University of Kentucky College of Law,** Juris Doctor
- **Georgetown College,** Bachelor of Arts in Political Science/Psychology

References

[redacted]

DeDe Davis

Vice President of Dental Management and Quality Improvement

DeDe is a proven executive with a diverse background in clinical and non-clinical health care operations across Medicaid, Medicare, and commercial lines of business. Her impressive track record demonstrates her abilities in designing and leading programs that result in statistically significant improvement in both clinical and operational outcomes within managed care plans. DeDe will oversee all quality assurance plan activities and ensure MLTC's program goals are met.

Experience

Vice President of Dental Management and Quality Improvement (2015 - Present)

MCNA Dental Plans

Operates in partnership with the Chief Dental Officer to implement and oversee MCNA's Utilization Management and Quality Improvement Programs.

- Member of Executive Management Team.
- Provides daily oversight of operational functions within the utilization management, case management, and quality improvement teams.
- Represents MCNA with state external quality review organizations related to MCNA's performance improvement plans.
- Enhanced MCNA's comprehensive profiling tool with a means to provide practice results against like specialty peer groups, monitor improvement following intervention and share best practices from top performers.
- Successfully led intervention strategies for MCNA's plan in Louisiana resulting in a 3-percentage point increase preventive care.

Vice President of Clinical and Medicare Operations (2011 - 2015)

ikaSystems

Initially lead the development of a comprehensive suite of medical and risk management cloud based technology products. Responsibilities expanded in the first year to include development and implementation of a base Medicare claims product and managing client operations and the relationship for one of ikaSystems' largest accounts, Blue Cross and Blue Shield of Michigan (BCBSM).

- Led multiple development teams to build an "off the shelf" Medicare claims product, preconfigured to process claims exactly like fee for service Medicare. Product includes Medicare pricing, benefits and clinical editing rules. BCBSM went live with this product January 1, 2012, for three pilot groups and subsequently with full membership of 260,000 lives January 1, 2013. Key results for this implementation:
    - 94% Auto Adjudication Rate
    - 97% Financial and Procedural Accuracy
    - Achieved every Financial Goal established for ikaSystems within contract

- Successfully designed and drove development of robust case and disease management products, compliant with NCQA, URAC and CMS requirements. The products were designed to be best in class across the country and are fully integrated with all other ikaSystems technology.
- Led design teams for prospective HEDIS tools and pay for performance technology that lead to improved Medicare STAR rating measures and a top 10 national ranking for the Medicaid business of ikaSystem's clients.

Vice President of Health Plan Operations, Vice President of Provider Contracting and Operations, Associate Vice President of Quality Improvement and Operations, Director of Quality Improvement, and Manager Quality Improvement (1998 - 2011)

AmeriHealth Mercy Family of Companies

Successfully led Passport Health Plan, a Medicaid Managed Care Organization under contract with the Commonwealth of Kentucky, and Passport Advantage, a Medicare Special Needs Plan under contract with the Centers for Medicare and Medicaid. The plans had 170,000 lives and 9,600 lives respectively and accounted for a total of $850 million in revenue under management.

- Achieved six consecutive annual Plan rankings as one of the top 25 Medicaid Health Plans in the Nation based upon Quality, Satisfaction and Accreditation Results.
- Developed and implemented a robust pay for performance program resulting in statistically significant improvement in women and children's health outcomes. Results were recognized at the Gartner's 2009 Healthcare IT Summit as Best Case Study, Insurer.

Project Management and Claims Operations (1990 - 1998)

Anthem Blue Cross and Blue Shield

Accountable for implementing efficiencies in all clinical and operations departments across three lines of business. Led Alternative Health, Inc. from a one-year to a three-year NCQA accreditation.

Yeoman First Class (1986 - 1997)

United States Navy

Accountable for administration of the Executive Offices Naval Air Station in Corpus Christi, Texas, Naval Reserve Intelligence Area Twelve in Columbus, Ohio, and Combined Air Operations Command in Vicenza, Italy.

Education

- **Six Sigma Green Belt**
- **Indiana University Southeast,** Business Administration
- **United States Naval Leadership**

References

[redacted] [redacted] [redacted]

Martha Bailey

Associate Vice President of Administration and Operations

Martha Bailey is a goal driven, versatile, and service-focused professional, with extensive experience in call center operations, provider relations, and project management. She is known for spearheading innovative policies, best practices, and technologies to increase productivity and profitability. Martha is knowledgeable about all facets of performance management, technology integration, service level improvements, contract compliance, staff training, and process improvement. She is equipped with strong communication, organizational, multitasking, and interpersonal skills. Martha oversees all aspects of call center operations and provider relations at MCNA. She understands that the functions of these areas are the soul of our member and provider relationships.

Experience

Associate Vice President of Administration and Operations (2014 - Present)

MCNA Insurance Company

Oversees the Administration and Operations functions of Call Center Operations, Provider Services, Project Management/Process Improvement, and Training and Quality Management functions as they relate to the operations teams for MCNA.

- Develops and implements strategies to maximize company growth, customer satisfaction, and client retention.
- Implements corporate training and leadership development protocols to continuously improve the quality of the MCNA leadership staff.
- Drives collaboration with cross-functional teams to ensure timely delivery of key business objectives.
- Ensures all required reports for all markets related to Provider Services and Call Center Operations are completed timely and accurately.
- Develops and maintains operational teams capable of exceeding customer needs.
- Assures contract compliance by delivering quality services and meeting all contractual, legal, and regulatory requirements.
- Ensures quality performance/quality improvement indicators are established, measured and reported on for all assigned operations.
- Assists in the initiation and development of new systems and strategies to streamline and standardize business operations.
- Thoroughly analyzes production and quality performance, evaluating current processes, making necessary workflow improvements, and facilitating change.

Senior Director of Call Center Operations (2011 - 2014)

MCNA Insurance Company

Responsible for all aspects of call center management and initiatives that impacted health plan member and provider operations.

- Managed service levels and identified service opportunities, new business implementations, and product expansions specific to service delivery.
- Developed, implemented, and managed programs centered on member satisfaction, training, and quality.
- Initiated, designed, and implemented process improvement initiatives and analysis, department business development, and annual satisfaction initiatives.
- Coordinated with business partners to diagnose and resolve issues and meet end user requirements.
- Developed and monitored service level reports to ensure compliance with company metrics and standards.
- Worked collaboratively with technical support to manage operational systems and ensure reporting and metrics were viable.

Director of Call Center Operations (2007 - 2011)

Health Help, LLC

Lead management team in all aspects of contact center operations for 200+ employees spanning two locations handling 1.1M inbound/outbound calls and 125K faxes annually.

- Attained 97% SLA fulfillment rate on contracts with Humana and other core accounts with key performance indicators for service levels as stringent as 95% within 30 seconds and 90% within 15 seconds.
- Guided deployment of NICE workforce optimization platform to drive key productivity gains, including 5% payroll and $0.30/call cost reduction.
- Initiated and managed relationship with BPO provider to increase productivity.

Senior Contact Center Operations Manager (2006 - 2007)

Chase Com, L.P.

Directed activities of inbound call center with more than 300 seats supporting Accenture contract with AT&T.

Education

- **North Texas State University/Lamar University,** Liberal Arts
- **Certified HIPAA Professional (CHP)**

References

[redacted] [redacted] [redacted]

Oteasa Townsend-Hardy, BHSA, RN

Director of Quality Improvement and Risk Management

Oteasa Townsend-Hardy serves as MCNA's Director of Quality Improvement and Risk Management. She is responsible for the development and monitoring of the internal and external Quality Improvement (QI) programs and identifying areas for intervention. Working closely with the EQROs for Florida, Kentucky, and Texas, Oteasa has developed a strong Quality Assurance and Performance Improvement (QAPI) program for MCNA.

Experience

Director of Quality Improvement and Risk Management
(2010 - Present)

MCNA Dental Plans

Responsible for the day-to-day activities of the Quality Improvement Program.

- Assures quality compliance oversight with regulatory agencies.
- Prepares quarterly QI reports.
- Evaluates annual external and internal QI program.
- Identifies, plans, evaluates, and monitors member care and service outcomes.
- Oversees all community outreach efforts.
- Designs clinical and non-clinical outcome studies.
- Participates in Quality Improvement Committee and subcommittees.
- Recommends improvement strategies as needed.
- Oversees MCNA's Risk Management Program.
- Provides risk management training to all MCNA employees.

Corporate Compliance Manager (2009 - 2010)

HealthSpring

Responsible for the overall operational auditing functions for the Medicare and Medicaid Managed Care organization.

- Prepared departments for external audit readiness for CMS regulations, Florida Agency for Health Care Administration (AHCA), and Sarbanes-Oxley controls.
- Prepared AHCA Risk Management on-site survey documentation.
- Developed and executed OIG compliance training for new hires.
- Maintained and reported on audit findings through the Compliance and Quality Improvement Committees.

Manager of Quality Improvement, Compliance, Grievance and Appeals (2007 - 2009)

Leon Medical Centers Health Plans by HealthSpring

Responsible for the organization's overall operational auditing functions.

- Conducted and presented HEDIS, CAHPS, and NCQA benchmarked quality improvement studies.
- Developed and implemented quality improvement activities (data analysis and document fulfillment).
- Designed and conducted plan achievement surveys and provided feedback to Quality Improvement Committee.

Compliance Coordinator (2006 - 2007)

Leon Medical Centers Health Plans

Responsible for conducting internal audits of each operational area to test adherence to CMS regulations.

- Prepared audit deficiency and compliance summaries for Quality Improvement Committee.
- Assisted the Vice President of Health Services with quality improvement studies and initiatives.
- Developed preliminary incident reports.

Compliance Analyst and Administrator of Licensure (2005 - 2006)

NationsHealth

Responsible for external audit requests by fulfilling requests from Medicare regions.

- Assisted Medicare Part D Compliance Manager in maintaining compliance with Medicare Part D Program Integrity Guidelines.
- Attended Open Door Forums for extended knowledge of Medicare and Medicaid.
- Maintained technical knowledge of legislation, rules and regulations governing the insurance industry.

Education

- **Florida International University**, Bachelor Degree in Health Services Administration
- **Agency for Health Care Administration (AHCA)**, Licensed Health Care Risk Manager
- **Miami-Dade College**, Registered Nursing Program

References

[redacted] [redacted] [redacted]

Meghan Henkel, LPN

Director of Utilization Management and Case Management

Meghan has a diverse background in utilization management and case management, through which she has developed an innate understanding of the balance between meeting the dental health care needs of our members and the responsible utilization of services. She is a skilled administrator with many years of staff supervision experience and excellence in operational improvement. Meghan leads the Utilization Management and Case Management Department with dedication to ensuring the best possible care for our Nebraska Medicaid members.

Experience

Director of Utilization Management and Case Management
(2014 - Present)

MCNA Dental Plans

Responsible for ensuring the delivery of high quality and cost effective medically necessary dental services to all members.

- Provides oversight of MCNA's Utilization Management and Case Management programs under the direction of the Vice President of Dental Management and Quality Improvement.
- Develops and implements work flow processes and monitors outcomes to ensure business goals are met and the department remains in compliance with all contracts.
- Evaluates utilization of services data on a regular basis to identify trends in patterns of usage and monitors for over- and underutilization of services.
- Ensures members identified as high-risk or as having special health care needs receive appropriate oral health assessments and dental services.
- Assists in the education of providers and in the development of collaborative relationships with them.
- Prepares and presents quarterly departmental reports for submission to individual plans, state programs, and internal Utilization Management and Quality Improvement committees.
- Identifies areas of opportunity in departmental processes and works with staff to develop and implement performance improvement projects.
- Conducts periodic performance measurement evaluations for all non-clinical departmental staff and assists with all Inter-rater Reliability audits required for clinical review staff.

Senior Manager of Case Management (2010 - 2014)

MCNA Dental Plans

- Ensured compliance with policies and procedures and state and federal regulations.
- Coordinated care for foster children and members with special health care needs.
- Assisted members with locating providers and scheduling dental appointments.
- Conducted follow-up with members and dental offices.

- Located non-profit agencies, governmental agencies, medical insurance companies, and dental associations to obtain care for members for non-covered services.
- Managed pre-authorizations, referrals, and claims for all members in the case management program.

Credentialing Coordinator (2009 - 2010)

MCNA Dental Plans

- Credentialed individual dentists interested in joining MCNA's networks in Florida and Kentucky.
- Managed application process for Kentucky providers applying for Medicaid numbers.
- Managed credentialing for large dental groups in Florida.

Billing Specialist (2007 - 2008)

Eye Physicians of Central Florida

- Liaison between front desk staff, billing department, and upper management.
- Entered daily charges into data system and billed insurance companies.

Assistant Office Manager (2003 - 2006)

Medchoice Medical Center

- Directed, coordinated, and managed the day-to-day operations of the medical practice.
- Ensured that services were provided within the context of the member benefit coverage.
- Functioned as a benefit interpretation resource for questions related to insurance coverage.

Provider Relations Representative (2002)

Health Care Solutions, Inc.

- Responsible for orientation of new providers.
- Conducted site surveys of health providers for manage care plans.

Education

- **Miami-Dade College**, Licensed Practical Nurse program
- **Miami-Dade College,** Associates in Business

References

[redacted]

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Carol Raspa

Director of Claims Management

Carol Raspa has an extensive background in claims processing, payment, and administration. She has a proven track record implementing solutions to improve processes and increase the accuracy and timeliness of claims payment. As Regional Director of Program Integrity for the Amerigroup Corporation, she oversaw the increase in recovery capture by 37% year over year. She has a wealth of experience in Medicare and Medicaid claims processing and uses her skills to ensure her team operates at the highest level of efficiency possible.

Experience

Director of Claims Management (2013 - Present)

MCNA Dental Plans

Responsible for all aspects of claims processing while working to identify process gaps to ensure accurate and timely service delivery.

- Develops quality and production standards for all classes of claims examiners to ensure consistent delivery of quality service.
- Provides oversight of audit program of claims examiners and auto-adjudication processes.
- Develops and maintains controls to ensure all claims are processed in chronological order and according to appropriate staff level of expertise.
- Provides oversight for all aspects of data entry scanning and electronic imaging of paper claims.
- Manages the reconsideration process for claims that have been previously denied.
- Ensures efficient and appropriate controls in place to manage overpayment recovery.
- Provides oversight of all audit activities designed to ensure the accuracy of Explanation of Benefits prior to posting.

Regional Director, Program Integrity (2011 - 2013)

Amerigroup Corporation

Provided leadership in the identification, analysis, and recovery of overpayments for major initiatives and other project management activities.

- Identified process gaps to improve overall quality of claims service delivery.
- Reported on the results and status of major initiatives to client health plans senior leadership, focusing on the achievement of financial targets.
- Increased recovery capture 37% year over year.
- Designed and published new manual for operational processes.

Senior Management Claims Recovery Operations (2007 - 2011)

United Healthcare

Led staff in identifying and recovering claims overpayments for clients while maintaining high level of accountability for all recovery operations with senior leadership.

- Identified claims overpayments and ensured recovery activities carried out to completion.
- Prepared and presented recovery packages to clients to gain approval for further action.
- Determined the recovery methodology for all approved recovery packages and set targets.
- Reconciled refunds and reported results and variances throughout recovery process.

Director of Claims (2002 - 2006)

UCare Minnesota

Held primary accountability for ensuring accurate and timely Medicare and Medicaid claims processing with overall responsibility for five functional areas.

- Participated in Medicare Part D Steering and Part D Implementation committees.
- Reduced claims processing turnaround time from 41% over 30 days to less than 1% over 30 days with resultant reduction in interest payments.
- Established production and quality standards for all functional areas.

Director of Claims Analysis & Recovery (2000 - 2002)

Medica Health Plans

Led oversight of all claims analysis, overpayment identification, funds recovery, and articulation of process gaps back to organization to achieve resolution.

- Designed and implemented claims analysis and recovery function four months ahead of schedule including infrastructure, process flows, tracking, and reporting functionality.
- Recovered $4.5 million in the first 10 months of operation with a staff of six individuals.

Director of Client Implementations, Operations (1993 - 1999)

Medco Health Solutions

Identified and documented requirements that ensured appropriate solutions to technical aspects of managed care, Third Party Administrator, and carrier client implementations.

- Primary responsibility for Document Control, Claims Data Entry, and Claims Processing.
- Participated in sale and implementation of 21 new managed care and commercial partners.

Education

- **University of Pennsylvania**, Bachelor of Arts in Psychology

References

[redacted] [redacted] [redacted]

Diana Davis

Director of Grievances and Appeals

Diana Davis has a wealth of experience assisting Medicaid, CHIP, Medicare, and commercial health insurance members with grievances and appeals. Her knowledge of industry regulations and URAC requirements makes her a valuable resource for MCNA's members. She has firsthand experience in preparing cases for State Fair Hearings. Diana was instrumental in the continued growth of the Grievance and Appeals Department at MCNA, and is responsible for its Florida, Kentucky, Texas, Louisiana, Iowa, and Idaho Medicaid grievances and appeals systems.

Experience

Director of Grievances and Appeals (2009 - Present)

MCNA Dental Plans

Responsible for the oversight of all grievances and appeals for all lines of business.

- Accountable for all responsibilities pertaining to Medicaid, Medicare, and commercial grievances and appeals processes.
- Responsible for implementation and supervision of grievances and appeals training materials and programs.
- Responsible for daily, weekly, and monthly reports of staff productivity and overall quality in resolution of grievances and appeals to the Chief Dental Officer.
- Responsible for quarterly reports to the Quality Improvement Committee.
- Works closely with management and Compliance Department on case review results.
- Investigates and provides verbal and written responses to Medicaid, Medicare, and commercial grievances and appeals, as required and in a timely manner.
- Provides research assistance to the plan's general counsel as necessary.

Grievances and Appeals Supervisor (2007 - 2009)

Vista Health Plans, Inc.

- Ensured that department activities were consistent with the established Medicaid policies and procedures.
- Reviewed all cases submitted for resolution for accuracy and appropriate case handling.
- Responsible for identification of departmental operational issues.
- Responsible for daily, weekly, and monthly reports of staff productivity and overall quality in resolution of grievances and appeals to the department supervisor.
- Investigated and responded verbally and in writing to grievances and appeals.
- Provided research assistance to the plan's corporate legal department as necessary.
- Developed and maintained cooperative work relationships with members, providers, regulators, associates, management, and other departments within the organization.

Grievance and Appeals Supervisor (2006 - 2007)

Leon Medical Centers Health Plans

- Supervised all aspects of the grievances and appeals department.
- Responsible for implementation and supervision of training materials and programs.

Grievance and Appeals Administrator II (1997 - 2006)

Neighborhood Health Partnership

- Communicated with the Department of Insurance, Agency for Health Care Administration (AHCA), and Health Care Financing Administration with respect to Medicaid member complaints, grievances, and appeals.
- Prepared cases presented to the Florida Subscriber Assistance Panel and Administrative Law Judge.
- Investigated and responded to members within regulatory time frames.
- Assisted the Director of Compliance with grievances and appeals quality improvement initiatives.
- Prepared, scheduled, and conducted grievance committee hearings.

Collections Manager (1996 - 1997)

Navix Radiology

- Oversaw the daily operations of the collections department, including supervision of a staff of six employees and interview of candidates for planned departmental growth.
- Prepared weekly reports regarding payment information and accounts receivable totals.
- Worked directly with the National Reimbursement Director to ensure maximum collections.
- Reviewed and summarized HMO, PPO, and POS contracts for CFO approval.

Office Manager (1995 - 1996)

South Florida Center for Digestive Diseases

- Oversaw the daily operations of a three-office medical practice containing 12 physicians.
- Responsible for all personnel matters including hiring and terminations, benefits, payroll and employee relations.
- Served as a liaison between patients, physicians, administrators, and clients.
- Created client presentations for introduction to physicians and management.

References

René Canales

Director of Network Development

René Canales is an accomplished professional in all areas of Medicaid, CHIP, and Medicare Advantage contracting including provider relations, claims processing, and customer service. He uses regular, concise communication to connect with co-workers at all levels of the organization in order to ensure his network management activities align with current development goals. René demonstrates the customer service know-how to engage providers and keep them invested in MCNA's strategy for meeting the dental health care needs of Medicaid and CHIP members.

Experience

Director of Network Development (2015 - Present)

MCNA Dental Plans

Guides and oversees the development and implementation of national Medicaid dental networks.

- Responsible for the establishment and maintenance of provider networks that include general and pediatric dentists, as well as specialty providers, meeting the time and distance access requirements as set forth by Medicaid and CHIP programs.
- Conducts market analysis for new and existing business.
- Conducts analysis of the adequacy of current operating networks and for new business.
- Develops and maintains strong working relationships with internal team, state regulators, and network dental providers.
- Recruits non-Medicaid providers into the Medicaid Program.
- Trains network providers with presentations about Medicaid dental policy updates and MCNA's policies, procedures, and operations, including cultural competency and cultural diversity concerns.

Smile Brands, Inc. (2013 - 2014)

Business Development Manager

- Increased dental plan revenue by 10% by negotiating contracts and compensation in a seven-market territory in Texas and Oklahoma within nine months.
- Served as single point of contact with key national accounts and regional dental carriers.
- Coordinated SBI dental office training to maximize DHMO and PPO Plan participation, implement new products/fee schedules, and resolve regulatory compliance matters.

Premier Access Insurance Co. (2011 - 2013)

Compliance Officer

- Responsible for all compliance activities, including mandatory regulatory filings, reports development, and facilitation of onsite audits resulting from regulatory changes.

- Developed and reviewed all internal policies to ensure compliance with applicable state and federal laws related to the operation of commercial and government programs (Medicaid and CHIP).
- Responsible for the oversight of the quality improvement program.

Metlife (2008 - 2010)
Manager of Network Development

- Managed team of provider relations representatives responsible for the network maintenance and growth to support sales expansion in the central region of the country.
- Established network recruitment growth goals for 14 states.

Safeguard Health Plans (2002 - 2008)
Director of Business Development and Director of Provider Relations

- Forged new relationships with large school districts, municipalities, and counties.
- Developed marketing and sales plan for expansion in major urban areas.
- Provided regulatory compliance oversight for Texas market.
- Managed network team to identify specific recruiting needs to support sales growth.

Texas Universities Health Plan (2000 - 2002)
Director of Product Development and Compliance

Texas Healthy Kids (1998 - 2000)
Director of THKC and CHIP Health Plan Contracts

Firstcare (1996 - 1998)
Director of Regulatory Compliance

PCA Health Plans of Texas (1994 - 1996)
Director of Regulatory Compliance

Texas Department of Insurance (1987 - 1994)
Insurance Specialist

Education

- **Southwest Texas State University**, Bachelor of Science in Business Administration

References

[redacted]

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Aldwin Gomez

Director of Call Center Operations

Aldwin Gomez is a dynamic, results-driven professional with widespread experience in Call Center Operations. He is highly skilled at developing and executing targeted business initiatives that enhance the member and provider experience and exceed performance objectives. Aldwin is a highly effective communicator with a proven ability to build long-term relationships with internal and external customers by establishing a high level of confidence and trust.

Experience

Director of Call Center Operations (2012 - Present)

MCNA Dental Plans

Responsible for all aspects of call center management and initiatives that impact health plan member and provider operations.

- Manages service levels and identifies service opportunities, new business implementations, and product expansions specific to service delivery.
- Develops, implements, and manages programs centered on member satisfaction, training and quality.
- Initiates, designs, and implements process improvement initiatives and analysis, department business development, and annual satisfaction initiatives.
- Implements new business initiatives including system design, implementation, and performance management.
- Coordinates with business partners to diagnose and resolve issues that will meet end user requirements.
- Develops and monitors service level reports to ensure compliance with company metrics goals and standards.
- Works collaboratively with technical support to manage operational systems and ensure reporting and metrics are viable.
- Monitors overall employee and company performance to provide successful results.
- Provides management and leadership to staff.
- Motivates call center agents to achieve high performance.
- Handles escalated concerns that fall outside the purview of floor supervisors.
- Reviews and analyzes call stats and complaint reports to identify trends and problems that need addressing.

Outreach and Recertification Manager (2006 - 2012)

Altegra Health

Responsible for all aspects of outbound call center initiatives for contracted health plans to deliver improvements in revenue cycle management.

- Created targeted outbound campaigns designed to educate members residing within all 50 states on benefits and improve utilization of services
- Led teams of supervisors, team leads, case managers, case reviewers and eligibility counselors.
- Managed all aspects of the member outreach and recertification process, specifically the application process for Medicare Advantage Plan members to qualify them for Medicare Savings Programs.
- Exceeded production and performance goals while maintaining high levels of service, quality control and HIPAA compliance.
- Earned repeated commendations for production results/leadership throughout 5+ year tenure with Altegra Health

Executive Cruise Consultant (2002 - 2006)

National Leisure Group

Inside sales position within a call center environment.

- Harnessed strengths in relationship building, opportunity identification, goal-setting and self-motivation to exceed sales expectations.

Customer Care Advocate (1999 - 2001)

Ancicare PPO

National provider of workers' compensation solutions for employers. Combined claims management technologies with medical cost containment services to meet the diverse needs of customers.

- Performed outreach within a call center to patients receiving workers' compensation benefits in order to schedule appointments for medically needed testing.

Education

- **Grand Canyon University**, Bachelor of Science in Business Management

References

Sophia Wallen

Director of Credentialing

Sophia Wallen is a highly motivated, results-oriented credentialing expert with over 20 years of leadership experience and over 15 years of experience working in managed care. Her vast knowledge of healthcare regulations and standards directly contributed to MCNA's accreditation with NCQA for Credentialing and Re-credentialing. She is a respected member of MCNA's leadership team with a proven track record for achieving business objectives and implementing approaches supporting operational excellence and high quality standards. Ms. Wallen has excelled at credentialing statewide networks within short implementation timeframes.

Experience

Director of Credentialing (2007 - Present)

MCNA Dental Plans

Responsible for all provider credentialing functions for MCNA.

- Develops policies and procedures for credentialing dental providers, ensuring that credentialing policies meet regulatory guidelines.
- Develops and maintains systems to ensure compliance with laws, rules, regulations, and accreditation requirements, and maintains oversight of credentialing database.
- Provides initial and ongoing training to all credentialing staff.
- Develops and maintains reporting systems to provide timely information to health plans and/or state agencies regarding compliance status with guidelines, rules/regulations and internal policies and procedures. Works through staff so that a systematic process for monitoring and reporting is timely and appropriate.
- Maintains a working knowledge of accreditation requirements (NCQA).
- Assures successful site visits, inclusive of mandatory requirements to protect the safety of MCNA members at over 40,000 access points across all lines of business.
- Achieved a perfect score on the Plan's NCQA certification review.
- Established peer review processes to oversee and evaluate clinical quality concerns brought forward to the Credentialing Committee.
- Facilitates a multi-disciplinary workgroup, consisting of members from provider relations, provider contracting, and quality improvement to reduce the volume of re-credentialing applications not returned in a timely manner to avoid interruption in participation.

Corporate Director of Credentialing (2006 - 2007)

PartnerCare Health Plan, Inc.

Responsible for the development and implementation of the Credentialing Department for a new health plan.

- Established organizational and structural measures for the department including policies and procedures and key performance indicators.
- Ensured activities met state, federal, and accreditation requirements and standards.
- Developed internal audit processes and tools to ensure compliance and accuracy of data included in the provider directories.
- Partnered with Dental Director to implement and coordinate Credentialing Committee meetings.
- Coordinated resolution of provider, contracting, and claims issues, including escalating providers with adverse issues to higher committees.
- Assisted with the development of credentialing database.
- Trained, supervised, and mentored staff.

Director of Credentialing (2004 - 2006)

DoctorCare, Inc.

Responsible for the development and implementation of the Credentialing Department for a new health plan.

- Established the credentialing program including the development of policies and procedures, credentialing application and verification processes, and development of credentialing committees.
- Ensured activities met state, federal, and URAC accreditation requirements and standards.
- Developed delegated audit processes and tools providing oversight of all delegated activities.
- Provided reports, audits, site reviews, and data as required for committees and regulations.
- Implemented and co-chaired the Credentialing Committee with the Chief Medical Officer. Prepared agendas, minutes, files, and documentation.

Consultant (2001 - 2004)

Total Managed Care Services, Inc.

Provided managed care consulting services to organizations across various segments within the industry including provider networks, dental networks, and other managed care organizations. Consultation services in utilization management, program descriptions, policies and procedures, and operations management.

Education

- **Miami-Dade Community College**, Psychology and Computer Science

References

[redacted] [redacted] [redacted]

Cynthia L. Johnson

Senior Claims Examiner

MLTC Key Personnel Role: Grievance System Manager

Cynthia Johnson has worked in the Nebraska dental industry for 24 years. She has held a variety of positions throughout her career, ranging from entry level to senior staff member. Cynthia's experience dealing directly with patients and providers and her in-depth knowledge of MCNA processes and procedures has prepared her well for the role of Grievance System Manager in Nebraska. In this role, Cynthia will be responsible for managing and adjudicating member grievances, appeals, and requests for fair hearings. She will also manage and adjudicate provider grievances and appeals.

Experience

Senior Claims Examiner (2013 - Present)
Claims Examiner (2009 - 2013)

MCNA Insurance Company

Responsible for examining and adjudicating claims. Assists junior claims examiners with process and procedural questions.

- Audits all paper and electronic claims for accuracy.
- Verifies member eligibility with appropriate resources as necessary.
- Assists call center with inquiries on the status of claims.
- Maintains thorough documentation and confidentiality.
- Fosters positive interactions and relationships with all internal departments and cultivates positive working relationships with external contacts.
- Performs other assigned duties and completes special projects on an ad hoc basis.
- Works with the Dental Director to handle issues and ensure proper payment of claims.
- Assists with timely review of claims payment and audits.

Hygiene Coordinator and Patient Administrator (1992 - 2009)

Private Dental Practice

Held several key positions at private dental practices.

- Scheduled and confirmed patient appointments.
- Handled patient complaints related to customer service, billing disputes, and dissatisfaction with quality of care or service.
- Organized/filed patient dental records.
- Completed routine recall activities using Eaglesoft software.
- Assisted patients with establishment of billing and financial arrangements.

- Billed insurance carriers for services rendered.
- Completed collections activities using Dentrix software.
- Sterilized instruments according to health and safety guidelines and regulations.
- Completed exam room setup and cleanup.

Medical Receptionist and Scheduling Coordinator (1988 - 1992)

Park Health Center

Responsible for coordinating the patient experience.

- Scheduled and confirmed appointments.
- Greeted patients and gathered information required for patient records.
- Verified patient eligibility with appropriate health plan.
- Served as first point of contact for patient issues. Escalated complex issues to office manager.
- Conducted recall activities.

Medical Claim Processor (1985 - 1986)

Physicians Health Plan (PHP)

Processed PHP/Share pharmacy claims within contract, state and federal guidelines.

Education

- **University of Minnesota**, Dental Hygiene
- **Mankato State University**, Nursing

References

[redacted] [redacted] [redacted]

Sherri O'Brien

Claims/Explanation of Benefits Supervisor

MLTC Key Personnel Role: Provider Services Manager and Member Services Manager

Sherri O'Brien brings over 17 years of management and Nebraska dental experience to her roles of Provider Services Manager and Member Services Manager. As the Provider Services Manager, Sherri oversees the Provider Relations Department in Nebraska and is responsible for the development and implementation of the policies, procedures, processes, and staff activities that allow MCNA to meet its state and federal requirements and plan accreditation standards. As the Member Services Manager, she is responsible for coordinating communications between MCNA and Nebraska Medicaid members. Sherri ensures that there is a sufficient number of Member Services Representatives able to offer culturally and linguistically appropriate services, enabling members to receive prompt resolution for their problems or questions and receive appropriate education about participation in the Nebraska Medicaid Dental Benefits Program.

Experience

Explanation of Benefits (EOB) Supervisor (2013 - Present)
Claims Examiner – Team Lead (2012 - 2013)
Claims Examiner (2009 - 2012)

MCNA Insurance Company

Responsible for the supervision of the Claims Department Explanation of Benefits (EOB) staff.

- Ensures staff is fully maximized and level loaded across all plans and associated EOBs.
- Monitors and drives claims analysis and recovery processes to achieve financial goals and objectives.
- Monitors staff performance against production and quality goals, provides coaching as necessary.
- Provides notification and feedback about systems issues requiring remediation to the Director of Claims.
- Identifies trends and escalates issues to appropriate level of management to ensure resolution.
- Develops strategies to alleviate all identified production barriers, as appropriate.

Office Manager (1999 - 2009)

Private Dental Practice

Responsible for all aspects of operations for multiple private dental practices.

- Managed staff, including hiring, supervision, employee development, and discipline.
- Created a positive and productive work environment to attract and retain the best staff.

- Provided excellent service to patients.
- Reviewed the operation, researching processes, recommending, and implementing improvements based upon approval.
- Assured practice compliance with federal and state regulations.
- Worked in partnership with the ownership to assure the efficiency of the practice.
- Assured that appropriate coverage is maintained.

Customer Service Representative (1998 - 1999)

Ameritas Life Insurance

Customer service representative supporting providers, members, and employers calling with questions about their benefits.

- Processed dental claims.
- Performed second review of claims before payment, as necessary.
- Assisted members with claim submission and claim status retrieval using the Ameritas web application.
- Completed provider search for members requesting assistance.
- Updated dental and vision benefits, as necessary.

Education

- **Central Community College**, Accounting

References

[redacted] [redacted] [redacted]

Vonnie Schaeffer

Claims Manager

MLTC Key Personnel Role: Claims Administrator

Vonnie Schaeffer has over 20 years of experience in all aspects of health plan operations. As MCNA's Claims Administrator in Nebraska, Vonnie is responsible for developing, implementing, and administering a comprehensive Medicaid Managed Care claims processing system for the Nebraska plan. She is responsible for hiring, developing, and training Claims Department team members and allocating appropriate resources to ensure claims are processed in compliance with contract, state, and federal requirements. She ensures all Claims Department team members are fully maximized to meet processing timelines, productivity, and quality standards. She works closely with the Director of Claims to develop cost avoidance processes, minimize claims recoupments and meet MLTC encounter reporting requirements. Vonnie's solid background in operations allowed her to help shape the evolution of MCNA's claims processing automation. Her understanding of MCNA's total claims management system, as well as her lifelong knowledge of the Nebraska geography and culture, positions her well to assist with our Nebraska implementation.

Experience

Claims Manager (2012 - Present)

MCNA Insurance Company

Responsible for managing all aspects of the Claims Department. Develops and executes strategies to improve productivity, quality, and customer service.

- Manages departmental staffing levels to sustain service and quality objectives.
- Monitors team performance and attendance, and initiates progressive disciplinary actions and performance improvement plans when appropriate.
- Identifies trends, handles escalated and complex issues, and ensures resolution and follow up.
- Maintains knowledge of current plans and effectively applies this knowledge in the payment of claims and in providing assistance.
- Alerts senior management when inventory levels are increasing or when timeliness is lagging.
- Provides recommendations for workflow and inventory reduction.
- Works on projects and new processes as requested by senior management.
- Fosters an environment that values courtesy and respect for all team members.
- Adheres to all contract, corporate, and departmental policies and procedures.
- Prepares and presents detailed performance reports to senior leadership.

Claims Supervisor (2010 - 2012)
Claims Examiner (2009 - 2010)

MCNA Insurance Company

Recruited as Claims Examiner and promoted to Supervisor within one year. Responsible for coaching, counseling, and training a staff of claims examiners and support staff in accordance with company policies, state and federal guidelines, and applicable labor laws.

- Performed internal quality audits.
- Developed and maintained department training materials.
- Facilitated departmental training.
- Performed pre-payment claims review and post-payment claims audits.
- Assured compliance with contractual, state, and federal requirements and regulations.
- Assisted claims staff with questions and escalated issues.
- Shared best practices to improve team productivity and quality.

Transcriptionist Report Auditor (2007 - 2009)

Private Secretary, Inc.

Reviewed, audited, and corrected medical transcripts for VA Hospitals.

- Transferred all completed documents to the appropriate hospitals and physicians.
- Revised reports and resent medical records as needed.
- Served as a subject matter expert for troubleshooting issues.
- Provided exceptional customer service.
- Managed multiple priorities and consistently met deadlines.

Medical Stop-Loss Underwriter (1997 - 2001)

American Insurance Managers, Inc.

Used actuarial information submitted from the company to determine proper medical, dental, and prescription drug insurance rates for company employees.

- Provided detailed knowledge of hospital charges, transplant costs, and the latest procedures in the industry.
- Trained client users, installed software, built interfaces, and converted data.
- Supported decision-making process for areas of operations associated with installation of new software.
- Served as liaison for internal and external stakeholders.

Presentation Specialist (1995 – 1997)

The TPA

Served as a client file preparation specialist for a Third-Party Administrator.

- Acquired census, medical history, and other information from employers who were looking for insurance coverage for their employees.
- Prepared benefit package details for prospective Medical Stop-Loss Underwriters to bid on TPA contracts.
- Collected bid responses and prepared a final procurement package for presentation to the client.

Senior Dental Claims Examiner (1986 - 1991)

Ameritas Insurance Company

Processed claims, investigated third-party liability, and ensured proper coordination of benefits.

- Processed patient dental claims based on company dental plan and schedule of benefits.
- Worked directly with in-house dental clinicians to review medical necessity issues.

Education

- **Waverly High School**, Waverly, Nebraska, High School Diploma

References

[redacted] [redacted] [redacted]

Jeanette Logan

Client Services Senior Manager

MLTC Key Personnel Role: Encounter Data Quality Coordinator

Jeanette Logan has over 14 years of experience working as an IT Business Analyst. She is an astute business leader and problem solver with a diverse background in healthcare service delivery, information technology, project management, and customer service in highly competitive industries. Jeanette uses creativity and innovation to attain strategic results while maintaining the integrity of corporate policies and procedures. In her role as the Encounter Data Quality Coordinator for Nebraska, she is responsible for organizing and coordinating services and communication between MCNA's administration and MLTC for the purpose of identifying, monitoring, and resolving encounter data validation and management issues.

Experience

Client Services Senior Manager (2016 – Present)
Lead IT Business Analyst (2013 – 2016)

MCNA Dental Plans

Responsible for oversight of multiple business units within MCNA's Client Services/IT Department including Business Analysts, Reporting Analysts, EDI Specialists, and Enrollment Specialists.

- Recruits, hires, and trains business units within Client Services/IT Department.
- Develops and implements processes and procedures to ensure business units are efficient and producing desired results.
- Monitors performance of business units and provides coaching, counseling, and disciplinary action as needed.
- Conducts monthly one-on-one meetings and annual performance reviews.
- Identifies processes that are inefficient and creates/changes processes that will lead to measurable gains in data quality and report processing time.
- Coordinates special reporting projects as required.
- Works with department heads to develop reports required by State partners and for internal monitoring.
- Develops and supports Electronic Data Interchange (EDI) processes and utilities, including testing, implementing and maintaining EDI transactions.
- Handles communications with State partners for EDI transaction set-up and ongoing maintenance and support.
- Oversees enrollment processes to ensure member data is accurate and works with State partners to correct eligibility discrepancies.

Global Application Development/IT Functional Business Analyst (2009 – 2013)
Global Application Support/IT Business Analyst (2007 – 2009)
IT Project Manager/Business Requirements Analyst (2004 – 2007)
Region Supervisor (2001 – 2004)

Kinetic Concepts, INC. (KCI)

Served in multiple roles with progressive responsibility. Provided functional support for KCI Global document management system and application support for KCI Custom applications, as well as Oracle 11i and R12.

- Assessed, defined, and developed business needs, business process flows and diagrams. Gathered and prioritized user functional requirements and documented system processes to ensure all gaps were appropriately mitigated and resolved.
- Served as the change management focal point. Identified tasks and interrelationships needed to evaluate cross-functional requirements. Develop and document test plans and developed and implemented Training Departments on new system changes.
- Researched, benchmarked and supported business application-related initiatives and provided ongoing guidance to clients to ensure ease of transition and use.
- Traveled to all geographically located end users within the United States, Budapest, Hungary, and others as needed.
- Ensured all operational and training materials for new and emerging systems and technologies were developed, designed, tested and taught to end users.
- Managed frequently asked questions, changes and transitions to the newly designed or updated software and systems related to customer applications used for placement and billing of durable medical equipment.
- Worked closely with other teams and individuals to identify gaps, develop the appropriate fix, and to communicate and implement change as needed.
- Identified business requirements for systems enhancements for Patient Financial Services Department.

Office Manager (1998 – 2002)

Comprehensive Benefits Service

Benefits Coordinator (1997 – 1999)

E.G. Hendrix Company

Customer Service Representative (1996 – 1997)

Prudential Health Care

Petty Officer Second Class (1990 – 1996)

United States Navy

Completed service with an Honorable Discharge and served in positions that included Police Officer, Shift Supervisor, Team Leader, and Radio Equipment Operator.

Education

- **Concordia University**, Master in Business Administration
- **Concordia University**, Bachelor of Business Administration

References

[redacted] [redacted] [redacted]

This content has been redacted.

Attachment 6-1
URAC Certificates: Dental Plan

Certificate Number: DPL003879 - 3666

Certificate of Full Accreditation

is awarded to

MCNA Insurance Company
4400 N.W. Loop 410, Suite 250
San Antonio, TX 78229

for compliance with

Dental Plan Accreditation Program

pursuant to the

Dental Plan, Version 7.2

Effective from the Monday 1st of December of 2014 through the Friday 1st of December of 2017

William Vandervennet
Chief Operating Officer

Susan DeMarino
Vice President of Accreditation Services

ACCREDITED

URAC accreditation is assigned to the organization and address named in this certificate and is not transferable to subcontractors or other affiliated entities not accredited by URAC.

URAC accreditation is subject to the representations contained in the organization's application for accreditation URAC must be advised of any changes made after the granting of accreditation. Failure to report changes can affect accreditation status.

This certificate is the property of URAC and shall be returned upon request.

Certificate Number: DPL003880 - 3648

Certificate of Full Accreditation

is awarded to

Managed Care of North America, Inc. d/b/a MCNA Dental Plans, Inc.
200 W. Cypress Creek Road, Suite 500
Fort Lauderdale, FL 33309

for compliance with

Dental Plan Accreditation Program

pursuant to the

Dental Plan, Version 7.2

Effective from the Monday 1st of December of 2014 through the Friday 1st of December of 2017

William Vandervennet

William Vandervennet
Chief Operating Officer

Susan DeMarino

Susan DeMarino
Vice President of Accreditation Services

ACCREDITED

URAC accreditation is assigned to the organization and address named in this certificate and is not transferable to subcontractors or other affiliated entities not accredited by URAC.

URAC accreditation is subject to the representations contained in the organization's application for accreditation. URAC must be advised of any changes made after the granting of accreditation. Failure to report changes can affect accreditation status.

This certificate is the property of URAC and shall be returned upon request.

Attachment 6-2
URAC Certificate: Claims

Certificate Number: B103604 - 3648

Certificate of Full Accreditation

is awarded to

Managed Care of North America, Inc. d/b/a MCNA Dental Plans, Inc.
200 W. Cypress Creek Road, Suite 500
Fort Lauderdale, FL 33309

for compliance with

Claims Processing Accreditation Program

pursuant to the

Claims Processing, Version 3.0

Effective from the Wednesday 1st of October of 2014 through the Sunday 1st of October of 2017

William Vandervennet
Chief Operating Officer

Susan DeMarino
Vice President of Accreditation Services

URAC accreditation is assigned to the organization and address named in this certificate and is not transferable to subcontractors or other affiliated entities not accredited by URAC.

URAC accreditation is subject to the representations contained in the organization's application for accreditation. URAC must be advised of any changes made after the granting of accreditation. Failure to report changes can affect accreditation status.

This certificate is the property of URAC and shall be returned upon request.

Attachment 6-3
NCQA Certificate

National Committee for Quality Assurance

has awarded

Managed Care of North America, Inc. d/b/a MCNA Dental Plans, Inc.

NCQA Certification in

Credentialing and Recredentialing

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in the area of Credentialing and Recredentialing.

CHAIR, BOARD OF DIRECTORS	PRESIDENT	CHAIR, REVIEW OVERSIGHT COMMITTEE

August 5, 2015	*August 5, 2017*
DATE GRANTED	EXPIRATION DATE

Business Continuity Planning and Emergency Coordinator

Purpose of Position

The Business Continuity Planning and Emergency Coordinator develops, maintains, and implements business continuity and disaster recovery strategies and solutions, including risk assessments, business impact analyses, strategy selection, and documentation of business continuity and disaster recovery procedures for MCNA's operations in Nebraska. Plans, conducts, and debriefs regular mock-disaster exercises to test the adequacy of existing plans and strategies. Updates procedures and plans regularly. Acts as a coordinator for continuity efforts after a disruption event.

Reports To

This position reports directly to the Chief Executive Officer.

Work Performed

- Manages and oversees MCNA's emergency management plan in coordination with MCNA's Chief Information Officer.
- Ensures continuity of benefits and services for members who may experience evacuation to other areas of the state or out of state during disasters.
- Tests documented disaster recovery strategies and plans.
- Reports a summary of testing activities to the Board of Directors.
- Conducts and oversees contingency plan integration and operations.
- Analyzes data to identify trends, patterns, or warnings that indicate threats to the security of people, assets, information, or infrastructure.
    - Assesses risks to business operations.
    - Analyzes business or financial data.
- Establishes, maintains, and tests "call trees" to ensure appropriate communication during disaster.
- Ensures all MCNA staff and subcontractors are trained on MCNA's Disaster Recovery and Business Continuity Plan.

Minimum Qualifications

- Bachelor's degree required, MBA preferred.
- Five or more years of experience building and executing disaster recovery and business continuity plans.

Claims Administrator

Purpose of Position

In coordination with MCNA's Claims Director, the Claims Administrator is responsible for developing, implementing, and administering a comprehensive Nebraska Medicaid Managed Care claims processing system capable of paying claims in accordance with state and federal requirements and the terms of the contract. Responsible for handling escalated claims and issues.

Reports To

This position reports directly to the Nebraska Operations Manager.

Responsibilities

- Develops cost avoidance processes.
- Meets claims processing timelines.
- Ensures minimization of claims recoupments.
- Meets MLTC encounter reporting requirements.
- Processes highly complex claims.
- Handles escalated claims and issues.
- Alerts senior management when inventory levels are increasing or when timeliness is lagging.
- Provides recommendations for workflow and inventory reduction.
- Assists examiners by responding to questions and providing explanation of claims policies.
- Works on projects and new processes as requested by senior management.
- Fosters an environment that values courtesy and respect for all team members.
- Adheres to all corporate and departmental policies and procedures.
- Other duties as assigned.

Minimum Qualifications

- High School Diploma or equivalent required.
- Associates degree preferred.
- Dental Coding experience, knowledge of CDT codes preferred.
- A minimum of two years of dental claims processing experience preferred.
- Experience in a managed care or dental organization preferred.

Knowledge and Skills

- Ability to read, analyze, and interpret state and federal laws, rules, and regulations.
- Ability to work well both independently and with others.
- Strong interpersonal skills.
- Excellent written and oral communication.
- Ability to maintain confidentiality.
- Ability to operate standard office equipment including, but not limited to, computers, fax machines, and copiers.
- Superior organizational, analytical, and problem-solving skills required.

Contract Compliance Coordinator

Purpose of Position

In coordination with MCNA's Chief Compliance Officer, the Contract Compliance Coordinator is responsible for planning, directing, and coordinating activities to ensure MCNA remains compliant with the Nebraska contract.

Reports To

This position reports to the Chief Compliance Officer and the Nebraska Executive Director.

Work Performed

- Coordinates the preparation and execution of contract requirements.
- Coordinates the tracking and submission of all contract deliverables.
- Answers inquiries from MLTC.
- Coordinates and performs random and periodic audits and ad hoc visits.
- Maintains documentation of compliance activities, such as complaints received or investigation outcomes.
- Conducts or directs the internal investigation of compliance issues.
- Identifies compliance issues that require follow up or investigation.
- Provides employee training on compliance-related topics, policies, or procedures.
- Verifies that all company and regulatory policies and procedures have been documented, implemented, and communicated.

Minimum Qualifications

- Bachelor's degree or equivalent work experience required.
- Five or more years of experience in healthcare contract management preferred.
- Experience conducting audits, preparing reports, and participating in committees preferred.

Dental Director

Purpose of Position

The Nebraska Dental Director is a State of Nebraska licensed dentist. This position is appointed by the Board of Directors and is responsible for providing oversight and direction to the Quality Improvement Committee and the Utilization Management Program and Committee, as well as other MCNA committees and programs as deemed necessary for the operation of the plan, including the Grievances and Appeals and the Credentialing committees. The Nebraska Dental Director is available Monday - Friday, between 8 am and 5 pm, CST, for Utilization Review decisions. Authorized and empowered to represent MCNA regarding clinical issues, utilization review, and quality of care inquiries. Responsible for the oversight and management of MCNA's Clinical Reviewers for the State of Nebraska, as well as the implementation of policies and procedures and monitoring the dental care delivery system.

Reports To

This position reports to MCNA's Chief Dental Officer and the Nebraska Plan President.

Responsibilities

- Responsible for the development, implementation, maintenance, and ongoing monitoring of the Quality Improvement Program, policies, procedures, and committee. Participates in the Quality Improvement Committee (QIC) and all clinically focused Performance Improvement Projects. Serves as co-chairman of the QIC.
- Responsible for the clinical oversight of the Utilization Management Program, policies, procedures, and committee. Performs annual review and approval of the Medical Necessity Criteria and staff clinical decision tools.
- Oversees and performs periodic evaluations of all Dental Clinical Reviewers as directed by corporate policies and procedures to ensure appropriate clinical decision making.
- Maintains a working knowledge of applicable federal and state regulations.
- Ensures all dental management activities are performed in accordance with applicable licensing, regulatory, and accreditation standards and requirements.
- Responsible for making the final decision to deny any service authorization requests or to authorize a service in an amount, duration, or scope that is less than requested.
- Participates in Nebraska Medicaid Program Integrity meetings to review and discuss investigations, compliance, prevention, and other program integrity-related activities.
- Other required duties and responsibilities as deemed necessary and appropriate for the plan.

Minimum Qualifications

- A current, unrestricted Nebraska dental license required.
- Ten or more years of clinical practice required.
- Five or more years of dental management responsibility preferred.
- Extensive knowledge of managed care companies and healthcare regulations required.

Encounter Data Quality Coordinator

Purpose of Position

The Encounter Data Quality Coordinator is responsible for organizing and coordinating services and communication between MCNA administration and MLTC for the purpose of identifying, monitoring, and resolving encounter data validation and management issues.

Reports To

This position reports directly to the Chief Information Officer.

Work Performed

- Serves as MCNA's encounter expert to answer questions, provide recommendations, and participate in problem solving and decision making related to encounter data processing and submissions.
- Analyzes activities related to the processing of encounter data and data validation studies to enhance accuracy and output.
- Supports interfaces between business systems.
- Acts as a technical contact for external trading partners on encounter-related issues, questions, and activities.
- Identifies problems with encounter processes and works with other technical and/or business resources as necessary to troubleshoot application problems.
- Oversees day-to-day encounter processes to identify and address problems as they arise and to track levels of activity in order to compile and track metrics for senior management.
- Works with business analysts and other IT team members to define requirements for applications supporting MCNA.
- Provides technical support to less experienced staff as needed.

Minimum Qualifications

- Bachelor's degree in Computer Science, Management Information Systems, or related field preferred.
- In lieu of a degree, an equivalent combination of education or equivalent work experience required.
- A minimum of three years of experience with EDI and data translation tools required.
- Experience with SQL and relational databases, or experience with multi-tiered client-server and web-based applications preferred.
- Knowledge of HIPAA transactions.
- Demonstrated ability to accurately interpret computer-issued error messages and take appropriate action.

Executive Director

Purpose of Position

The Executive Director of the Nebraska plan provides leadership for the development and alignment of all MCNA activities in the Nebraska market. The Executive Director is a key member of the MCNA executive management team. Authorized and empowered to represent MCNA regarding all matters pertaining to the Nebraska contract. Acts as the liaison between MCNA and MLTC.

Reports To

This position reports directly to the Nebraska Plan President.

Responsibilities

- Ensures compliance with the terms of the contract, including securing and coordinating the resources necessary for such compliance.
- Receives and responds to all inquiries and requests made by MLTC related to the contract, in the time frames and formats specified by MLTC.
- Attends regular meetings and participates in conference calls with MLTC.
- Promptly resolves any issues related to the contract that are identified by MCNA or MLTC.
- Attends meetings with MLTC representatives on a periodic or ad hoc basis to review MCNA's performance and resolve issues.
- Meets with MLTC at the time and place requested, if MLTC determines that MCNA is not in compliance with the requirements of the contract.
- Attends Nebraska Medicaid Program Integrity meetings with MCNA's Program Integrity Officer and the Nebraska Dental Director to review and discuss investigations, compliance, prevention, and other program integrity-related activities.
- Participates in, and ensures other key staff members participate in, business reviews as requested by MLTC, and ensures MCNA is prepared to participate pursuant to an MLTC-developed agenda and/or presentation template.

Minimum Qualifications

- Bachelor's Degree required.
- In lieu of degree, six or more years of relevant experience required.
- Extensive experience and expertise working with the populations served by the Medicaid Program required.
- Outstanding presentation and communication skills.
- Strong commitment to the professional development of staff with a successful track record of recruiting and retaining a diverse team.
- Knowledge of leadership and management principles as they relate to managed care.
- Knowledge of current community challenges and opportunities relating to the mission of the Nebraska Medicaid Dental Benefits Program.

Finance Manager

Purpose of Position

The Finance Manager will have direct responsibility for oversight of all financial related activities, including audit activities, accounting systems, financial reporting, and budgeting for the company's Nebraska plan.

Reports To

This position reports directly to the Chief Financial Officer and the Chief Executive Officer.

Responsibilities

- Oversees all of MCNA's financial-related activities, including audit activities, accounting systems, financial reporting, and budgeting.
- Provides leadership in the development of short and long-term strategic financial objectives.
- Evaluates and advises on the impact of long range planning, introduction of new programs/ strategies and regulatory action.
- Provides executive management with advice on the financial implications of business activities.
- Provides the Management Team with an accurate operating budget. Works with the team to ensure budget success through cost analysis support.
- Works with the Management Team on the strategic vision including fostering and cultivating stakeholder relationships.
- Trains the Accounting Department and other staff on raising awareness and knowledge of financial management matters.

Minimum Qualifications

- A Bachelor's degree in Accounting or Finance required, preferably accompanied by Certified Public Accountant license.
- A minimum of 3 years of experience in an accounting managerial capacity required.

Grievance System Manager

Purpose of Position

The Grievance System Manager oversees the system for managing and resolving member grievances, appeals, and requests for a fair hearing, and provider grievances and appeals for the State of Nebraska. Ensures that these issues are resolved in compliance with mandatory guidelines as established by state and federal regulatory agencies and accrediting organizations standards, and in accordance with the policies and procedures of MCNA's Grievances and Appeals Department.

Reports To

This position reports to the Director of Grievances and Appeals and the Nebraska Provider and Member Services Manager.

Responsibilities

- Researches and resolves member complaints, grievances, and appeals, as well as provider appeals involving provision of service and benefit coverage issues, ensuring compliance with the policies and procedures of MCNA's Grievances and Appeals Department.
- Contacts members and providers to gather information, communicates disposition of case, and documents interactions.
- Maintains grievances and appeals case files within the Grievance and Appeals module.
- Communicates with members, providers, and contracted health plans verbally or in writing.
- Prepares written summaries and resolution letters using clear and grammatically correct language for members and providers, which include a summary of member grievance or appeal and steps taken to resolve the issue.
- Prepares files for appeals to regulatory agencies.
- Communicates with MLTC to ensure a requested Medicaid Fair Hearing occurs according to contract requirements.
- Maintains current knowledge about all regulatory requirements as they apply to grievance and appeal processes.
- Maintains the confidentiality of all sensitive documents, records, discussions, and other information generated in connection with any grievance or appeal, and makes no disclosures of such information except to persons authorized to receive it in the conduct of business
- Participates in quality improvement activities.
- Participates in grievances and appeals orientation for new employees.
- Collaborates with internal departments such as Member Services, Provider Relations, and Utilization Management during the grievance and appeal processes.
- Oversees the maintenance of grievance and appeal logs and files.
- Other duties as assigned.

Minimum Qualifications

- High School Diploma or equivalent required.
- Bachelor's degree or equivalent combination of college credits and work experience preferred.
- Three to five years of related experience that includes customer service in a managed care environment, medical office, or health insurance organization desired.

Information Management and Systems Director

Purpose of Position

The Information Management and Systems Director is responsible for technological direction within MCNA as it relates to the contract with MLTC. Responsible for proposing budgets for programs and projects, overseeing the purchase and upgrade of software and hardware, supervising the Information Technology (IT) Department, and presiding over all IT-related projects. Serves as a member of the senior management team for MCNA, participates in all strategic planning processes, and shares responsibility for providing leadership in the achievement of its established goals.

Reports To

This position reports directly to the Chief Executive Officer.

Responsibilities

- Establishes and maintains connectivity with MLTC information systems.
- Provides all necessary data reports to MLTC in a timely manner.
- Supervises information system and communications network.
- Designs, establishes, and maintains a network infrastructure for local and wide area connectivity and remote access.
- Consults with administration, department managers, and external representatives to exchange information, present new approaches, and to discuss equipment/system changes.
- Participates as key decision maker in vendor contract negotiations for all new computer equipment and software purchased for MCNA.
- Manages the day-to-day operations of the IT Department including the direction of staff that support administrative computing, networking, user services, telecommunications, and other IT functions.
- Assesses and anticipates technology projects and recommends the appropriate action to be taken and resources to be utilized.
- Establishes and directs strategic and tactical goals, policies, and procedures for the IT Department.
- Proposes hardware and software solutions to accomplish MCNA's business objectives.
- Identifies user needs and resolves problems.

Minimum Qualifications

- Bachelor's degree in Engineering, Computer Science, or other related field of study required.
- Seven or more years of experience in information systems, data processing, and data reporting required.
- Seven or more years of experience as Chief Information/Technology Officer in large organizations, with related accomplishments in oversight of information systems, data processing, and data reporting preferred.

Member Services Manager

Purpose of Position

The Member Services Manager is responsible for coordinating communications between MCNA and Nebraska Medicaid members. Manages the Member Services staff and ensures a sufficient number of Member Services Representatives are available, including sufficient culturally and linguistically appropriate services, to enable members to receive prompt resolution for problems or questions and appropriate education about participation in the Nebraska Medicaid Dental Benefits Program. Provides leadership and guidance to Member Services staff by promoting teamwork, professionalism, and outstanding service.

Reports To

This position reports directly to the Nebraska Operations Manager.

Work Performed

- Responsible for departmental results, identifying performance trends, and managing performance to ensure optimal quality and achievement of performance targets.
- Provides guidance in the hiring, training, and coaching of employees to deliver efficient, quality responses to members.
- Develops, coaches, and motivates Member Services staff to maximize performance, embrace change, and recommend improvement opportunities.
- Provides efficient and effective service by working with call center managers to staff the appropriate number of employees for business hours, operational activities, call volumes, and new business.
- Builds and maintains effective relationships, ensures call center representatives are fully informed of all new information related to procedures and client needs, and serves as the escalation point with clients when necessary.
- Works with call center Quality Assurance team to identify needs and arrange regular training and skill enhancement programs.
- Works with senior management to develop business objectives for the call center.
- Monitors calls, appraises performance, resolves departmental issues, maintains policies and procedures, and prepares and approves all necessary reports
- Other duties as assigned.

Minimum Qualifications

- High School Diploma or equivalent required.
- Associates Degree or equivalent work experience preferred.
- Minimum of five years of Call Center/Contact Center management experience required.

Operations Manager

Purpose of Position

The Nebraska Operations Manager is responsible for managing the day-to-day operations of all MCNA departments, staff, and functions to ensure that performance measures and MLTC and federal requirements are met. Serves as the primary point of contact with MLTC for all operational issues.

Reports To

This position reports directly to the Nebraska Plan President.

Work Performed

- Oversees daily operations of all MCNA functional areas.
- Responsible for overseeing the recruiting, hiring, training, and supervision of all staff.
- Monitors and evaluates staff performance based on quality and productivity measures.
- Establishes performance standards, identifies areas for improved quality and efficiency, and implements and manages change.
- Coordinates resources to establish effective processes for triage, routing, and escalation of issues between various MCNA departments including Claims, Grievances and Appeals, Provider Relations, Utilization Management, Special Investigations Unit, and Case Management.
- Ensures successful tracking and resolution of escalated issues, complicated customer issues, and grievances and appeals received through various channels.
- Oversees all reporting functions and analyzes departmental reports to ensure the successful function of all operational areas.
- Manages disaster recovery and contingency plans for all departments, including emergency preparedness for extreme events, as well as loss of operations at all corporate and regional locations.
- Other duties as assigned.

Minimum Qualifications

- Bachelor's degree or equivalent work experience required.
- Ten or more years of experience in management of day-to-day operations required.
- Dental managed care experience required.
- Experience working with Medicaid and CHIP programs preferred.

Performance and Quality Improvement Coordinator

Purpose of Position

The Performance and Quality Improvement Coordinator is responsible for managing clinical improvement initiatives for MCNA members in Nebraska. Ensures regulatory compliance and promotes improved health care outcomes.

Reports To

This position reports to the Vice President of Dental Management and Quality Improvement and the Nebraska Operations Manager.

Responsibilities

- Serves as MLTC's primary contact for quality performance measures.
- Focuses organizational efforts on the improvement of clinical quality performance measures.
- Utilizes data to develop intervention strategies designed to improve outcomes.
- Develops and implements Performance Improvement Projects.
- Reports quality improvement and performance outcomes to MLTC.
- Participates in the ongoing development of a clinical data repository and dashboard reporting.
- Participates in quarterly Quality Improvement Committee meetings and performs requested follow-up duties.

Minimum Qualifications

- Bachelor's degree or equivalent work experience required.
- Minimum of 10 years of overall professional experience required.
- CPHQ or CHCQM certification or comparable experience and education in data and outcomes measurement as described in 42 CFR 438.200 - 438.242 required.

Program Integrity Officer

Purpose of Position

The Nebraska Program Integrity Officer coordinates with company-wide program integrity personnel to oversee new and ongoing audits, surveys, and reviews. Monitors and investigates program integrity issues regarding the Medicaid Program. Ensures compliance with program integrity legislation, and all regulatory and policy requirements binding upon MCNA. Provides policy direction and recommendations concerning Medicaid Program Integrity requirements that affect business practices and operations.

Reports To

This position reports MCNA's Chief Compliance officer and the Nebraska Executive Director.

Work Performed

- Oversees all activities required by state and federal rules and regulations related to the monitoring and enforcement of the fraud, waste, and abuse (FWA) and erroneous payment compliance program.
- Develops and oversees methods to prevent and detect potential FWA and erroneous payments.
- Develops policies and procedures, investigates unusual incidents, and designs and implements corrective actions plans as necessary.
- Reviews records and refers suspected member FWA to MLTC and other duly authorized enforcement agencies.
- Manages the Special Investigations Unit to communicate as appropriate with Nebraska's Medicaid Fraud Control Unit.

Minimum Qualifications

- Bachelor's degree or equivalent work experience required.
- Experience in a managed care environment or related medical field in such areas as Quality Improvement, Risk Management, Enrollment and Disenrollment, Member Services, Grievance and Appeals, and Credentialing preferred.
- Minimum of three to five years of management experience preferred.

Provider Services Manager

Purpose of Position

The Provider Services Manager oversees MCNA's Provider Relations Department in Nebraska. Responsible for the development and implementation of the policies, procedures, processes, and staff activities that allow MCNA to meet its state and federal requirements and plan accreditation standards.

Reports To

This position reports directly to the Nebraska Operations Manager.

Work Performed

- Manages provider contracting and credentialing services.
- Coordinates communication between MCNA and its subcontracted providers.
- Manages the Provider Relations staff.
- Works collaboratively with MLTC to establish methodologies for processing and responding to provider concerns.
- Develops provider training tools in response to identified needs or changes in protocols, processes, and forms.
- Notifies MLTC of correspondence sent to providers for informational and training purposes.
- Establishes and implements the Provider Relations Department processes, staffing needs, education and training manuals, and overall network functions.
- Serves as the day-to-day liaison between providers and the plan.
- Develops and enhances ongoing methods of and strategies for communication with providers about changes, revisions, issue resolution, and general notices from the plan.
- Establishes network development strategies to ensure compliance with member access and availability requirements, and ongoing member needs.
- Develops reports and ensures all updates, revisions, and analysis is submitted to appropriate internal staff and the Dental Management Committee.
- Develops training and educational manuals and processes, documentation, and reviews.
- Represents MCNA at the Medicaid Fair Hearings.

Minimum Qualifications

- High School Diploma or equivalent required.
- Associates Degree preferred.
- Five or more years of experience in healthcare provider relations as a supervisor or manager preferred.
- Experience in healthcare-related fields, including physician networks, health insurance, governmental regulation of health care companies.
- Experience conducting audits, preparing reports, committee participation.

Tribal Network Liaison

Purpose of Position

The Tribal Network Liaison is responsible for planning and working with Provider Relations staff to expand and enhance dental services for American Indian members in the State of Nebraska.

Reports To

This position reports directly to the Nebraska Member Services Manager and Provider Services Manager.

Work Performed

- Serves as the single point of contact with tribal entities and MCNA staff on American Indian issues and concerns.
- Advocates for American Indian members with case management and member services staff.
- Informs MCNA members of their rights and responsibilities with the plan.
- Assists members in writing and filing grievances and appeals, and monitors progress throughout the grievance and appeal processes.
- Informs members about how to access care and assists them with the referral process.
- Assists members in understanding available community resources and refers them as necessary to help meet their needs.
- Attends health fairs, and enrollment and other community events.
- Conducts member educational meetings regarding benefits, medically necessary covered dental services, and preventive services related to Medicaid and CHIP.
- Provides input to senior management based on interaction with members about actions necessary to improve the quality of dental care provided or the way in which dental care is delivered.

Minimum Qualifications

- Associates degree or equivalent work experience preferred.
- Dental managed care experience required.
- Experience working with communities and American Indian populations preferred.

Knowledge and Skills Required

- Excellent oral, written, networking, and presentation skills.
- Ability to travel and represent MCNA at health fairs, and enrollment and other community events.
- Ability to work on multiple projects under tight deadlines.
- Knowledge of state and federal regulations concerning the use, disclosure, and confidentiality of all patient records.
- Knowledge of Microsoft Office programs.

mcnadental

Member Handbook

Nebraska Dental Medicaid

If you have questions, please call Member Services at **1-844-351-6262** (Toll Free).

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: **1-844-351-6262.**

Welcome to MCNA

Welcome to MCNA Dental (known as "MCNA"). We are a proud provider for the Nebraska Medicaid dental benefits program. MCNA works with the Nebraska Department of Health and Human Services (DHHS) to provide dental services to people enrolled in the Medicaid program.

We are happy to be your dental plan! We have a network of general dentists and specialists to treat you. Our dentists will serve as Primary Care Dentists (PCDs) for all eligible Nebraska Medicaid Dental Benefit Program members.

This handbook has the information you need to access these dental services. Please read it to understand your benefits. The handbook is available in audio, larger print, Braille, and other languages. Call our Member Hotline toll-free at **1-844-351-6262** or email us at **MemberHotlineNE@mcna.net** if you would like another member handbook. If you are deaf or hearing impaired, call the TTY line toll-free at **1-800-833-7352** for help.

Please call MCNA's Member Hotline for help with choosing your child's Primary Care Dentist for regular dental checkups. After you choose your Primary Care Dentist, call their office to schedule your first dental visit. This will help you keep good dental habits.

You can also call the Member Hotline if you would like to change your Primary Care Dentist or need assistance in scheduling an appointment.

Good dental health is important to us. We hope you and your child use the dental benefits provided by MCNA. We look forward to serving you!

MCNA's Member Services

Our Member Hotline is available during normal business hours Monday to Friday, 7 a.m. to 7 p.m., CST (excluding state-approved holidays). MCNA has staff that speaks English and Spanish. We can also help you in other languages.

You can contact our Member Hotline toll-free at **1-844-351-6262** to speak with a Member Services Representative. For the deaf or hearing impaired, please call the TTY line toll-free at **1-800-833-7352.** 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.

Our Member Services Representatives will answer any questions you may have and give you information on:

- MCNA policies and procedures
- Prior authorizations
- How to access information
- MCNA's covered services and limitations
- Choosing a dentist/dental home
- Changing to another dentist/dental home
- Referrals to participating specialists
- Resolution of problems with dental services and how they are delivered
- Scheduling appointments
- Filing a grievance or appeal
- Getting help in a dental emergency

MCNA has Member Advocates that can help you file grievances and appeals. They will also help you during the grievances and appeals process. You can speak with a Member Advocate by calling our Member Hotline.

Health Education and Promotion

Our Member Services Representatives 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's Member Services

MCNA has many oral health educational materials that promote good oral health and hygiene. We attend many health fairs and community events where we hand out these flyers. You can get these flyers by calling our Member Hotline. You can also download them from MCNA's main website (**www.mcna.net**). Games, puzzles, and videos about oral health are available in MCNA's Kids Zone on the website.

MCNA makes and gives out educational materials at least twice a year. Many are included in your Member Welcome Packet. They help our members learn about dental care, oral health promotion, or other related topics.

You can request an MCNA Member Welcome Packet at least once per year. We will let you know of any changes to important information at least 30 calendars days before the changes take place.

Important Resources

MCNA Member Services

- **Hours of Operation:** Monday – Friday, 7 a.m. – 7 p.m., CST
  (Excluding state-approved holidays)
- **Toll-Free Member Hotline:** 1-844-351-6262
- **Hearing Impaired (TTY):** 1-800-833-7352
- **MCNA Fraud Hotline:** 1-855-392-6262
- **Website:** www.mcnane.net
- **Mailing Address:** 200 West Cypress Creek Road, Suite 500, Fort Lauderdale, Florida 33309

Nebraska Medicaid Customer Service Center

- **Toll-Free Phone Number:** 1-855-632-7633
- **Lincoln Local Calls:** 1-402-473-7000
- **Omaha Local Calls:** 1-402-595-1178
- **Hearing Impaired (TTY):** 1-402-471-7256
- **Website:** http://www.dhhs.ne.gov

Office of Inspector General (OIG)

- **Toll-Free Fraud Hotline:** 1-855-460-6784

Other Useful Numbers

- **To find assistance with non-covered dental services in your area:** 2-1-1
  (Financial help, low-cost services)
- **For emergency services:** 9-1-1
- **Nebraska Relay Service:** 7-1-1
  (Call if you have lost your hearing or if it is hard for you to hear)

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Eligibility

The Nebraska Department of Health and Human Services (DHHS) will give you information on:

- Medicaid Eligibility
- Enrollment
- Disenrollment
- Other State Programs
- Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Can I be taken out of the Medicaid Dental Benefits Program?

You may be taken out of the Medicaid Dental Benefits Program if you lose Medicaid eligibility. You may be unable to get Medicaid for one of the following reasons:

- You permanently move out of the state
- You or your authorized representative requests (in writing) to leave the program (voluntary disenrollment)
- You become an inmate in a public institution
- You intentionally submit fraudulent information
- You allow someone else to use your member ID card
- A hearing officer makes a decision about you in response to an appeal or as ordered by a court of law
- In the event of your death

If you have a major change in your life, please visit your local eligibility office or call the Medicaid Customer Service Center within 10 days of the change at **1-855-632-7633**. You can also call our Member Hotline at **1-844-351-6262**.

Some examples of changes are:

- A change in your name
- A move to a different address
- A change in the size of your family
- A change in your job
- A change in ability/disability
- A move out of state

If you have questions about your Medicaid dental benefits, please call our Member Hotline at **1-844-351-6262**. For questions about eligibility, please call the Medicaid Customer Service Center toll-free at **1-855-632-7633.**

Eligibility

The Department of Health and Human Services will also help you:

- Understand your rights and covered services
- Advocate for you
- Resolve problems, including access to care

What if I am no longer eligible for Medicaid?

You will be disenrolled from MCNA if you are no longer eligible for Medicaid. If you lose eligibility but become eligible again within 6 months or less, you will be automatically re-enrolled. You will be assigned to the same Primary Care Dentist as you had before. To find out more, call our Member Hotline toll-free at **1-844-351-6262.**

Member ID Cards

When you become eligible for Medicaid, MCNA will provide you with a member ID card. This is the card you will use to access your dental benefits. Remember to bring the ID card to all of your dental appointments.

This card has important information about your dental benefits:

- Only you can use your member ID card for dental services.
- No one else can use your member ID card to get services. If so, that person will be charged for the services he or she receives.
- MCNA may not be able to keep you in the plan if someone else uses your member ID card.

How to Use Your Card

To use your member ID card:

- Have your ID card ready when calling the Member Hotline.
- Take your ID card with you when you go to the dentist.
- Show your ID card when you see the dentist. The dentist needs your ID card to check eligibility and benefits.

How to Replace Your Card if Lost

If you lose your member ID card, call MCNA toll-free to get a new one:

- Member Hotline: **1-844-351-6262**
- Hearing Impaired: **1-800-833-7352**

Member ID Cards

Who to Call in an Emergency

If you have an emergency and you feel your life is in danger, call 911. If you do not feel that your life is in danger but need help with a dental emergency, please call your Primary Care Dentist during normal business hours. Your dentist will tell you how to get emergency dental services. If you need emergency dental services after the Primary Care Dentist's office has closed, do one of the following:

- **Call your Primary Care Dentist**. The office answering service will instruct you on how to get in touch with your dentist.
- **Call 911.** You can also go to the closest hospital or urgent care center.

Benefits

What are my dental benefits with Medicaid?

Your benefits are listed below. These services must be medically necessary. They must also be:

- Carried out or handled by an MCNA dentist, or
- Carried out or handled by Indian Health Services/Tribal 638/Urban Indian Health (I/T/U) providers

Preventive Services

- Prophylaxis
- Topical Fluoride
- Sealants
- Space maintainers (passive appliances)
- Recementation of space maintainers

Diagnostic Services

- Oral evaluations
- Radiographs
- Diagnostic casts

Restorative Services

- Amalgam or resin fillings
- Crowns - resin
- Crowns - porcelain
- Recement inlay
- Recement crown
- Prefabricated stainless steel crowns
- Prefabricated stainless steel crowns with resin window
- Sedative fillings
- Core buildup - including pins
- Pin retention
- Prefabricated post and core in addition to crown
- Temporary crown
- Crown repair
- Therapeutic pulpotomy and pulpal therapy
- Root canal therapy and re-treatment of previous root canals
- Apicoectomy
- Emergency treatment to relieve endodontic pain
- Unspecified restorative procedures

Benefits

Periodontic Services

- Gingivectomy or Gingivoplasty per tooth or per quadrant
- Periodontal scaling and root planing
- Full mouth debridement
- Periodontal maintenance procedures

Prosthodontic Services

- Complete dentures (maxillary and mandibular)
- Immediate dentures (maxillary and mandibular)
- Maxillary partial resin base
- Mandibular partial resin base
- Maxillary partial cast metal base
- Mandibular partial cast metal base
- Adjustments – dentures and partials
- Repairs to dentures and partials
- Rebase of dentures and partials
- Reline of dentures and partials
- Interim dentures (maxillary and mandibular)
- Flipper Partial Dentures (maxillary and mandibular)
- Tissue conditioning
- Recement fixed partial denture

Oral and Maxillofacial Surgery

- Extractions-routine and surgical
- Tooth reimplantation and/or stabilization of an accidentally evulsed or displaced tooth and/or alveolus
- Surgical exposure of impacted or unerupted tooth for orthodontic reasons
- Biopsy of oral tissue (hard or soft)
- Alveoplasty
- Excisions
- Occlusal orthotic device

Orthodontic Services

- Orthodontic treatment
- Removable and fixed appliance therapy (thumb sucking and tongue thrust)
- Repair of orthodontic appliances
- Orthodontic retainers (replacement)
- Repair of bracket and standard fixed orthodontic appliances

Benefits

Adjunctive General Services

- Palliative treatment
- General anesthesia
- Analgesia, anxiolysis, inhalation of nitrous oxide
- Intravenous sedation/analgesia
- Non-intravenous conscious sedation
- House call (nursing facility call), hospital call, ambulatory surgical center (ASC) call
- Office visit – after regularly scheduled hours
- Occlusal Guard

Cosmetic dental procedures are not covered as a benefit and/or service.

Some services may require prior approval. Your dentist will contact MCNA when prior approval is required.

Benefits

How do I get these services?

Your Primary Care Dentist (PCD) can give you these services or arrange for you to get the dental care you need. After choosing a Primary Care Dentist you should:

- Call your PCD to schedule an appointment.
- Tell the PCD you are covered by Nebraska Medicaid.
- Make sure the dentist is an MCNA network dentist for the Nebraska Medicaid Dental Benefits Program.
- Visit your PCD regularly for checkups.
- Follow your PCD's instructions for brushing and flossing.

What services are not covered?

The following services are not covered for members under the Nebraska Medicaid Dental Benefits Program:

- Services that are not medically necessary
- Dental care for cosmetic reasons
- Experimental procedures, unless approved by DHHS
- Plaque control
- Certain types of x-rays
- Routine post-operative services – these services are covered as part of the fee for initial treatment provided.
- Treatment of incipient or non-carious lesions (other than fluoride)
- Dental expenses related to any dental services:
    - Started after the member's coverage ended
    - Received before the member became eligible for these services
- Prescriptions or drugs
- Administration of in-office pre-medication

How much do I have to pay for dental care?

Members under age 21 do not have to pay for Medicaid medically necessary covered dental services. You will have to pay for the following services:

- Non-covered or optional services you choose to have done
- Services provided by an out-of-network dentist
- Services received before dental coverage with the Nebraska Medicaid Dental Benefits Program starts

Dental coverage is limited to $1,000 per fiscal year for individuals aged 21 and older.

Benefits

What if I have other insurance coverage?

If you have other insurance coverage, that insurance is considered primary. Please tell MCNA about your other insurance coverage by calling our Member Hotline at **1-844-351-6262**

Your dentist must file your claim with the primary insurance first. Then your dentist will file your claim with MCNA as secondary. MCNA will pay up to MCNA's allowed fee after your primary insurance has paid their portion.

If you have coverage through Indian Health Services or a Tribal plan, your dentist should always file your claim with MCNA first. In this instance, MCNA is your primary insurance.

How do I get drugs the dentist has ordered for me (prescriptions)?

Prescriptions are not covered under this program. You may want to contact the DHHS or your health plan to see if they can help you by covering prescriptions.

Dental Providers

What do I need to bring when I go to the dentist?

You must take your member ID card. You will need to show them your ID card each time you go to the dentist. If you have other dental coverage, bring that information to show your dentist.

What is a Dental Home?

A Dental Home is a dentist assigned to each member by MCNA. This dentist is called your Primary Care Dentist (PCD). A PCD can be a general dentist of pediatric dentist. You can choose a PCD from our network of dentists. If you do not choose one, MCNA will assign one for you. This dentist will provide regular dental care that prevents problems with teeth and gums. You should see your PCD every 6 months.

What is a Primary Care Dentist?

A Primary Care Dentist can be a general dentist or a dentist who only treats children. This is the dentist who gives you services that prevent problems with your teeth. If you already have a problem with your teeth, this dentist can treat it in most cases. Your PCD can send you to a specialist for problems that are harder to fix. A member with special health care needs can choose a specialist as their PCD.

How can I find a dentist?

Look in your MCNA Provider Directory to find a list of dentists in your area. You can choose any dentist listed in the directory. This directory will also give you information about each dentist such as:

- Office telephone number
- Office address
- Dentist practice name
- Type of practice

If you need help finding a dentist, you may call our toll-free Member Hotline at **1-844-351-6262**. You may also go to our website at **http://www.mcnane.net** to find a dentist using our online Provider Directory. You can view dentist information such as:

- Dentist or office name
- The language that the dentist or office speaks
- The ages that the dentist treats
- Dentists that are accepting new patients
- Office address
- Office telephone number
- Office hours

Dental Providers

Please call our toll-free Member Hotline at **1-844-351-6262** for a complete listing of all dentists in your area. You may also ask for a printed copy of the entire MCNA Provider Directory and we will send it to you by regular mail.

At what age can an MCNA member start seeing a Primary Care Dentist?

An MCNA member can start seeing a Primary Care Dentist as early as 6 months of age.

What are in-network and out-of-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.

Can a Rural Health Clinic/Federally Qualified Health Center be my Primary Care Dentist?

Yes. Rural Health Clinics/Federally Qualified Health Centers (RHCs/FQHCs) can be your Primary Care Dentist.

How can I change my Primary Care Dentist?

You can change your Primary Care Dentist at any time by calling us toll-free at **1-844-351-6262**. You can also write to us:

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

How many times can I change my Primary Care Dentist?

You can change your Primary Care Dentist as many times as you like. Look in your MCNA Provider Directory to find a new dentist or call our Member Hotline toll-free at **1-844-351-6262.**

If I change my Primary Care Dentist, when can I start getting services from that dentist?

You can start getting services from your new Primary Care Dentist immediately. Once the change has been made, call your new Primary Care Dentist to schedule an appointment.

Dental Providers

Is there any reason I might be denied if I ask to change my Primary Care Dentist?

We might turn down your request for one of the reasons listed below:

- The Primary Care Dentist you want to change to is not accepting new patients.
- The Primary Care Dentist you want to change to does not provide the types of dental services you need.

Can a Primary Care Dentist ask to move me to another Primary Care Dentist?

You can be moved from one Primary Care Dentist to another for one of the reasons listed below:

- If you do not follow the dentist's advice
- If you are repeatedly loud or disruptive while in the dentist's waiting room or treatment area
- If you are a "no show" for more than 1 dental appointment
- If your relationship with your Primary Care Dentist is not working for either you or the dentist

Can I go to another dentist who is not my Primary Care Dentist?

No, your Primary Care Dentist will provide you with preventive care and will refer you to a specialist as needed. You will need a referral from your Primary Care Dentist to see a specialist.

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

MCNA's plan begins in Nebraska on July 1, 2017. You will be able to continue to see your current Primary Care Dentist for up to 90 days after that. After 90 days has passed you must see a Primary Care Dentist enrolled in MCNA's network. If you have special health care needs, you may be able to continue to see your current Primary Care Dentist for longer than 90 days.

Please call our toll-free Member Hotline at **1-844-351-6262** for more information. We will tell you about continuing care with your current Primary Care Dentist and give you information about MCNA's Member Advocates. You may also choose a new Primary Care Dentist by calling the hotline.

Dental Providers

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. We will send the letter within 15 calendar days of when your dentist tells us they are leaving. If that happens, MCNA will assign you to a new Primary Care Dentist. In some cases, we may allow your old dentist to keep treating you for up to 30 days after they leave our network, or until you care is done We may do this if you are being treated for a serious dental problem.

Please call our toll-free Member Hotline at **1-844-351-6262** if you want to change the Primary Care Dentist we assign for you. You can choose any dentist in the MCNA network as long as the dentist is accepting new patients. Please visit our online Provider Directory or call our Member Hotline for help finding a new dentist. Do you have a favorite dentist that is not an MCNA network dentist? Please tell us. We can ask them to join the plan.

We encourage you to ask your previous dentist to forward your dental records to your new Primary Care Dentist so they know about the care you have received.

What if I choose to go to a dentist that is out of MCNA's network?

If MCNA does not have a dentist in your area to treat you, you will be allowed to receive Medicaid covered dental services from an out-of-network dentist at no cost to you. Please call our toll-free Member Hotline at **1-844-351-6262** for help finding a dentist near you. If we cannot find an in-network dentist to treat your covered dental condition, we will help you find an out-of-network dentist.

If MCNA has an in-network dentist in your area but you choose to go to an out-of-network dentist, you will have to pay for services not authorized by MCNA, except for emergency care.

Dental Providers

What if I choose to go to a dentist that does not accept MCNA members?

You will have to pay for any dental services that you receive from a dentist that does not accept MCNA members.

How do I make, change, or cancel a dental appointment?

You can call your Primary Care Dentist's office and tell them that you would like to make, change, or cancel an appointment.

You can also call MCNA's toll-free Member Hotline at **1-844-351-6262** and a Member Services Representative can help you make, change, or cancel an appointment.

Do I need to cancel my appointment if I cannot make it to the dentist at the scheduled time?

It is very important that you call your Primary Care Dentist's office to cancel if you cannot make it to a scheduled appointment. If you do not cancel the appointment you will be considered a "no show."

If you repeatedly fail to cancel appointments and become a chronic "no show" patient, your Primary Care Dentist may request that you select another dental provider.

How do I get dental care after the dentist's office is closed?

If you need of dental care after the office is closed and it is not an emergency, you can call the dentist's office and leave a message with the answering service. The dentist's staff will call you back when the office reopens. You can also contact our Member Hotline toll-free at **1-844-351-6262** for information about providers in your area that may have evening or more convenient office hours.

Dental Care and Services

What is routine dental care?

Routine dental care includes:

- Diagnostic and preventive visits
- Therapeutic services such as fillings, crowns, root canals, and extractions

What is preventive dental care?

Preventive dental care helps you maintain good oral health. It prevents or reduces future problems with teeth and gums. Praventive dental care includes:

- Regular dental exams
- Routine cleanings
- Fluoride therapy
- Dental sealants
- X-rays
- Patient education
- Good dental care habits at home

What is fluoride therapy?

Fluoride therapy is when the dentist puts fluoride on teeth. Fluoride protects teeth against cavities and keeps them strong.

What does "medically necessary" mean?

Medically necessary is the standard for deciding whether the Medicaid Dental Program will cover a dental service for you. Services must be:

- Necessary to meet your basic health needs.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service.
- Consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies.
- Consistent with the diagnosis of the condition.
- Required for means other than convenience for you or your provider (dentist).
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency.
- Of demonstrated value.
- No more intensive level of service than can be safely provided.

Dental Care and Services

How often should I see my dentist for routine checkups? How soon can I expect to be seen?

You should see the dentist for a routine checkup every 6 months. When you call the office to ask to see the dentist, you should be scheduled for appointments to be seen:

- Within 24 hours for urgent care
- Within 6 weeks (42 days) for routine, non-urgent, or preventive care

What is EPSDT?

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program helps children and young adults under the age of 21 receive regular health care services. These services keep children and teens healthy.

It is important for children to start getting health care at an early age. Children can receive dental and medical care, and vision and hearing testing through EPSDT. Immunizations are also a part of the program. If you have any questions about EPSDT dental services, call our Member Hotline at **1-844-351-6262.** Please contact Medicaid Customer Service at **1-855-632-7633** for questions about all other EPSDT services.

What if I need routine dental care or emergency dental services when I am out of town or out of Nebraska?

If you need routine dental care when traveling, call us toll-free at **1-844-351-6262** and we will help you find a dentist.

If you need emergency dental services while traveling, go to a nearby hospital or urgent care clinic.

What if I need dental services when I am out of the country?

The Medicaid Dental Program does not cover dental services performed out of the country.

What do I have to do if I move?

As soon as you have your new address, contact the Medicaid Customer Service Center at **1-855-632-7633** to let them know.

You can also call MCNA's Member Hotline toll-free at **1-844-351-6262**.

Dental Care and Services

What if I get a bill from my 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 our Member Hotline for help at **1-844-351-6262.**

What information will they need?

Please have your member ID card and the bill you received from your dentist ready when you call. You will need to tell us who sent you the bill, the date of service, the amount of the bill, 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 dentist, or disagree with their opinion about your treatment plan. You can get a second opinion at no cost from another MCNA dentist or an out-of-network dentist for any reason including:

- You are not sure if the treatment is reasonable and necessary
- Your dentist cannot diagnose the problem
- You have questions about the work your dentist wants to do
- You think that the suggested treatment may harm you
- The treatment you are currently getting is not helping

Call our Member Hotline toll-free at **1-844-351-6262** if you need help getting a second opinion.

How do I get covered services approved?

If the dentist thinks you need services that require approval and you meet the requirements for coverage, the dentist will send MCNA a request (prior authorization) before you can get the service. MCNA will accept your request for care through the Member Hotline or in writing, and we will refer you to a dentist for evaluation. 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 process takes 14 calendar days for regular requests, and less than 72 hours for an expedited request.

We will let your dentist know if we approve the request. The dentist will contact you to make an appointment. We will tell you and your dentist if we deny or limit the services.

If you would like to check the status of your dentist's request, call our Member Hotline toll-free at **1-844-351-6262.**

Emergency Dental Services

How do I get urgent dental care and who do I call?

You can see any dentist in MCNA's network for urgent care. Your dentist will tell you how to get urgent care, including how to call and reach an MCNA network dentist 24 hours a day, 7 days a week. You should receive urgent care within 24 hours after you call.

If you do not have a dentist, you can call MCNA's Member Hotline at **1-844-351-6262** or visit **http://www.mcnane.net/find-dentist** to find a dentist and location where urgent dental care is provided.

What kinds of things may need urgent care?

You may need to get urgent care if you have pain, if there is infection, or if there is something that you think the dentist needs to see or look at right away.

What if I need urgent care and I can't find a dentist?

Call MCNA's Member Hotline. If you can't find an in-network dentist and you need urgent care we will find an out-of-network dentist to treat you.

What is an emergency dental condition?

An emergency dental condition is a dental or oral condition that requires immediate treatment for relief of symptoms and stabilization of the condition. Some examples are:

- Severe pain
- Hemorrhage (severe bleeding)
- Acute infection
- Traumatic injury to the teeth or gums
- Unusual swelling of the face or gums

What if I have a dental emergency?

If you have a dental emergency, you can receive care at any hospital emergency room or urgent care clinic. The hospital or clinic does not need to be in our network. Please call your Primary Care Dentist's office first. If you cannot reach your dentist after hours, call 911 or go to any hospital or urgent care clinic. You can also call MCNA for help. You do not need approval for a dental emergency.

You may need dental care after the emergency. This care does not need approval. These services will be covered by MCNA. You can call our Member Hotline at **1-844-351-6262** and we will help you to get the care that you need.If you had an emergency, call MCNA to let us know. We will need to pay the dentist who treated you.

Emergency Dental Services

When should I go to the emergency room or call 911?

You should try to see your Primary Care Dentist first. If they cannot see you, go to the emergency room if you have hurt your mouth or jaw. You should also go if you have severe pain.

Other reasons to go to the emergency room are listed below:

- Bleeding in the mouth that will not stop
- Swelling under or on the tongue
- Swelling of the face with pain
- Pain in the jaw after a hit to the jaw
- Pain when the jaw is opened or closed

Call your Primary Care Dentist if you have questions about going to tha hospital. You should always try to see your Primary Care Dentist first before going to a hospital for a dental emergency. You can also call MCNA's Member Hotline at **1-844-351-6262** for help.

Who can see a special dentist (specialist)?

All Medicaid Dental Program members can see a specialist.

What if I need to see a special dentist (specialist)?

Your Primary Care Dantist will give you a raferral so you can go to a specialist.

MCNA has dental specialists in all areas of Nebraska. If your Primary Care Dentist thinks specialty care is needed, you will be sent to an MCNA specialist in your area.

How do I get specialty services approved?

If you need special dental 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 14 calendar days for regular requests, and less than 72 hours for an expedited request.

We will let your Primary Care Dentist know if we approve the request. The dentist will contact you to make an appointment. We will tell you and your dentist if we deny or limit the services.

If you would like to check the status of your dentist's request, call our Member Hotline toll-free at **1-844-351-6262.**

Dental Specialists

What dental services do not need a referral?

Any services done by your Primary Care Dentist do not need a referral.

What if I am getting treatment for a dental condition from a specialist when I am enrolled?

You may be getting treatment from a specialist for a dental condition that was approved by the Nebraska Department of Health and Human Services or your previous dental plan. To make sure your care does not stop, we will allow you to keep seeing your specialist for medically necessary covered services:

- For 30 days after you become an MCNA member, or
- Until you see your new MCNA dentist.

Call our Member Hotline toll-free at **1-844-351-6262** for help.

Interpreters

Can someone interpret for me when I talk with my dentist?

Yes. You may talk with your dentist in the language you prefer. Call MCNA's Member Hotline toll-free at **1-844-351-6262** to let us arrange oral interpretation services for you.

Who do I call for an interpreter?

If you need an interpreter when you go to the dentist, call our Member Hotline toll-free at **1-844-351-6262**. MCNA will provide oral interpretation services for you free of charge.

Member Rights and Responsibilities

Member Rights

- You have the right to be treated with respect and with due consideration for your dignity and privacy.
- You have the right to participate in decisions regarding your healthcare, including the right to refuse treatment and the right to express preferences about future treatment decisions.
- You have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulations.
- You have the right to be able to request a copy of your medical records (one copy free of charge) and request that they be amended or corrected.
- You have the right to receive healthcare services that are easy to access. These services should be comparable in amount, duration, and scope to those provided under Medicaid Fee-for-Service. They should be sufficient in amount, duration, and scope to reasonable be expected to achieve their purpose.
- You have the right to receive services that are appropriate and are not denied or reduced because of diagnosis, type of illness, or dental condition.
- You have the right to receive all information, like enrollment notices, informational materials, instructional materials, and available treatment options and alternatives in a way that is easy to understand.
- You have tha right to receive assistance from the Nebraska Department of Health and Human Services in understanding the requirements and benefits of MCNA.
- You have the right to receive oral interpretation services for free and in all non-English languages, not just those that are the most common.
- You have the right to be notified that interpretation services are available and how to access those services.
- You have the right to receive information on MCNA's services, to include, but not be limitad to:
    - Benefits covered
    - The way to use benefits, including any authorization requirements
    - Service area
    - Names, locations, telephone numbers of, and non-English language spoken by current network providers, like Primary Care Dantists, specialists, Fedarally Qualified Health Centers, Rural Health Clinics, and hospitals.
    - Any restrictions on your freedom of choice among network providers
    - Providers who are not accepting new patients
    - Benefits not offered by MCNA that are available to you and how to obtain them, including transportation
- You have the right to receive a complete description of disenrollment rights at least once a year.
- You have the right to receiva notice of any major changes in core benefits and sarvices at least 30 days before the intended effective date of the change.

Member Rights and Responsibilities

- You have the right to receive information on grievance, appeal, and State Fair Hearing procedures.
- You have the right to receive detailed information on emergency and after-hours coverage, to include, but not be limited to:
  - What constitutes an emergency medical condition and emergency services, and post-stabilization services.
  - That emergency services do not require prior authorization.
  - The process and procedures for getting emergency services.
  - The locations of any emergency rooms and other places where MCNA has contracted to furnish emergency dental services and post-stabilization services.
  - The right to use any hospital or other setting for emergency care.
  - The rules about post-stabilization services after emergency care.
- You have the right to receive MCNA's policy on referrals for specialty care and other benefits not provided by your Primary Care Dentist.
- You have the right to have your privacy protected according to legal privacy requirements.
- You have the right to exercise your rights without being treated differently by MCNA, our network providers, or the Nebraska Department of Health and Human Services.

Member Responsibilities

You and MCNA both have an interest in seeing your dental health improve. You can help by assuming these responsibilities these responsibilities:

- Present your MCNA member ID card when getting services from your dentist.
- Be familiar with MCNA's procedures to the best of your ability.
- Call or contact MCNA to obtain information and have questions answered
- Let the dentist know any reasons your treatment cannot be followed as soon as possible.
- Live a healthy lifestyle and avoid behavior that can hurt your health.
- Follow the grievance process that MCNA provides for you if you have a disagreement with a dentist.
- Use the preventive dental services that are a part of your benefits.
- Be respectful of the dentist and their staff.
- Be respectful of the rights of other patients.
- Follow the dentist's rules and regulations about patient care and conduct while at the dental office.
- Provide the dentist and their office staff with true and complete information so they can give you proper care.
- Obtain services from only in-network Primary Care Dentists or specialists, except if you have e dental emergency.
- Ask the dentist questions about his or her instructions.
- Ask the dentist about the care you receive.

Member Rights and Responsibilities

- Understand your dental problems and work with your dentist to decide treatment goals.
- Make good decisions about your dental health and avoid things that can damage it.
- Follow the plan of treatment for dental care agreed upon by you and your dentist and/or their staff.
- Make sure that payments for non-covered dental services are fulfilled as soon as possible.
- Report unexpected changes in your dental condition to your dentist.
- Keep all appointments and arrive on time. If you are unable to do so for any reason, call your dentist's office as soon as you can.

If you think you have been treated unfairly or discriminated against, please call MCNA's Member Hotline at **1-844-351-6262**. You can also file your complaint via email at **MemberHotlineNE@mcna.net**.

Complaint and Grievance Process

How can I get help with a problem or a complaint?

If you need help with a problem, we want to help. If you have a complaint, please call us toll-free at **1-844-351-6262**. MCNA's Member Services staff can fix most issues you report. If we cannot find a way to help you within 24 hours, we will send your complaint to our Grievances and Appeals Department.

What is a grievance?

A grievance is when you are not happy with issues other than a denial for services. An example could be when you are unhappy with your dentist or the care you received. MCNA will not treat you any differently if you file a grievance.

Can someone from MCNA help me file a grievance?

Yes, an MCNA Member Advocate can help you file a grievance. Please call our Member Hotline toll-free at **1-844-351-6262** for help. Tell us that you want a Member Advocate to help you file a grievance. You can also get information and griavance forms on our website at www.mcnane.net.

Can someone else file a grievance for me?

Your dentist, your legal counsel, or somaone you name to act for you may file a grievance 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 during the grievance process. You can also get information and complaint forms on our wabsite at www.mcnane.net.

Complaint and Grievance Process

How long will the process take?

You can tell us about a grievance verbally or in writing. We will send you a letter within 10 days. This letter lets you know that we have received your grievance.

We will look at your grievance and make a decision. We will notify you what happened and what we decided. MCNA will take no more than 90 days to make a decision about your grievance.

Call our Member Hotline at **1-844-351-6262** to file a grievance verbally.

To file a written grievance you can send a letter to:

MCNA Dental
Attn: Grievances and Appeals Department
200 West Cypress Creek Road, Suite 500
Fort Lauderdale, Florida 33309

You can give us more information about your grievance at any time during the process. This can be done in person or in writing. You can also ask to add up to 14 calendar days to the process. You can ask for this extra time by writing or calling us.

We can also take an extra 14 calendar days if we need more time to get more information that will help us make a decision in your favor. We will send you a letter if we need extra time. The letter will tell you why we need more time.

You have the right to look at your case file and any other documents involved in the process. To ask to see your case file or to ask for extra time, please call our Member Hotline at **1-844-351-6262**.

If I don't like what happens with my complaint or grievance, who else can I call?

If you are not happy with our answer to your complaint, you can call the Medicaid Customer Service Center toll free at **1-855-632-7633**.

Informal Reconsideration Process

What is an informal reconsideration?

An informal reconsideration is when you ask MCNA to review a request that was made on your behalf for dental services. This request is called a service authorization.

If you are unhappy because MCNA did not approve a service authorization request or approved a reduced amount of the services requested, you have the right to ask for an informal reconsideration.

We will take no more than 1 business day from the date we receive your request for an informal reconsideration to make a decision about it.

How can I ask for an informal reconsideration?

You can request an informal reconsideration by calling our Member Hotline toll-free at **1-844-351-6262.** You can also send a letter to:

MCNA Dental
Attn: Grievances and Appeals Department
200 West Cypress Creek Road, Suite 500
Fort Lauderdale, Florida 33309

There is a deadline for submitting an informal reconsideration request to MCNA. You have 30 calendar days after the date on our letter about your denial (Notice of Action) to make your request. Our dentist who made the original decision will meet with you or your dentist within 1 business day after we receive your informal reconsideration request. You or your dentist can tell us why you disagree with our determination.

We will give you a response at the end of our meeting. Than we will send you a letter within 30 days of when you first requested the informal reconsideration. The letter will tell you what we decided and why.

You have the right to look at your case file and any other documents involved in tha process. Call an MCNA Member Advocate toll-free at **1-844-351-6262** if you would like to look at your file.

Informal Reconsideration Process

Can someone else request an informal reconsideration for me?

Your dentist or someone you name to act for you may request an informal reconsideration with MCNA if they have your permission in writing. We will send you a form that you can sign and return to us. You can also get this form from your dentist or from our website at www.mcnane.net. This form tells us that you give permission to the person you name to represent you during the informal reconsideration process.

If I don't like what happens with my request for an informal reconsideration, who else can I call?

If you are not happy with our answer to your request for an informal reconsideration, you may still be able to file an appeal. You have the option to request an appeal for denial of payment for services in whole or in part. If you are not happy with our decision to deny or limit requested services, call our Member Hotline at **1-844-351-6262** within 60 days from when you get our Notice of Action. Please see the Appeals Process section of this handbook for more information on how to appeal.

Appeals Process

What can I do if MCNA denies or limits a service that my 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 our Member Hotline toll-free at **1-844-351-6262** and ask for an appeal. Your dentist can send us more information to show why you do not agree with our decision. You may send a written appeal to MCNA at this address:

MCNA Dental
Attn: Grievances and Appeals Department
200 West Cypress Creek Road, Suite 500
Fort Lauderdale, Florida 33309

How will I find out if services are denied?

MCNA will send you and your dentist a letter (Notice of Action) letting you know if a covered service requested by your dentist is denied or limited. The letter will list the reason why we denied it. The letter will also tell you about how to file an appeal and your right to ask for a State Fair Hearing.

What are the time frames for the appeal process?

After we receive your appeal in writing, we will send you a letter within 10 calendar 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. We can also extend the deadline if we need more information and the delay is in your best interest. If MCNA needs to extend, we will call you to let you know the reason for the delay. You will also receive written notice of the reason for delay within 2 calendar days.

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 **1-844-351-6262** if you would like to look at your file.

Appeals Process

When can I ask for an appeal?

If you are not happy with our decision to deny or limit requested services, call our Member Hotline at **1-844-351-6262** within 60 days from when you get our Notice of Action.

You have the option to request an appeal for denial of payment for services or authorized services. You also have the right to continue your benefits while your appeal is pending. In order to make sure you continue to receive your current benefits, you must request continued services 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.

How long will I receive current authorized services?

You will continue to receive current authorized services until one of the following occurs:

- You withdraw the appeal;
- Ten (10) calendar days pass after MCNA mails the Notice of Action providing the resolution of the appeal unless you request a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached;
- A State Fair Haaring Officer issues a hearing decision against you; or
- The time period or service limits of a previously authorized service has been met.

You may have to pay for the continued services if the final decision is that MCNA does not have to cover them.

Can someone from MCNA help me file an appeal?

Yes, an MCNA Member Advocate can help you file an appeal. Please call the Member Hotline toll-free at **1-844-351-6262** for help. Tell us that you want to file an appeal. You can also get information and appeal forms on our website at www.mcnane.net.

Can someone else file an appeal for me?

Your dentist, your legal counsel, or someone you name to act for you 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 during the appeal process.

What else can I do if I'm still not happy?

You can request a State Fair Hearing within 120 days after the completion of MCNA's appeals process. Please see the State Fair Hearing section of this handbook for more information.

Expedited Appeals

What is an expedited appeal?

Ask for an expedited appeal when you don't have time to wait for a standard appeal or when your 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 health.

How do I ask for an expedited appeal?

The expedited appeal can be made either verbally or in writing. Call MCNA's Member Hotline toll-free at **1-844-351-6262** for help. You or your 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 72 hours from when we get your appeal. We will also send you a letter telling you our decision. The letter will tell you that you can ask for an expedited State Fair Hearing with the Nebraska Department of Health and Human Services. You will only be able to begin the State Fair Hearing process after you have exhausted MCNA's internal appeal process.

What happens if MCNA says it won't do an expedited appeal?

If MCNA determines that your request does not qualify for an expedited appeal, the appeal will be processed through the normal appeal process. It will be resolved within 30 days

Who can help me file an expedited appeal?

Please call MCNA's Member Hotline toll-free at **1-844-351-6262** and tell us that you want to file an expedited appeal. A Member Advocate will help you file. You can also get information and appeal forms on our website www.mcnaar.net.

State Fair Hearing

Can I ask for a State Fair Hearing?

If you disagree with MCNA's decision, you have the right to ask for a State Fair Hearing. You may name someone to represent you by writing a letter to MCNA telling us the name of that person. 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 120 days of the date on MCNA's Notice of Appeal Resolution. If you do not ask for the fair hearing within 120 days, you may lose your right to a fair hearing. To ask for a fair hearing, you or your representative should call or write a letter to us that includes a completed Department of Health and Human Services Request for State Fair Hearing Form (located on the next page):

MCNA Dental
Attn: Grievances and Appeals Department
200 West Cypress Creek Road, Suite 500
Fort Lauderdale, Florida 33309

You can also ask for a hearing by calling us toll-free at **1-844-351-6262.**

To request a State Fair Hearing directly from the state, send a letter to:

Nebraska Department of Health and Human Services
Division of Legal and Regulatory Services
Legal Services - Hearing Section
P.O. Box 98914
Lincoln, Nebraska 68509-8914

For additional information you can go to the Department of Health and Human Services wabsite at www.dhhs.ne.gov. You can also call **1-855-632-7633**.

Your benefits will not end during the State Fair Hearing unless your Medicaid coverage ends. You may have to pay for the services if the final decision is that MCNA does not have to cover them.

Reporting Fraud and Abuse

What is Waste, Abuse, and Fraud?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other healthcare 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 MCNA member ID card
- Using someone else's member ID card
- Not telling the truth about the amount of money or resources he or she has to get benefits

How do I report Waste, Abuse, or Fraud?

To report waste, abuse, or fraud, choose one of the following:

- Call the Nebraska Medicaid Fraud Hotline toll-free at **1-800-727-6432**
- Complete a Medicaid Fraud and Abuse Complaint Form, which is available online at https://ago.nebraska.gov
- Report directly to MCNA:

  MCNA Dental
  Attn: Special Investigations Unit
  200 West Cypress Creek Road, Suite 500
  Fort Lauderdale, Florida 33309

  MCNA's toll-free Fraud Hotline: **1-855-392-6262**

Reporting Fraud and Abuse

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

Protecting Your Privacy

MCNA is committed to protecting the privacy of our members. We want you to know that we have policies and procedures in place to protect your privacy. We are responsible for protecting the security of your personal health information.

By law we have to:

- Keep your personal health information private
- Tell you about your rights regarding the health information we keep about you
- Tell you how your health information may be used and disclosed
- Tell you how to get access to your information and make changes
- Tell you about a breach of unsecure personal information that affects you
- Give you information about our Privacy Practices

You have the right to ask for a copy of our Notice of Privacy Practices. You can also go to our website at **http://www.mcna.net/en/hipaa** to see it.

Questions or Complaints

You can call MCNA's Member Hotline toll-free at **1-844-351-6262** if you have questions or want to know more about our privacy practices. You can also contact us if you feel your privacy rights were violated.

You can also send us a letter, fax, or email:

- **Mailing Address:** 200 West Cypress Creek Road, Suite 500, Fort Lauderdale, FL 33309
- **Fax:** 1-208-298-3850
- **Email:** **info@mcna.net**

You may also send a written complaint to the U.S. Department of Health and Human Services. You can call our Member Hotline and we will give you the mailing address. If you need help filing a complaint with the U.S. Department of Health and Human Services, you can send an email to the Office of Civil Rights at **OCRMail@hhs.gov** or call 1-800-368-1019.

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.MCNANE.net**.

MCNA Dental

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

www.MCNANE.net

If you have questions, please call Member Services at **1-844-351-6262** (Toll Free).

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Attachment 22-1
Grievances & Appeals Flowchart

This content has been redacted.

Attachment 24-1
Provider Contract Template

MASTER DENTAL PROVIDER AGREEMENT

THIS DENTAL PROVIDER AGREEMENT ("***Agreement***") is made and entered into this ___ day of _____, 20__ (the "***Effective Date***"), by and between _____ (the "***Provider***") and Managed Care of North America, Inc., d/b/a/ MCNA Dental Plans *("**MCNA**").*

WHEREAS, Provider is actively engaged in the practice of dentistry as a primary care or specialty Provider, and is duly licensed and practicing in accordance with the laws of the State;

WHEREAS, MCNA is a duly licensed dental benefits administrator which contracts with MCNA's Affiliate, MCNA Insurance Company, various state agencies and private health insurance plans, to arrange for the provision of covered dental services to children and adults enrolled in commercial health insurance, Medicare, Medicaid and Children's Health Insurance (CHIP) programs;

WHEREAS, MCNA wishes to contract with Provider to provide certain Covered Services to Covered Persons.

WHEREAS, Provider desires to provide the Covered Services specified in this Agreement to Covered Persons for the consideration, and under the terms and conditions, set forth in this Agreement;

NOW, THEREFORE, in consideration of the premises and mutual promises herein stated, the parties hereby agree as follows:

ARTICLE I
DEFINITIONS

In addition to the defined terms highlighted and in bold herein, each of the following terms used in this Agreement and its Attachments, (and the plural thereof, when appropriate) shall have the meaning set forth herein:

"Affiliate(s)" means MCNA Insurance Company, a Texas accident and health insurance company, and any other person or entity controlling, controlled by, or under common control with MCNA.

"Attachment(s)" means the attachment(s) to this Agreement, including product attachments, addenda, and exhibits incorporated herein by reference. Attachments are state specific or product specific, amend or supplement the terms and conditions of this Agreement, and are incorporated herein.

"Clean Claim" has, as to each particular product, the meaning set forth in the Attachment pertaining to each such product. If there is no definition for a particular product, "Clean Claim" shall have the meaning set forth in the Provider Manual.

"Covered Person" means a person eligible for, and enrolled in, MCNA or an Affiliate to receive Covered Services. Covered Person(s) shall include the patient, parent(s), guardian, spouse or any

other legally or potentially legally, responsible person of the Covered person being served.

"Covered Services" means those Medically Necessary dental care services covered under the terms of the applicable Payor Contract and rendered in accordance with the Provider Manual.

"Emergency or Emergency Care" has, as to each particular product, the meaning set forth in the Attachment pertaining to each such product. If there is no definition for a particular product, Emergency Care shall mean inpatient and outpatient Covered Services furnished by a qualified provider that are needed to evaluate or stabilize an Emergency Medical Condition.

"Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

"Dental Director" means a duly licensed General Dentist or Specialist designated by MCNA to monitor and evaluate the appropriate utilization of Covered Services by Covered Persons.

"Medically Necessary" means, unless otherwise defined in the applicable Attachment, any dental care services determined by MCNA's Dental Director or Dental Director's designee to be required to preserve and maintain a Covered Person's oral health, provided in the most appropriate setting and in a manner consistent with the most appropriate type, level, and length of service, which can be effectively and safely provided to the Covered Person, as determined by acceptable standards of medical practice and not solely for the convenience of the Covered Person, Covered Person's Provider, Provider or other health care provider.

"Participating Dental Care Provider" means Provider, or any other dental care provider listed on the group roster attached hereto as Appendix A, that has contracted directly or indirectly with MCNA to provide Covered Services to Covered Persons and is credentialed in accordance with the MCNA's credentialing criteria.

"Payee" means a Participating Dental Care Provider.

"Payor" means MCNA Insurance Company, or any other entity identified in an Attachment to this Agreement that contracts with MCNA for the provision of dental benefits administrative services.

"Payor Contract" means MCNA or MCNA Insurance Company's contract with any Payor that governs the provision of Covered Services to Covered Persons.

"Provider Manual" means the MCNA manual of policies, procedures, and requirements to be followed by Participating Dental Care Providers. The Provider Manual includes, but is not limited to, utilization management, quality management, grievances and appeals, and Payor- specific program requirements, and may be changed from time to time by MCNA.

"State" means the state set forth in the Attachment(s) attached hereto.

"State Contract" means a contract to provide Covered Benefits between MCNA and a State.

ARTICLE II
MCNA'S OBLIGATIONS

1. **Administration**. MCNA shall be responsible for the administrative activities necessary or required for the commercially reasonable operation of a dental benefits administrative services organization. Such activities shall include, without limitation, provider network development, quality improvement, utilization management, grievances and appeals, claims processing, and maintenance of provider directories and records.

2. **Provider Manual**. MCNA shall make the Provider Manual available to Provider via MCNA's website and upon Provider's request. MCNA shall post changes to the Provider Manual on MCNA's website and provide Provider with prior written notice of material changes to the Provider Manual. The Provider Manual is specifically incorporated herein and made a part of this Agreement. Provider and MCNA intend for, and shall be bound by this Agreement, any Attachments, and the Provider Manual, as one integrated contract.

3. **Identification Cards**. If applicable, MCNA shall issue to Covered Persons an identification card that shall bear the name of the Covered Person and a unique identification number.

4. **Benefits and Eligibility Verification**. MCNA or , as determined by the Payor or State Contract, shall be responsible for all eligibility and benefit determinations regarding Covered Services and all communications to Covered Persons regarding final benefit determinations, eligibility, bills, and other matters relating to their status as Covered Persons.

5. **MCNA's Dental Director**. MCNA shall provide a Dental Director to be responsible for the professional and clinical operations of MCNA.

ARTICLE III
PROVIDER'S OBLIGATIONS

1. **Covered Services**. Provider shall provide to Covered Persons those Covered Services described in the applicable Attachment(s) in accordance with the Provider Manual and according to the generally accepted standards of dental practice in the Provider's community, the scope of Provider's license and the terms and conditions of this. Unless otherwise specified in an Attachment hereto, Provider shall make necessary and appropriate arrangements to assure the availability of Covered Services to Covered Persons (i) on a twenty-four (24) hour per day, seven (7) day per week basis, (ii) urgent care services, including urgent specialty care, shall be provided within twenty four (24) hours of a Covered Person's request, and (iii) therapeutic and diagnostic care shall be provided within fourteen (14) days of a Covered Person's request. Provider will make arrangements to ensure coverage of Covered Persons after-hours or when Provider is otherwise absent. Provider agrees that such arrangements will be with a Provider that is a Participating Dental Care Provider. All Participating Dental Care Providers, including those portable, mobile, or non-office based Providers, are required to provide comprehensive care to all Covered Persons within the time and distance requirements set forth in this Agreement. Participating Dental Care Providers cannot limit their practices to diagnostic and preventive services only.

2. **Provider Qualifications**. Provider shall be licensed to practice dentistry in the State, maintain good professional standing at all times, and maintain throughout the term of this Agreement all necessary licenses, certifications, registrations and permits as are required to provide the Covered Services. Evidence of such licensure shall be submitted to MCNA upon request.

3. **Compliance with MCNA Policies and Procedures**. Provider shall at all times cooperate and comply with the policies and procedures of MCNA as set forth in this Agreement, the Provider Manual, and any Provider Manual updates contained in periodic provider bulletins and other written notices intended for that purpose.

4. **Determination of Covered Person Eligibility**. Provider shall verify, in accordance with the Provider Manual, whether an individual seeking Covered Services is a Covered Person. If MCNA determines that such individual was not eligible for Covered Services at the time the services were rendered, such services shall not be eligible for payment under this Agreement, and Provider may bill the individual or other responsible entity for such services.

5. **Emergency Care**. Provider shall provide Emergency Care in accordance with applicable federal and state laws and the State Contract. MCNA shall not require a prior authorization of any kind for Emergency Care. Provider shall notify MCNA within twenty-four (24) hours or by the next business day of rendering or learning of the rendering of Emergency Care to a Covered Person.

6. **Acceptance of New Patients**. To the extent that Provider is accepting new patients, Provider must also accept new patients who are Covered Persons. Provider shall provide MCNA forty-five (45) days prior written notice of Provider's decision to no longer accept new Covered Persons. In no event shall any established patient of Provider who becomes a Covered Person be considered a new patient.

7. **Referrals**. If Provider is a specialist, Provider shall deliver Covered Services to Covered Persons upon referral from a MCNA primary dental care provider ("***PDP***") or MCNA. Provider shall arrange for any appropriate referrals of Covered Persons as needed in accordance with the requirements of the Provider Manual.

8. **Coordination of Care; Reporting to Primary Care Providers**. Provider shall, within a reasonable time following consultation with, or testing of, a Covered Person (not to exceed one (1) week), make a complete written report to the Covered Person's PDP. However, with respect to findings which indicate a need for immediate or urgent follow-up treatment or testing, or which indicate a need for further or follow-up care outside the scope of the referral authorization or the scope of Provider's area of expertise, Provider shall make an immediate oral report to the Covered Person's PDP (if applicable), not to exceed twenty-four (24) hours from the time of Provider's consultation or receipt of the report of the testing, as applicable.

9. **Treatment Decisions**. MCNA shall not be liable for, nor will it exercise control over, the manner or method by which Provider provides or arranges for Covered Services. Provider may not refuse to provide medically necessary or Covered Services to Covered Persons specified in the State Contract for non-medical reasons, except those services allowable under federal law for religious and moral objections. However, the Provider is not required to accept or continue treatment of a patient with whom the Provider determines a professional relationship cannot be

maintained/established. The Provider understands that MCNA's determinations, if any, to deny payments for services which MCNA does not deem to constitute Covered Services or which were not provided in accordance with the requirements of this Agreement, the Attachments or the Provider Manual, are administrative decisions only. Such a denial does not absolve Provider of Provider's responsibility to exercise independent judgment in Covered Person treatment decisions. Nothing in this Agreement is intended to interfere with Provider's provider-patient relationship with Covered Person(s).

10. **Covered Person Communication**. Provider shall obtain MCNA's approval for Covered Person communication as required by the Payor or State Contract and applicable State and federal law. Nothing in this Agreement shall be construed as limiting Provider's ability to communicate with Covered Persons with regard to quality of dental care or treatment decisions or alternatives regardless of Covered Service limitations under the Payor Contract.

11. **Dental Office Space**. Provider agrees that the dental office space at which Covered Services are provided hereunder shall be maintained in accordance with applicable federal and State laws and the standards contained in the Provider Manual.

12. **Disparagement Prohibition**. Provider agrees not to disparage Payor or MCNA in any manner during the term of this Agreement or in connection with any expiration, termination or non-renewal of this Agreement. Provider shall not interfere with MCNA's contractual relationships including, but not limited to, those with other Participating Dental Care Providers. Nothing in this provision, however, shall be construed as limiting Provider's ability to inform patients that this Agreement has been terminated or otherwise expired, or to promote Provider to the general public or to post information regarding other health plans consistent with Provider's usual procedures, provided that no such promotion or advertisement is directed at any specific Covered Person or group of Covered Persons.

13. **Nondiscrimination**. Provider will provide services to Covered Persons without discrimination on account of race, sex, sexual orientation, age, color, religion, national origin, place of residence, health status, type of payor, source of payment, physical or mental disability or veteran status, and will ensure that its facilities are accessible as required by Title III of the Americans With Disabilities Act of 1991 (the "***ADA***"). Provider recognizes that as a governmental contractor, MCNA is subject to various federal laws, executive orders and regulations regarding equal opportunity and affirmative action, which also may be applicable to subcontractors.

14. **Notification of Adverse Action**. Provider shall give written notice to MCNA of: (i) any action involving Provider's hospital privileges or conditions relating to Provider's ability to admit patients to any hospital or inpatient facility; (ii) any situation which develops regarding Provider, when notice of that situation has been given to the State agency that licenses Provider, or any other licensing agency or board, or any situation involving an investigation or complaint filed by the State agency that licenses Provider, or any other licensing agency or board, regarding a complaint against Provider's license; (iii) when a change in Provider's license to practice dentistry is affected or any form of reportable discipline is taken against such license; (iv) suspension or exclusion under a federal health care program, including but not limited to, Medicaid; (v) any government agency request for access to records; or (vi) any lawsuit or claim or transaction filed or asserted against Provider alleging professional malpractice, regardless of whether the lawsuit or claim involves a

Covered Person that may reasonably be considered to have a material impact on the Provider's ability to perform the services included in its contract with MCNA. In any such instance described above, Provider must notify MCNA in writing within ten (10) days from the date Provider first receives notice, whether written or oral, with the exception of those lawsuits or claims which do not involve a Covered Person, with respect to which Provider has thirty (30) days to notify MCNA.

15. **Use of Name**. Provider agrees that MCNA may use Provider's name, address, phone number, type of practice, and an indication of Provider willingness to accept additional Covered Persons in MCNA's roster of Participating Dental Care Providers and marketing materials.

ARTICLE IV
COMPLIANCE WITH LAW

1. **Compliance with Law and Payor Contracts**. Provider and MCNA agree that each party shall carry out its obligations in accordance with terms of the Payor or State Contract and applicable federal and State laws and regulations, including, but not limited to, the requirements of the Stark law (42 U.S.C. § 1395nn) and applicable federal and State self-referral and fraud and abuse statutes and regulations. If, due to Provider's noncompliance with law, the State Contract, the Payor Contract or this Agreement, sanctions or penalties are imposed on MCNA, MCNA may, in its sole discretion, offset the sanction or penalty amounts against any amounts due Provider from MCNA, or require Provider to reimburse MCNA for the amount of any such sanction or penalty.

2. **HIPAA Compliance**. Provider and MCNA shall abide by the administrative simplification provisions of the Health Insurance Portability and Accountability Act ("HIPAA"), its implementing regulations [42 C.F.R. §§ 160 & 164] and all other federal and State laws regarding confidentiality and disclosure of medical records and other health and Covered Person information, including safeguarding the privacy and confidentiality of any protected health information ("PHI") that identifies a particular Covered Person. The Provider will also comply with the Health Information Technology For Economic and Clinical Health Act (HITECH) provisions of the American Recovery and Reinvestment Act of 2009. Provider shall assure its own compliance and that of its business associates with HIPAA and HITECH.

3. **Federal False Claims**. If Provider receives annual payments for services rendered to Medicaid and/or Childrens' Health Insurance Program enrollees of at least Five Million and 00/100 ($5,000,000) dollars cumulative from all sources, Provider shall:

A. Establish written policies for all its employees, managers, officers, contractors, subcontractors, and agents which provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A) thereof;

B. Include as part of such written policies detailed provisions regarding Provider's policies and procedures for detecting and preventing Fraud, Waste, and Abuse;

C. Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A), the rights of employees to be protected as whistleblowers, and

the Provider's policies and procedures for detecting and preventing Fraud, Waste and Abuse.

For more information about the False Claims Act please refer to http://oig.hhs.gov/.

ARTICLE V

CLAIMS SUBMISSION, PROCESSING, AND COMPENSATION

1. **Claims or Encounter Submission**. Provider shall promptly submit to MCNA claims or encounters for Covered Services in accordance with the Provider Manual. MCNA reserves the right to deny payment to Provider if Provider fails to submit its claims in accordance with the Provider Manual. If applicable based on Provider's compensation arrangement, Provider shall submit encounter data to MCNA in a timely fashion, which shall contain such statistical and descriptive dental and patient data and identifying information as specified in the Provider Manual.

2. **Compensation**. Provider shall be paid for services rendered to Members on a fee for service basis in accordance with the fee schedule applicable to the MCNA plan(s) in which Provider is participating provider as indicated in an Attachment to this Agreement (e.g. Medicaid, Medicare and CHIP plans). If a Provider provides any Covered Service not specified in the State Contract or any non-covered Service, Provider shall not be entitled to any compensation for such services. Provider shall accept final payment made by MCNA, with the exception of applicable copayments, and/or deductibles (Co-payments) as payment in full for all services provided by Provider except as otherwise provided by this Agreement, and Provider shall not solicit or accept any surety or guarantee of payment from state authorities or Covered Person(s).

3. **Financial Incentives**. Nothing in this Agreement shall, or shall be construed to, create any financial incentive for Provider to withhold medically necessary Covered Services from a Covered Person.

4. **Covered Person Hold Harmless**. Provider agrees that in no event including, but not limited to, non-payment by MCNA, MCNA insolvency, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Covered Person for Covered Services provided pursuant to this Agreement. This provision shall not prohibit collection of any applicable copayments or other amounts that are the Covered Person's financial responsibility. This provision shall survive termination or expiration of this Agreement for any reason, shall be construed for the benefit of Covered Persons, and supersedes any oral or written agreement entered into between the Provider and a Covered Person.

5. **Recoupment Rights**. Payor or MCNA shall have the right to immediately recoup any and all amounts owed by Provider to Payor, MCNA or any Affiliate against amounts owed by Payor, MCNA or Affiliate to Provider. Provider agrees that all recoupment and any offset rights under this Agreement shall constitute rights of recoupment authorized under State or federal law and that such rights shall not be subject to any requirement of prior or other approval from any court or other government authority that may now have or hereafter have jurisdiction over Provider.

6. **Coordination of Benefits**: Provider shall bill and process forms for any and all third- party payors who have primary liability, prior to submission to MCNA. To collect any amounts due, Provider shall supply MCNA such relevant information as it has collected from Covered Persons regarding coordination of benefits. If Provider fails to commence such billing and processing within ninety (90) days of the rendition of care, MCNA shall have the exclusive right, at its sole discretion, to pursue such collections and retain all funds received. MCNA shall perform coordination of benefits for all other services and shall be entitled to retain all funds collected. Provider shall only bill MCNA for the difference, if any, between the amount due from all other third-party payors and the amount due under Attachment A to this Agreement, to the extent that such other payments do not constitute payment in full by such other third-party payors under applicable laws, regulations or agreements between Provider and other third-party payors. MCNA shall reimburse said difference from Provider according to applicable State and federal laws.

ARTICLE VI
RECORDS/INSPECTIONS

1. **Dental Records**. Provider shall maintain a complete and accurate permanent dental record for each Covered Person to whom Provider renders services under this Agreement and shall include in that record all reports from Participating Dental Care Providers and all documentation required by applicable law, regulations and professional standards. The Provider Manual, and State Contract. Dental records of Covered Persons shall be treated as confidential so as to comply with all federal and State laws and regulations regarding the confidentiality of the patient records.

2. **Records**. Provider shall maintain records related to services, service providers, charges, dates and all other commonly required information elements for services rendered to Covered Persons and provide such dental, financial and administrative information to MCNA and State and federal government agencies as may be necessary for compliance by Payor or MCNA with State and federal law and accreditation standards, as well as for the administration of this Agreement and the State Contract. MCNA shall have access at reasonable times to books, records, and papers of the Provider relating to the dental care services provided to Covered Persons for Covered Services.

3. **Period of Retention.**

   A. Medical and Dental Records. Any and all medical and dental records, including but not limited to graphic matter, images, X-ray films, and related matter that were necessary to produce a diagnostic or therapeutic report shall be retained, preserved, safeguarded, and properly stored by Provider (whether electronic or paper) for a minimum period of six (6) years from the date a patient is last treated by Provider.

   B. Other Records. Other types of records, including but not limited to administrative and financial records (whether electronic or paper) related to the services provided by Provider under this Agreement to MCNA, shall be retained by Provider for a minimum period of six (6) years from termination of the State Contract.

4. **Consent to Release Dental Records**. Provider shall obtain Covered Person authorizations relative to the release of dental information required by applicable law to provide MCNA or other authorized parties with access to Covered Persons' records. Provider shall give Covered Persons and

their representatives access to, and the same can request copies of, the Covered Person's medical records, to the extent and in the manner provided by applicable State law.

5. **Access**. In accordance with applicable law, Provider shall provide access to Provider's records to the following, including any designee or duly authorized agent:

A. Payor and MCNA during regular business hours and upon three (3) days prior notice;

B. Government agencies including the U.S. Department of Health and Human Services (HHS), CMS, Office of Inspector General Comptroller, State Legislative Auditor's Office, and other applicable State authorities, to the extent such access is necessary to comply with regulatory requirements that apply to MCNA or Payor;

C. Accreditation agencies.

6. **Record Transfer.** Subject to applicable law, the State Contract and Payor Contract requirements, Provider shall cooperate in the timely transfer of Covered Persons' dental records to any other health care provider or the State or Department at no charge and when required. Provider shall cooperate with MCNA to make available to the applicable State agency, or its designated representatives, any and all records, whether medical or financial, related to MCNA and the Provider's activities undertaken pursuant to this Agreement.

7. **On-Site Inspections**. Provider agrees that dental office space or its facilities, as applicable, shall be maintained in accordance with applicable federal and State regulatory requirements, and the MCNA Provider Manual. Provider shall cooperate in announced and unannounced on-site inspections of dental office space by MCNA, authorized government officials, and accreditation bodies. Provider shall compile any and all information in a timely manner required to evidence Provider's compliance with this Agreement, as requested by such agency(ies), or as otherwise necessary for the expeditious completion of such on-site inspection.

ARTICLE VII
INSURANCE

1. **Provider Insurance**. During the term of this Agreement, Provider shall maintain policies of general and professional liability insurance and malpractice insurance coverage that are necessary to insure Provider and any other person providing services hereunder on Provider's behalf, against any claim(s) of personal injuries or death alleged or caused by Provider's performance under this Agreement. Such insurance shall include, but not be limited to, tail or prior acts coverage necessary to avoid any gap in coverage. Unless otherwise specified in an Attachment hereto, the insurance shall be underwritten through a licensed carrier in a minimum amount of one million dollars ($1,000,000) per occurrence, and have an annual aggregate of no less than three million dollars ($3,000,000) unless a lesser amount is accepted by MCNA or where State law mandates otherwise. Provider will provide MCNA with at least fifteen (15) days notice of the cancellation, non-renewal, lapse, or adverse material modification of coverage. Provider will furnish such insurance coverage upon execution of this Agreement and shall provide MCNA with written of the existence of such coverage upon request.

2. **Other Insurance**. All parties to this Agreement shall maintain in full force and effect

appropriate workers' compensation protection and unemployment insurance as required by law.

3. **FTCA Coverage**. Notwithstanding the foregoing requirements of Article 7 Section 1, so long as Dental Provider is a federally qualified health center that is covered under Section 224 of the Public Health Service Act for protection under the Federal Tort Claims Act (FTCA), the minimum insurance requirements covering Dental Provider and its FTCA qualified employees shall not apply. Dental Provider shall provide MCNA with proof satisfactory to MCNA of FTCA coverage no later than three (3) days after the effective date of this Agreement.

ARTICLE VIII
INDEMNIFICATION

1. **MCNA Indemnification**. Provider agrees to indemnify and hold harmless (and at MCNA's request defend) MCNA, its Affiliates, officers, employees and agents from and against any and all claims, loss, damages, liability, costs, expenses (including reasonable attorney's fees, and attorney's fees to enforce this indemnity), judgments, or obligations arising from or in connection with third party claims alleging any negligence or otherwise wrongful act or omissions of Provider, its agents or employees in the performance of Provider's obligations under this Agreement.

2. **Provider Indemnification**. MCNA agrees to indemnify and hold harmless (and at Provider's request defend) Provider, its officers, employees and agents from and against any and all claims, loss, damages, liability, costs, expenses (including reasonable attorney's fees and attorney's fees to enforce this indemnity), judgments, or obligations arising from or in connection with third party claims alleging any negligence or otherwise wrongful act or omission of MCNA, its agents or employees in the performance of MCNA's obligations under this Agreement.

ARTICLE IX
DISPUTE RESOLUTION

Informal Dispute Resolution. MCNA and Provider are jointly responsible for resolving any disputes that may arise between the two and at no time, will a dispute disrupt or interfere with the provision of services under this Agreement. Any disputes between the parties arising with respect to the performance or interpretation of this Agreement ("***Dispute***") shall first be resolved by exhausting the processes available in the Provider Manual, then through good faith negotiations between designated representatives of the parties that have authority to settle the Dispute. If the matter has not been resolved within sixty (60) days of the request for negotiation, either party may initiate litigation in accordance with this Agreement.

ARTICLE X
TERM AND TERMINATION

1. **Term**. This Agreement shall have an initial term of one (1) year commencing on the Effective Date. Thereafter, this Agreement shall automatically renew for terms of one (1) year each. Notwithstanding the foregoing, this Agreement may terminate in accordance with the Termination sections below.

2. **Termination of Agreement**. This Agreement may be terminated under any of the following circumstances:

A. By either party upon ninety (90) days prior written notice;

B. By either party upon thirty (30) days prior written notice if the other party is in material breach of this Agreement, except that such termination shall not take place if the breach is cured within the thirty (30) days following the written notice;

C. Immediately upon written notice by MCNA if there is imminent harm to patient health, or fraud or malfeasance is suspected;

D. Immediately upon written notice by either party if the other party becomes insolvent or has bankruptcy proceedings initiated against it;

E. Immediately upon written notice by Provider if MCNA loses, relinquishes, or has materially affected its certificate of authority to operate as an administrative services organization; or

F. Immediately upon written notice by MCNA if Provider fails to adhere to MCNA's credentialing criteria, including, but not limited to, if Provider (1) loses, relinquishes, or has materially affected its license to provide Covered Services in the State, (2) fails to comply with the requirements set forth in this Agreement; or (3) is convicted of a criminal offense related to involvement in any Medicare, Medicaid or other government sponsored program or has been terminated, suspended, barred, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from any Medicare, Medicaid or other government sponsored program.

3. **Rights and Obligations Upon Termination**. Upon termination, the rights of each party hereunder shall terminate; provided, however, that such action shall not release the Provider or MCNA of their obligations with respect to: (i) payments accrued to Provider prior to termination; (ii) Provider's agreement not to seek compensation from Covered Persons for Covered Services prior to termination; (iii) completion of treatment of Covered Persons until continuation of the Covered Person's care can be arranged by MCNA as determined by the Dental Director or as required by applicable law, the Payor Contract, or the State Contract. Services provided during the continuation of care period shall be reimbursed in accordance with the terms of this Agreement.

4. **Notification of Specialist Termination**. If Provider is a specialist, Provider acknowledges the right of MCNA to inform Covered Persons of Provider's termination. In the event this Agreement is terminated, MCNA shall provide written notice within thirty (30) business days of receipt, or issuance of a notice of termination, to all Covered Persons who are seen on a regular basis by Provider, regardless of whether the termination was for cause or without cause.

5. **Survival of Obligations.** The following provisions shall survive the termination of this Agreement: Article III Section 12 (Disparagement Prohibition); Article IV (Compliance With Law); Article V Section 4 (Covered Person Hold Harmless); Article VI (Records/Inspection); Article VII (Insurance); Article VIII (Indemnification); Article IX (Dispute Resolution); Article X Section 3 (Rights and Obligations Upon Termination).

ARTICLE XI
MISCELLANEOUS

1. **Relationship of Parties.** The relationship among the parties is that of independent contractors. None of the provisions of this Agreement are intended to create, or to be construed as creating, any agency, partnership, joint venture, employee-employer, or other relationship. Neither party shall have or exercise any control or direction over the means or methods by which the other shall perform such work or render or perform such services and functions. MCNA shall have no right to control the means, methods, manner or scope by which Provider renders or performs Covered Services.

2. **Conflicts Between Certain Documents.** In the event of a conflict between this Agreement and an Attachment, the Attachment shall control with respect to the product described in that Attachment. In the event of any conflict between any Attachment and the Provider Manual, the Attachment shall control as to the product described in that Attachment.

3. **Assignment; Delegation of Duties**. This Agreement is intended to secure the services of and be personal to Provider, and shall not be assigned, sublet, delegated or transferred by Provider without the prior written consent of MCNA. In the event that Provider is a professional corporation, professional association or partnership rather than an individual dentist or provider, Provider agrees that all of the terms set forth herein applicable to a Provider shall apply with equal force to both the professional corporation, professional association or partnership and the individual dentist or Providers associated with such entity.

4. **Headings/Recitals**. The headings of the sections of this Agreement are inserted merely for the purpose of convenience and do not, expressly or by implication, limit, define, or extend the specific terms of the section so designated. The Recitals are incorporated into this Agreement.

5. **Governing Law**. All matters affecting the interpretation of this Agreement and the rights and obligations of the parties hereto shall be governed by and construed in accordance with applicable federal and state laws of the State where the Covered Services are provided pursuant to this Agreement.

6. **Third Party Beneficiary**. Except as specifically provided herein, the terms and conditions of this Agreement shall be for the sole and exclusive benefit of Provider and MCNA. Nothing herein, express or implied, is intended to be construed or deemed to create any rights or remedies in any third party.

7. **Amendment**. Unless otherwise prohibited by federal or state law, MCNA may propose amendments to this Agreement upon thirty (30) days prior written notice. Unless Provider objects in writing to such amendment within the thirty (30) day notice period, Provider shall be deemed to have accepted the amendment. Notwithstanding the foregoing, this Agreement shall be automatically amended as necessary to comply with any applicable State or federal laws or regulations, and applicable provisions of the Payor Contract or State Contract (hereafter, a "***Conforming Amendment***"); provided, however, that Provider may refuse to accept a Conforming Amendment by terminating this Agreement in accordance with Article X Section 2.

8. **Entire Agreement**. This Agreement, its Attachments, and the Provider Manual contain all the terms and conditions agreed upon by the parties and supersede all other agreements, oral or otherwise, of the parties hereto, regarding the subject matter of this Agreement.

9. **Severability**. The invalidity or unenforceability of any terms or provisions hereof shall in no way affect the validity or enforceability of any other terms or provisions.

10. **Waiver**. The waiver by either party of the violation of any provision or obligation of this Agreement shall not constitute the waiver of any subsequent violation of the same or other provision or obligation.

11. **Notice.** Any notice required to be given pursuant to the terms and provisions hereof shall be in writing and shall be sent by certified mail, return receipt requested, postage prepaid, or by recognized courier service, addressed as follows:

To MCNA at:	To Provider at:
Attn: General Counsel MCNA Dental Plans 200 W. Cypress Creek Blvd. Suite 500 Ft. Lauderdale, Fl. 33309	

12. **Force Majeure.** Neither party shall be liable or deemed to be in default for any delay or failure to perform any act under this Agreement resulting, directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquake, flood, strikes or other work stoppages by either party's employees, or any other similar cause beyond the reasonable control of such party.

13. **Confidentiality.** Neither party shall disclose the substance or content of this Agreement or any information acquired from the other party to any third party unless required by law. Provider acknowledges and agrees that all information relating to MCNA's programs, policies, protocols and procedures is proprietary information and further agrees not to disclose such information to any person or entity without MCNA's express written consent.

14. **Conflict of Interest**. Provider warrants that he or she does not have an interest, and shall not acquire any interest, direct or indirect, which conflicts in any manner or degree with the performance of the services hereunder. Provider shall inform MCNA promptly of any potential conflict which may arise. MCNA warrants that it shall remove any conflict of interest prior to executing the Agreement, or thereafter, if the conflict arises after the start of the Agreement.

15. **Authority.** The parties whose signatures are set forth below represent and warrant that they are duly empowered to execute this Agreement.

[SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, the parties hereto have executed this Agreement effective as of the date first above written.

Managed Care of North America, Inc., d/b/a/ MCNA Dental Plans, a Florida corporation

By: _____
Printed Name:
Title:

Signature Date:

Effective Date of Agreement: _____
(To be completed by MCNA only)

[Provider]

By: _____
Printed Name:
Title:

Signature Date:

Tax Identification Number: _____

National Identification Number: _____

Dentist Medicaid Number: _____

Group Medicaid Number (If applicable):

_____

Group Corporate Address (If applicable):

_____

_____

Appendix A to Dental Provider Agreement

Provider may send updates to this Attachment Appendix A to Plan from time to time; provided however, any Additional Practice Providers reflected on such update shall not provide Covered Services under this Agreement until such Practice Providers have been credentialed and approved by Plan's or its designee's credentialing committee (Plan shall give Provider written notice of such approval).

Last Name	First Name	Middle Initial	Degree	Specialty	Practice Address	City	State	Zip Code	County	Phone	Fax	NPI #	Medicaid #	TIN	Employed by Group (Y/N)	Accepts New Patients

A roster with all information reference above may be attached in lieu of completing this form.

☐

☐ **Roster Attached**

STATE OF NEBRASKA MEDICAID PROGRAM PRODUCT ATTACHMENT TO DENTAL PROVIDER AGREEMENT

ATTACHMENT A

This State of Nebraska Product Attachment (the "***Product Attachment***") is incorporated into the Dental Provider Agreement (the "***Agreement***") entered into by and between _____ (the "***Provider***") and Managed Care of North America, Inc., d/b/a/ MCNA Dental Plans ("***MCNA***").

ARTICLE I
GENERAL TERMS

1.1 MCNA has been contracted by its affiliate, MCNA Insurance Company, a Texas accident and health insurance company ("***MIC***") to arrange for the provision of covered dental services to children and adults enrolled in the Nebraska Medicaid Program. MIC is the Payor and Provider is the Payee with respect to this Agreement.

1.2 Provider has entered into the Agreement with MCNA. This Product Attachment is intended to supplement the Agreement by setting forth the parties' rights and responsibilities related to the provision of Covered Services to Covered Persons as it pertains to the Nebraska Medicaid and CHIP programs. Provider agrees to adhere to all requirements set forth in the contract between MCNA and the Nebraska Department of Health and Human Services (DHHS) and Department-issued guidelines. The same shall be furnished to Provider upon request. In the event of a conflict between the terms and conditions of the Agreement and the terms and conditions of this Product Attachment, this Product Attachment shall govern.

1.3 Notwithstanding any provisions set forth in this Product Attachment, to the extent applicable, Provider shall comply with all duties and obligations under the Agreement, the Provider Manual and this Product Attachment through the last day the Agreement is in effect. Provider agrees and understands that Covered Services shall be provided in the amount, duration and scope of core benefits and services specified in the Nebraska Medicaid State Plan as set forth in the MCNA Provider Manual, any applicable State handbooks or policy and procedure guides, and all applicable State and federal laws and regulations. All final Medicaid benefit determinations are within the sole and exclusive authority of DHHS or its designee. To the extent Provider is unclear about Provider's duties and obligations, Provider shall request clarification from MCNA.

ARTICLE II
DEFINITIONS

The defined terms in this Product Attachment have the same meaning set forth in the Agreement, unless otherwise defined herein.

"***Covered Persons or Member***" means a person eligible to receive Covered Services from MIC.

"***Dental Home***" means 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.

"***Dental Records***" shall have the meaning set forth in Article III, Section 3.4 herein.

"Department" means the State of Nebraska, Department of Health and Human Services ("***DHHS***"), or its designee.

"***Emergency Dental Condition"*** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or, (3) serious dysfunction of any bodily organ or part.

"***Emergency Dental Services"*** means covered inpatient and outpatient services that are either furnished by a provider that is qualified to furnish these services under Title 42 CFR, or the services needed to evaluate or stabilize an emergency medical condition.

"***Medically Necessary" or "Medical Necessity"*** means health care services and supplies that are medically appropriate and:

1. Necessary to meet the basic health needs of the member.
2. Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service.
3. Consistent in type, frequency, and duration of treatment with scientifically-based guidelines of national medical, research, or health care coverage organizations or governmental agencies.
4. Consistent with the diagnosis of the condition.
5. Required for means other than convenience of the client or his/her provider.
6. No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency.
7. Of demonstrated value.
8. No more intensive level of service than can be safely provided.

"***MIC***" means MCNA Insurance Company, a Texas accident and health insurance company.

"***Payor***" means MCNA Insurance Company.

"***Payee***" means the Dental Provider.

"***Primary Care Dentist" or "PCD"*** means a licensed or certified dentist or health clinic including a FQHC or rural health clinic that functions within the scope of licensure or certification and agrees to provide primary dental care services to Members. The PCD is the patient's initial and most important contact with MCNA. The PCD functions as the member's Dental Home.

"***State"*** means the State of Nebraska, as represented through any agency, department, board, or commission.

"State Contract" means the agreement between DHHS and MIC whereby MIC is obligated to administer the dental benefits available to children and adults enrolled in the Nebraska Medicaid Program.

"Third Party Liability" or "TPL" refers to the legal obligation of third parties to pay part or all of the expenditures for medical assistance furnished under a Medicaid state plan.

"Third Party Resource" means any individual, entity, or program that is or may be liable to pay all or part of the cost of any medical services furnished to a member.

"Urgent Care" means care for a condition not likely to cause death or lasting harm but for which treatment should not wait for a normally scheduled appointment.

ARTICLE III
PRODUCT REQUIREMENTS

3.1 **Compliance with State Contract**. Provider shall comply with all applicable federal, State and local laws and regulations, and all amendments thereto. Provider understands and agrees that this Product Attachment and/or the Agreement shall be deemed automatically amended as necessary to comply with any applicable State or federal or regulation, or any applicable provision of the State Contract. Any provision of the Agreement or this Product Attachment deemed to conflict with the State Contract by DHHS shall be null and void, and all other provisions shall remain in full force and effect.

3.2 **Urgent and Routine Care, and Wait Times.** Urgent Care must be provided within twenty-four (24) hours [42 CFR §438.206(c)(1)(i)]; Urgent care may be provided directly by the primary care dentist (PCD) or directed by MCNA through other arrangements.

Routine or preventative dental services within six (6) weeks.

Wait times for scheduled appointments should not routinely exceed forty-five (45) minutes, including time spent in the waiting room and the examining room, unless the provider is unavailable or delayed because of an emergency. If a Provider is delayed, the Member should be notified immediately. If a wait of more than ninety (90) minutes is anticipated, the Member should be offered a new appointment.

3.3 **Encounter Records.** Provider shall comply with MCNA's electronic health encounter records submission in a format to be provided by MCNA to Provider and as required by the Department. Such encounter records shall be submitted in a timely fashion as directed by MCNA. Provider shall submit encounter records in the format specified by Department so that the MCNA can meet Department's specifications. Encounter records must be at the line level of detail and allow all discrete services provided to be identified through the inclusion of the specific CDT codes that would have been billed if the Provider was reimbursed under the fee-for-service model.

3.4 **Dental Records.** Any and all medical and dental records, including but not limited to graphic matter, images, X-ray films, and related matter that were necessary to produce a diagnostic or therapeutic report (the "***Dental Records***") shall be retained, preserved, safeguarded, and properly stored by Provider (whether electronic or paper) such as working papers related to the preparation of fiscal reports, and medical records, progress notes, charges, journals ledgers, and electronic media shall be retained and safeguarded by the Provider for a period of seven (7) years from the last date of treatment of the Member.

Dental Records must be further retained in the event of litigation, claims, or other actions involving the records, in which case the files must be retained until the completion of the action and the resolution of all issues that arose from it. If the Dental Records are stored on microfilm or microfiche or other electronic means, the subcontractor must agree to produce at its expense legible hard copy records upon the request of state or federal authorities, within twenty-one (21) calendar days of the request. This requirement does not include Dental Records pertaining to once-in-a-lifetime events that must be retained indefinitely and may not be destroyed.

Dental Records shall be made available for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring upon request of an authorized representative of DHHS. Provider shall allow MCNA, the Department, NMPI, MFPAU, and and other authorized State and federal agents, including DHHS, U.S. Department of Health and Human Services (HHS), CMS, Office of Inspector General Comptroller, State Legislative Auditor's Office, and the Nebraska Attorney General's Office, to the extent such access is necessary to comply with regulatory requirements that apply to MCNA or MIC. The previously mentioned entities shall have the right to evaluate through audit,

inspection, or other means, whether announced or unaccounted, any records (including without limitation Dental Records) pertinent to the contract between DHHS and MCNA, including quality, appropriateness and timeliness of services and the timeliness and accuracy of encounter data and practitioner claims submitted to MCNA. Such evaluation when performed shall be performed with the cooperation of MCNA. Upon request, MCNA shall assist in such reviews.

Provider shall give Covered Persons and their representatives access to, and the same can request copies of, the Covered Person's Dental Records, to the extent and in the manner provided by State law.

3.5 **Cultural Consideration and Competency**. In accordance with Title IV of the Civil Rights Act of 1964 (42 U.S.C. §2000d *et. seq.*) and its implementing regulation, 45 C.F.R. §80 (2001) (as amended), Provider shall deliver Covered Services in a culturally competent manner to all Covered Persons, including those with limited English proficiency and diverse cultural and ethnic backgrounds and must take adequate steps to ensure that persons with limited English skill receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this Agreement.

3.6 **Qualifications and Credentialing Criteria.** Provider shall hold all necessary licenses, registrations and/or certifications required under State or federal law to provide the services contracted for hereunder and shall at all times meet, maintain and adhere to the policies and procedures of MCNA with respect to (1) certification to participate in any federal or State health care program including but not limited to the Medicaid and Medicare programs; (2) the MCNA Provider Manual; (3) requirements of the Department; (4) licensure, certification, accreditation, utilization management/quality assurance (including requirements for review of Provider's services by MCNA personnel and committees), complaints/appeals; and (4) administrative policies such as those (by way of example but not limitation) relating to claims submission, coordination of benefits, and coverage verification. Provider will be subject to re-credentialing by MCNA every thirty-six (36) months from the Provider's immediately preceding credentialing committee approval date. Provider shall give immediate notice to MCNA of any event that causes Provider to be out of compliance with its ability to fulfill its obligations under this Agreement, or of any change in Provider's name, ownership, control, or taxpayer identification number.

3.7 **Nondiscrimination by MCNA.** MCNA shall not discriminate against any Provider who services high-risk populations or who specializes in conditions that require costly treatment or based upon that Provider's licensure or certification.

3.8 **Non-interference by MCNA.** MCNA shall not prohibit or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient (in compliance with 1932(b)3(D) and 42 C.F.R. §438.102(a)(1)(i),(ii),(iii) and (iv)): (a) for the

enrollee's health status, medical care or treatment options, including any alternative treatment that may be self-administered; (b) for any information the enrollee needs in order to decide among all relevant treatment options; (c) for the risks, benefits, and consequences of treatment or non-treatment ; and (d) for the enrollees right to participate in decisions regarding his or her health care, including the right to refuse, and to express preferences abut future treatment decisions.

3.9 **Ethical Reasons for Non-Performance of Medical Treatment.** MCNA shall not require Provider to perform any treatment or procedure which is contrary to the Provider's conscience, religious beliefs, or ethical principles and shall meet the requirements of 42 C.F.R. §438.102 (2012). In such instances, Provider shall consult MCNA when referring the Covered Person to another health care provider licensed, certified or accredited to provide care for the individual service or assigned to another Provider licensed to provide care appropriate to the Covered Person's dental condition.

3.10 **Covered Person Communications**. Nothing in the Agreement shall be construed as imposing restrictions upon Provider's free communication with a Member about the Member's medical condition, treatment options, MCNA referral policies, and other MCNA policies regarding financial incentives or arrangements and all managed care plans with whom the Provider contracts.

3.11 **Representation and Warranty.** Provider represents and warrants that neither Provider nor any individual who has a direct or indirect ownership or controlling interest of 5% or more of the Provider, nor any officer, director, agent or managing employee (i.e., general manager, business manager, administrator, director or like individual who exercises operational or managerial control over Provider or who directly or indirectly conducts the day-to-day operation of Provider) is an entity or individual (1) who has been convicted of any offense under Section 1128 (a) of the Social Security Act (42 U.S.C. §1320a-7(a)) or of any offense related to fraud or obstruction of an investigation or a controlled substance described in Section 1128(b)(1)-(3) of the Social Security Act (42 U.S.C. §1320a-7(b)(1)-(3)); or (2) against whom a civil monetary penalty has been assessed under Section 1128A or 1129 of the Social Security Act (42 U.S.C. §1320a-7a; 42 U.S.C. §1320a-8); or (3) who has been excluded from participation in a program under Title XVIII, 1902(a)(39) and (41) of the Social Security Act, Section 4724 of the BBA or under a Commonwealth health care program.

3.12 **Compliance with Laws**. Provider understands and agrees that it is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to this Agreement and the State Contract, and all persons or entities receiving state and federal funds. The Provider understands and agrees that any violation by a provider of a state or federal law relating to the delivery of services pursuant to this Agreement, or any violation of the State Contract could result in liability for money damages, and/or civil or criminal penalties and sanctions under

state and/or federal law. By signing this Agreement, Provider certifies to the best of its knowledge and belief that federal funds have not been used for lobbying in accordance with 45 CFR Part 93 and 31 USC 1352. We instruct providers to disclose any lobbying activities using non-federal funds in accordance with and to the extent required by 45 CFR Part 93 and the laws of the State of Nebraska.

Provider further understands and agrees that the following laws, rules, and regulations, and all amendments or modifications thereto, are incorporated by reference to this Agreement and shall comply with the following laws, among others:

A. Requirements set forth in 42 C.F.R. §438.210(e), compensation to MCNA or any individuals who many conduct utilization management activities is not structured so as to provide incentives for the individual or MCNA to deny, limit, or discontinue medically necessary services to any member;

B. Requirements set forth in 42 C.F.R. §438.106(c) and §1932(b)(6), stating that Providers shall not bill members any amount greater than would be owed if the MCNA provided the services directly;

C. Requirements set forth in 42 C.F.R. §455, Subpart B, stating that Provider shall comply and submit to MCNA disclosure of required information;

D. Environmental Protection Laws:

i. Pro-Children Act of 1994 (20 U.S.C. §6081 et seq.) regarding the provision of a smoke-free workplace and promoting the non-use of all tobacco products;

ii. National Environmental Policy Act of 1969 (42 U.S.C. §4321 et seq.) and Executive Order 11514 ("Protection and Enhancement of Environmental Quality") relating to the institution of environmental quality control measures;

iii. Clean Air Act and Water Pollution Control Act regulations (Executive Order 11738, "Providing for Administration of the Clean Air Act and Federal Water Pollution Control Act with Respect to Federal Contracts, Grants, and Loans");

iv. State Clean Air Implementation Plan (42 U.S.C. §740 et seq.) regarding conformity of federal actions to State Implementation Plans under §176(c) of the Clean Air Act; and

v. Safe Drinking Water Act of 1974 (21 U.S.C. §349; 42 U.S.C. §300f to 300j-9) relating to the protection of underground sources of drinking water;

E. State and federal anti-discrimination laws:

i. Title VI of the Civil Rights Act of 1964, (42 U.S.C. §2000d et seq.) and as applicable 45 C.F.R. Part 80 or 7 C.F.R. Part 15;

ii. Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794);

iii. Americans with Disabilities Act of 1990 (42 U.S.C. §12101 et seq.);

iv. Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107);

v. Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681-1688);

vi. Food Stamp Act of 1977 (7 U.S.C. §200 et seq.);

vii. Executive Order 13279, and its implementing regulations at 45 C.F.R. Part 87 or 7 C.F.R. Part 16; and

viii. The Immigration Reform and Control Act of 1986 (8 U.S.C. §1101 et seq.) and the Immigration Act of 1990 (8 U.S.C. §1101, et seq.) regarding employment verification and retention of verification forms;

F. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191);

G. The Health Information Technology for Economic and Clinical Health Act (HITECH Act) at 42 U.S.C. 17931 *et. seq.*

3.13 **Laboratory Services**. If Provider performs laboratory services, the same must be conducted in accordance with all applicable state requirements and 42 C.F.R. §§493.1 & 493.3, and any other federal requirements.

3.14 **Access to Premises**. Provider shall allow duly authorized agents or representatives of the State or federal government or the independent external quality review organization required by Section 1902 (a)(30)(c) of the Social Security Act, 42 U.S.C. §1396a(a)(30), access to their premises during normal business hours. Provider shall cause similar access or availability to their premises to assist in internal and external quality assessment review, utilization management, and grievance procedures established by MCNA and/or DHHS or its designee and provide adequate space on the premises to reasonably accommodate the State, federal, or external quality review personnel conducting the audit, investigation, or inspection effort. As set forth, Provider shall forthwith produce all records, documents, or other data requested as part of such review, investigation, or audit.

In the event right of access is requested under this Section, Provider shall provide and make available staff to assist with the process. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of Provider's activities. All information obtained will be accorded confidential treatment as provided under applicable laws, rules and regulations.

The Provider agrees to provide to DHHS:

A. All information required under the State Contract, including but not limited to the reporting requirements and other information related to the Provider's performance of its obligations under the Agreement;

B. Any information in its possession sufficient to permit DHHS to comply with the federal Balanced Budget Act of 1997 or other federal or state laws, rules, and regulations. All information must be provided in accordance with the timelines, definitions, formats, and instructions specified by the Department.

All such information must be provided in accordance with the timelines, definitions, formats, and instructions specified by DHHS. Upon receipt of a record review request from DHHS or another state or federal agency authorized to conduct compliance, regulatory, or program integrity functions, Provider must provide, at no cost to the requesting agency, the records requested within three (3) business days of the request. If DHHS or another state or federal agency representative reasonably believes that the requested records are about to be altered or destroyed or that the request may be completed at the time of the request and/or in less than 24 hours, the Provider must provide the records requested at the time of the request and/or in less than 24 hours. The request for record review includes, but is not limited to clinical medical or dental Member records; other records pertaining to the Member; any other records of services provided to Medicaid or other health and human services program recipients and payments made for those services; documents related to diagnosis, treatment, service, lab results, charting; billing records, invoices, documentation of delivery items, equipment, or supplies; radiographs and study models related to orthodontia services; business and accounting records with backup support documentation; statistical documentation; computer records and data; and/or contracts with providers and subcontractors. Failure to produce the records or make the records available for the purpose of reviewing, examining, and securing custody of the records may result in the DHHS imposing sanctions as provided by state law, against the Provider.

3.15 **Corrective Action Plan.** In the event that a corrective action plan is initiated by MCNA and/or required by DHHS, the Provider shall comply with the same. MCNA may assess and Provider shall pay any monetary fines or other sanctions imposed on Provider at the direction of DHHS for failure or refusal to respond to

MCNA's requests for credentialing information, access to dental records, or other material information in respect of this Agreement

3.16 **Provider Indemnity**. Provider shall indemnify, defend and hold DHHS harmless from all claims, losses, or suits relating to activities undertaken pursuant to the contract between DHHS and MCNA. Provider further covenants and agrees that in the event of a breach of this Agreement by MCNA, termination of this Agreement, or insolvency of MCNA, Provider shall provide all services and fulfill all of its obligations pursuant to the Agreement for the remainder of any month for which DHHS has made payments to MCNA, and shall fulfill all of its obligations respecting the transfer of Covered Persons to other providers, including record maintenance, access and reporting requirements, all such covenants, agreements, and obligations of which shall survive the termination of this Agreement.

3.17 **State as Third Party Beneficiary**. Provider acknowledges and agrees that the State is the intended third-party beneficiary of this Agreement and, as such, the State is entitled to all remedies available to third-party beneficiaries under Nebraska law.

3.18 **Incorporation of State Contract Provisions**. All provisions of the State Contract with respect to: (i) MCNA's Quality Assessment Performance Improvement ("QAPI") program; (ii) Utilization Management ("UM") requirements; (iii) all record keeping and reporting requirements; (iv)the confidentiality of patient information; and (v) all other applicable State and federal laws, are hereby incorporated by reference into this Agreement.

3.19 **Suspected Fraud and Abuse**. Provider shall immediately report all suspected fraud and abuse to MCNA.

3.20 **Coordination of Benefits (COB)**. Provider must report all COB information to MCNA.

3.21 **Accreditation**. If applicable, Provider shall provide MCNA with a copy of its current certificate of accreditation from NCQA/URAC or other national accreditation body, if and as applicable, together with a copy of any survey report in connection therewith, subject to the applicable restrictions of such accrediting body.

3.22 **Non-Discrimination by Provider**. At all times during the performance of this Agreement, the Provider agrees as follows:

A. Provider shall not discriminate against any employee or applicant for employment because of race, color, religion, sex, or national origin. Provider will take affirmative action to ensure that applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex or national origin. Such action shall include, but not be limited to

the following: employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. Provider agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of this nondiscrimination clause.

B. Provider will, in all solicitations or advertisements for employees placed by or on behalf of Provider, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex or national origin.

C. If applicable, Provider will send to each labor union or representative of workers with which he has a collective bargaining agreement or other contract or understanding, a notice, to be provided by the agency contracting officer, advising the labor union or workers' representative of Provider's commitments under Section 202 of Executive Order No. 11246 of September 24, 1965, and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

D. If applicable, Provider will comply with all provisions of Executive Order No. 11246 of Sept. 24, 1965, and of the rules, regulations, and relevant orders of the Secretary of Labor.

E. If applicable, Provider will furnish all information and reports required by Executive Order No. 11246 of September 24, 1965, and by the rules, regulations, and orders of the U.S. Secretary of Labor, or pursuant thereto, and will permit access to his books, records, and accounts by the contracting agency and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

F. In the event of Provider 's noncompliance with the applicable nondiscrimination clauses of this Agreement or with any of such rules, regulations, or orders, this Agreement may be cancelled, terminated or suspended in whole or in part and Provider may be declared ineligible for further Government contracts in accordance with procedures authorized in Executive Order No. 11246 of Sept. 24, 1965, and such other sanctions may be imposed and remedies invoked as provided in Executive Order No. 11246 of September 24, 1965, or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

G. If applicable, Provider will include the provisions of paragraphs (A) through (G) in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Section 204 of Executive Order No. 11246 of September 24, 1965, so that such provisions will be binding upon each subcontractor or vendor. The contractor will take

such action with respect to any subcontract or purchase order as may be directed by the Secretary of Labor as a means of enforcing such provisions including sanctions for noncompliance: Provided, however, that in the event Provider becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction, Provider may request the United States to enter into such litigation to protect the interests of the United States.

3.23 Quality of Services. Provider shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with the level of care, which is recognized as acceptable professional practice in Nebraska and/or the standard established by DHS or its designee. Provider shall also submit all reports and clinical information as required by MCNA in order to comply with reporting purposes such as HEDIS, CMS 416, DQA, AHRQ, and EPSDT.

3.24 Prohibited Conduct. Provider shall not encourage or suggest that members be placed in state custody in order to receive medical or specialized behavioral health services covered by DHHS.

ARTICLE IV
STATE MANDATED REQUIREMENTS

4.1 **Audit or Investigation.** The Provider agrees to provide the following entities or their designees with prompt, reasonable, and adequate access to this Agreement and any records, books, documents, and papers that are related to this Agreement and the Provider's performance of its responsibilities under this Agreement:

A. Nebraska Department of Health and Human Services (DHHS);

B. U.S. Department of Health and Human Services (HHS);

C. Centers for Medicare and Medicaid Services (CMS);

D. Nebraska Medicaid Program Integrity (NMPI);

E. Nebraska Medicaid Fraud and Patient Abuse Unit (MFPAU);

F. An independent verification and validation contractor or quality assurance contractor acting on behalf of DHHS;

G. Any State or federal law enforcement agency;

H. Special or general investigation committee of the Nebraska Legislature;

I. Comptroller;

J. The Office of the State Auditor of Nebraska; and

K. The Nebraska Attorney General's Office and any other state or federal entity identified by DHHS, or any other entity engaged by DHHS.

The Provider must provide aeccss wherever it maintains such records, books, documents, and papers. The Provider must provide such access in reasonable comfort and provide any furnishings, equipment, and other conveniences deemed reasonably necessary to fulfill the purposes described herein. Requests for access may be for, but are not limited to: examination; audit; investigation; contract administration; the making of copies, excerpts, or transcripts; or any other purpose DHHS deems necessary for contract enforcement or to perform its regulatory functions.

Provider understands and agrees that the acceptance of funds under this Agreement acts as acceptance of the authority of the State Auditor's Office ("***SAO***"), or any successor agency, to conduct an investigation in connection with those funds. Provider further agrees to cooperate fully with the SAO or its successor in the conduct of the audit or investigation, including providing all records requested.

4.2 **Changes to Compensation and Fee Schedules.** If MCNA elects to make any changes to the Provider's fee schedule or payment for Covered Services, MCNA shall provide Provider at least ninety (90) days notice prior to the effective date of the change.

4.3 **Claims Payment.** Provider shall submit all clean claims for payment in accordance with the Timely Filing requirements set forth the in the Provider Manual. MCNA shall pay Ninety percent (90%) of all clean claims within fifteen (15) business days of the date received. MCNA shall pay ninety-nine (99%) of all clean claims within thirty (30) calendar days of the date of receipt. MCNA and Provider may, by mutual agreement, establish an alternative payment schedule. Any alternative payment schedule must be stipulated in the Agreement. Provider is prohibited from billing or collecting any amount from a Medicaid Member for dental services provided pursuant to this Agreement. Federal and state laws provide severe penalties for any provider who attempts to bill or collect any payment from a Medicaid recipient for a Covered Service. Provider understands and agrees that DHHS is not liable or responsible for payment for Covered Services rendered pursuant to this Agreement.

4.4 **Payment Terms**. The following additional terms for claims payment are applicable:

A. The method of payment applicable to this Agreement is set forth on **Appendix A** hereto and in the Provider Manual.

B. In order to submit a clean claim, Provider must attach all of the information as required in the Provider Manual for each claim submittal.

C. MCNA will provide the Provider at least 90 days notice prior to implementing a change in the above-referenced claims guidelines, unless the change is required by statute or regulation in a shorter timeframe.

D. Provider must submit claims for processing and/or adjudication to MCNA at the place and in the manner described in the Provider Manual.

E. MCNA will notify Provider in writing of any changes in its list of claims processing or adjudication entities at least 30 days prior to the effective date of change. If MCNA is unable to provide 30 days notice, MIC or MCNA shall give Provider a 30-day extension on their claims filing deadline to ensure claims are routed to the correct processing center.

4.5 **Complaints and Appeals.** The complaint and appeal processes that apply to Provider are contained in the Provider manual. The Provider understands and agrees that DHHS and MCNA reserve the right and retains the authority to make reasonable inquiry and to conduct investigations into Provider and Member complaints.

4.6 **Confidentiality.** Provider must treat all information that is obtained through the performance of the services included in this Agreement as confidential information to the extent that confidential treatment is provided under state and federal laws, rules, and regulations. This includes, but is not limited to, information relating to applicants or recipients of DHHS Programs, this Agreement, MCNA's Provider Manual, internet portal, and all other materials provided by MCNA to Provider in connection with this Agreement. Provider shall not use information obtained through the performance of this Agreement in any manner except as is necessary for the proper discharge of its obligations under this contract. Provider shall protect the confidentiality of Member Protected Health Information (PHI), including patient records in accordance with State and federal law. Provider shall comply with all applicable Federal and State laws, including the HIPAA Privacy and Security Rule governing the use and disclosure of PHI.

4.7 **Continuation of Care.** Provider shall, upon termination of the Agreement for reasons other than a quality of care issues or fraud, continue to provide and be compensated for Covered Services to Covered Persons under the terms and conditions of the Agreement until the earlier of such time that: (1) such Covered Person has completed his/her course of treatment; or (2) reasonable and medically appropriate arrangements have been made for a Participating Dental Provider to

render health care services to the Covered Person. If Provider is a facility, Provider shall continue to provide and be paid for Covered Services to Covered Persons under the same terms and conditions of the Agreement until such Covered Person is discharged from the facility. For purposes of this provision, "discharge" shall mean the Covered Person's physical release from the facility. This provision shall survive the termination of the Agreement.

4.8 **Costs of Non-covered Services.** Provider must inform Members of the costs for non-covered services prior to rendering such services and must obtain a signed Private Pay Form (to be supplied by Provider) from such Member.

4.9 [Intentionally left blank]

4.10 **Fraud and Abuse.** Provider understands and agrees to the following:

A. DHHS Nebraska Medicaid Program Integrity and/or the Nebraska Medicaid Fraud and Patient Abuse unit shall be allowed to conduct private interviews of Provider and its employees, agents, contractors, and patients;

B. Requests for information from such entities must be complied with, in the form and language requested;

C. Provider and its employees, agents, and contractors must cooperate fully with such entities in making themselves available in person for interviews, consultation, grand jury proceedings, pre-trial conference, hearings, trials and in any other process, including investigations at the Provider's own expense;

D. Compliance with these requirements, including all record production requirements, will be at the Provider's own expense.

E. Provider understands and agrees to the following:

i. Provider is subject to all state and federal laws and regulations relating to fraud, abuse or waste in health care and the Medicaid and/or CHIP Programs, as applicable;

ii. Provider must cooperate and assist DHHS and any state or federal agency that is charged with the duty of identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste;

iii. Provider must provide originals and/or copies of any and all requested information, allow access to the premises, and provide its records to the Office of Inspector General, DHHS, NMPI, MFPAU, the Centers for Medicare and Medicaid Services (CMS), the U.S. Department of

Health and Human Services, federal investigative agencies, the Nebraska Attorney General's Medicaid Fraud Control Unit or other unit of state or federal government, upon request, and free-of-charge;

iv. If the Provider places required records in another legal entity's custody, such as a hospital, the Provider is responsible for obtaining a copy of these records for use by the above-named entities or their representatives;

v. Provider must report any suspected fraud or abuse including any suspected fraud and abuse committed by MIC, MCNA, or a Member to Nebraska Medicaid Program Integrity.

4.11 **Liability.** In the event MCNA becomes insolvent or ceases operations, the Provider understands and agrees that its sole recourse against MCNA will be through MCNA's bankruptcy, conservatorship, or receivership estate. Provider understands and agrees that MCNA Members may not be held liable for MIC's or MCNA's debts in the event of the entity's insolvency. Provider understands and agrees that DHHS does not assume liability for the actions of, or judgments rendered against, MIC, MCNA, their employees, agents or subcontractors. Further, the Provider understands and agrees that there is no right of subrogation, contribution, or indemnification against DHHS for any duty owed to the Provider by MIC or MCNA or any judgment rendered against MIC or MCNA.

MIC or MCNA has full authority to initiate and maintain any action necessary to stop a Provider or employee, agent, assignee, trustee, or successor-in-interest from maintaining an action against DHHS, an HHS Agency, or any Member to collect payment from DHHS, any DHHS Agency, or any Member, excluding payment for non-covered services. This provision does not restrict Provider from collecting allowable copayment and deductible amounts from Members. Additionally, this provision does not restrict Provider from collecting payment for services that exceed an adult Member's benefit cap, if any.

Provider understands and agrees that DHHS is not liable or responsible for payment for Covered Services rendered pursuant to the Provider contract.

4.12 **Marketing.** Provider agrees to comply with DHHS's marketing policies and procedures, as set forth in the State Contract. Provider is prohibited from engaging in direct marketing to Members that is designed to increase enrollment in a particular health plan. The prohibition does not constrain Providers from engaging in permissible marketing activities consistent with broad outreach objectives and program application assistance.

4.13 **Material Changes; Amendments.** This Agreement, including any and all attachments, may only be modified through a written amendment that is incorporated and attached to this Agreement and duly signed by the parties.

Notwithstanding, MCNA may propose amendments to this Agreement upon thirty (30) days prior written notice to Provider and DHHS. Unless Provider objects in writing to such amendment within the thirty (30) day notice period, Provider shall be deemed to have accepted the amendment. MCNA and Provider agree to negotiate such further amendments as may be necessary to correct any inequities that result to either party as a result of changes to the Agreement made by MCNA, or any changes to applicable federal or state law that materially affects the position of either party. Notwithstanding the foregoing, MCNA shall make any material changes to this Agreement or any attachments and exhibits that are reasonably necessary to comply with any applicable State or federal law and applicable provisions of the State Contract. In the event Provider wishes to opt out of any material change to the Agreement, Provider may terminate this Agreement in accordance with its terms.

4.14 **Participation in Other MCNA Benefit Plans.** MCNA shall not require Provider, as a condition of participation under the Agreement, to participate in any of MCNA's other dental benefit plans without affording Provider the opportunity to opt out. MCNA will give Provider thirty (30) days advance notice of any additional dental benefit plans to be offered and Provider may opt out of such additional plans by giving written notice to MCNA within ten (10) days of its receipt of the MCNA notice.

4.15 **Professional Conduct.** While performing the services described in the Agreement, the Provider agrees to:

A. Comply with applicable state laws, rules, and regulations and DHHS' requests regarding personal and professional conduct generally applicable to the service locations;

B. Otherwise conduct themselves in a businesslike and professional manner.

4.16 **Provider's Disclosure to Covered Persons.** MCNA shall not limit, penalize or terminate the Agreement due to Provider's disclosure to a Covered Person who is Provider's patient (i) all treatment options with the Covered Person; (ii) any information that the Provider determines to be in the best interest of the Covered Person; and (iii) financial incentives and financial arrangements between the Provider and MCNA.

4.17 **Provider Subcontracts.** Provider shall not, without prior approval from MCNA, enter into any subcontract or other agreement for any of the work contemplated under this Agreement without receiving approval from MCNA. In the event Provider secures prior approval and enters into any subcontract agreement with another provider to provide Covered Services to Covered Persons, such agreement shall meet all requirements of the Agreement.

4.18 **Provider Linkages.** MCNA may establish from time to time, a maximum number of linkages to a participating Primary Care Dentist (PCD) in accordance with state law and DHHS regulations.

4.19 **Third Party Recovery.** Provider understands and agrees that it may not interfere with or place any liens upon the State's right or MCNA's right, acting as the State's agent, to recovery from third party resources.

Providers must identify TPL coverage, including Medicare and long-term care insurance as applicable, and seek all TPL payments before submitting claims for dental care services to MCNA for reimbursement. All claims involving TPL must include the Remittance Advice or Explanation of Benefits from the Third Party Resource as an attachment to the claim and the claim must be properly noted as involving Coordination of Benefits or TPL.

IN WITNESS WHEREOF, the parties hereto have executed this Product Attachment to the Master Provider Agreement effective as of the date all required Parties have affixed their signature below.

Managed Care of North America, Inc.,
d/h/a/ MCNA Dental Plans,
a Florida corporation

By: _____
Printed Name:
Title:

Signature Date:

Effective Date of Agreement: _____
(To be completed by MCNA only)

[Provider]

By: _____
Printed Name:
Title:

Signature Date:

Tax Identification Number: _____

National Provider Identifier: _____

Dentist Medicaid Number: _____

Group Medicaid Number: _____

Group Corporate Address: _____
_____
_____

DRAFT

APPENDIX A

PROVIDER REIMBURSEMENT

MCNA will pay one hundred percent (100%) of the most current Medicaid allowable fee schedule on file with the Nebraska Department of Health and Human Services as of July 1, 2017 for the provision of the Medicaid dental services contemplated in this Agreement.

For any subcontract with an FQHC/RHC, MCNA shall reimburse the FQHC/RHC in accordance with 471 NAC Chapters 29 and 34.

DRAFT

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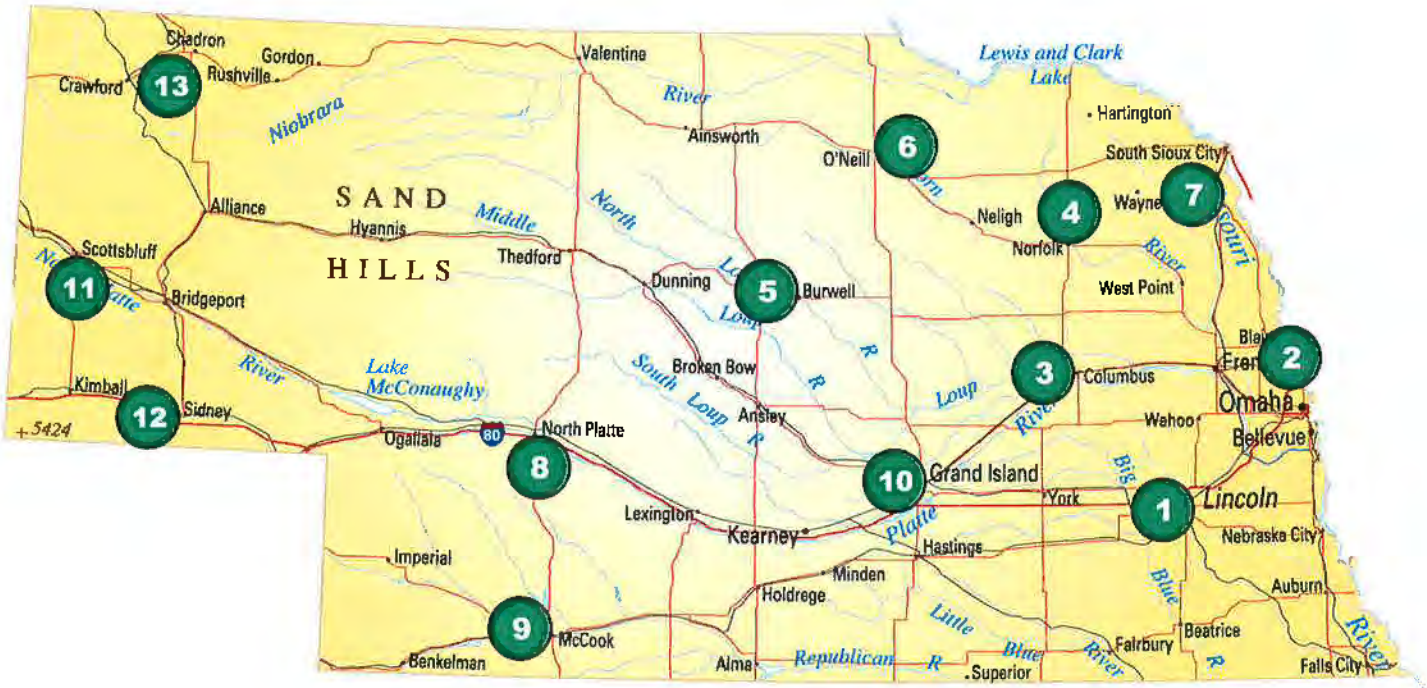
Attachment 28-1
Provider Site Audit Tool

This content has been redacted.

Attachment 35-1
Provider Training Seminars

mcnadental

MCNA Regional Provider Recruiting and Training Seminars in Nebraska



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

For more information about these seminars, please contact the MCNA Provider Hotline at **1-844-353-6262**. Note that dates and locations are subject to change. Please visit our website **http://www.mcnane.net** regularly to check for schedule updates.

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

2017 Regional Training Seminars

1	**Lincoln**	**April 3rd and 7th** 10am-12pm or 2pm-4pm	**Best Westen Plus** 2201 Wildcat Circle, Lincoln, NE 68521
2	**Omaha**	**April 4th and 7th** 10am-12pm or 2pm-4pm	**Comfort Inn & Suites - Grover** 2502 W Clark Rd, Clarksville, AR 72830
3	**Columbus**	**April 5th** 10am-12pm or 2pm-4pm	**Ramada Columbus Hotel and Conf Center** 265 33rd Ave, Columbus, NE 68601
4	**Norfolk**	**April 6th** 10am-12pm or 2pm-4pm	**Divots Conference Center** 4200 W Norfolk Ave, Norfolk, NE 68701
5	**Burwell**	**April 3rd** 10am-12pm or 2pm-4pm	**Calamus Lodge** 46358 828th Rd, Burwell, NE 68823
6	**O'Neill**	**April 4th** 10am-12pm or 2pm-4pm	**Holiday Inn Express O'Neill** 1020 Douglas Street, O'Neill, NE 68763
7	**Sioux City**	**April 5th** 10am-12pm or 2pm-4pm	**Marina Inn Hotel & Conference Center** South Sioux City, NE 67886
8	**North Platte**	**April 17th** 10am-12pm or 2pm-4pm	**Holiday Inn Express North Platte** 300 Holiday Frontage Rd, Nort Platte, NE 69101
9	**McCook**	**April 18th** 10am-12pm or 2pm-4pm	**Horse Creek Inn** 1 Bison Holiday Dr, McCook, NE 69001
10	**Grand Island**	**April 19th** 10am-12pm or 2pm-4pm	**Quality Inn & Conference Center** 7838 S US Hwy 281, Grand Island, NE 68803
11	**Scottsbluff**	**April 17th** 10am-12pm or 2pm-4pm	**Hampton Inn & Suites Conference Center** 301 W Hwy 26, Scottsbluff NE 69361
12	**Sidney**	**April 18th** 10am-12pm or 2pm-4pm	**Country Inn & Suites by Carlson** 664 Chase Blvd, Sidney, NE 69162
13	**Chadron**	**April 19th** 10am-12pm or 2pm-4pm	**Best Western West Hills Inn** 1100 West 10th St, Chadron, NE 69337

Snacks and refreshments will be provided.

2017 Online Webinars

Online at http://mcnadental.webex.com April 9, 10, 11, 12, 13, 23, 24, 25, 26, 27

All Online Webinars are available in an afternoon session from **1:00 pm - 2:30 pm**.
Webinar access information will emailed to you upon your RSVP.

Louisiana Provider Manual

Last Updated: October 2016

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1. Welcome

Dear MCNA Provider:

Managed Care of North America (MCNA) would like to take this opportunity to welcome you and your staff as part of our national network of dental providers. We are pleased that you have chosen to participate with us. Throughout your ongoing relationship with MCNA this Provider Manual will give you useful information concerning the MCNA plans in which you have chosen to participate.

MCNA was founded by a group of dentists with extensive backgrounds in the field of dental care and dental plan operations. MCNA's goal is to provide quality dental services to members and providers. MCNA recognizes the vital role the dental office plays in a successful dental plan. The purpose of this Provider Manual is to provide you with an explanation of MCNA's administrative policies and procedures, provisions, and the role you play as a dentist.

When communicating with our network providers, we make every effort to be clear and concise. Our expectation is to answer questions promptly when they arise. We strive to provide accurate and effective information that allows you and your dental team to understand which American Dental Association (ADA) Current Dental Terminology (CDT) codes are covered and what to expect from MCNA.

For the latest version of this manual in digital form, please access the MCNA Provider Portal at:

http://portal.mcna.net

or visit:

http://manuals.mcna.net/louisiana

to download a PDF version directly.

MCNA may make additions, deletions, or changes to the policies and procedures described in this Provider Manual at any time and will give providers at least 30 days advance notice before implementation. As a participating provider, your agreement requires you to comply with MCNA policies and procedures including those contained in this manual.

If you require assistance or information that is not included within this manual, please contact our Provider Hotline (See Section 2: Contact Information).

We will communicate changes in MCNA's policies and procedures as well as state and federal laws to you through the dissemination of provider bulletins.

Again, we welcome you and your staff to the growing list of MCNA providers. We look forward to a successful relationship with you and your practice.

Sincerely,
MCNA Provider Relations Department

2. Contact Information

For the quickest service, please use the contact information listed below. Please note that calls may be recorded for quality assurance purposes.

2.1. MCNA Member Hotline

Our Member Services Department is open from 7am – 7pm CST, Monday – Friday, excluding national holidays.

Main:	1-855-702-MCNA (1-855-702-6262)
TDD/TTY:	1-800-846-5227

2.2. MCNA Automated Eligibility Verification

Our Automated Member Eligibility Hotline is available 24 hours a day, 7 days a week.

Main:	1-855-702-MCNA (1-855-702-6262)
Online:	http://portal.mcna.net

2.3. MCNA Provider Hotline

For provider enrollment, direct deposit issues, reporting changes and ownership, NPI, etc.

Main:	1-855-701-MCNA (1-855-701-6262)
eFax:	1-877-563-8560

2.4. MCNA Credentialing

Main:	1-855-701-MCNA (1-855-701-6262)
Main Fax:	1-954-730-7131

2.5. MCNA Utilization Management (Pre-Authorizations and Referrals)

Main:	1-855-701-MCNA (1-855-701-6262)
eFax:	1-954-628-3331 *(Not for pre-authorization/referral submissions.)*
Email:	um_la_group@mcna.net *(For questions and status updates only, not for pre-authorization/referral submissions.)*

2.6. MCNA Provider Portal Helpdesk

Main:	1-855-232-MCNA (1-855-232-6262)

2.7. MCNA Hotlines

Fraud, Waste, and Abuse:	1-855-FWA-MCNA (1-855-392-6262)
Compliance:	1-855-683-MCNA (1-855-683-6262)

2.8. MCNA Corporate Headquarters

When sending mail to a specific department, please address it to the attention of that department.

Main:	1-800-494-MCNA (1-800-494-6262)
Main Fax:	1-954-730-7875
Online:	http://www.MCNA.net
Mailing Address:	**MCNA Dental** 200 West Cypress Creek Road, Suite 500 Fort Lauderdale, FL 33309

2.9. Louisiana Recipient Eligibility Verification (REVS)

Main:	1-800-776-6323

2.10. Medicaid Eligibility Verification System (MEVS)

An automated eligibility verification system using a swipe card device or PC software through vendors.

2.11. E-Medicaid Eligibility Verification System (E-MEVS)

A web application accessed through www.lamedicaid.com

2.12. Louisiana Office of Management and Finance (Bureau of Health Services Financing) - Medicaid

For general Medicaid and ID card questions.

Main:	1-888-342-6207
TDD/TTY:	1-800-220-5404
Online:	www.healthy.la.gov
Email:	MedWeb@dhh.la.gov
Mailing Address:	**Bureau of Health Services Financing** P.O. Box 91030 Baton Rouge, LA 70821

2.13. Louisiana Office of Aging and Adult Services (OAAS)

Main:	1-866-758-5035
Main Fax:	1-225-219-0202
Email:	OAAS.Inquiries@la.gov
Mailing Address:	**Office of Aging and Adult Services** P.O. Box 2031 Baton Rouge, LA 70821

2.14. Health Plan Relations

Main:	1-855-229-6848
TDD/TTY:	1-800-220-5404
Main Fax:	1-225-342-9855
Online:	www.MakingMedicaidBetter.com
Email:	Healthy@la.gov
Mailing Address:	**Health Plan Relations** P.O. Box 1283 Baton Rouge, LA 70821

2.15. Louisiana Program Integrity (PI)

Main:	1-225-219-4149
Main Fax:	1-225-219-4155
Fraud and Abuse Hotline:	1-800-488-2917
Mailing Address:	**Medicaid Program Integrity** Attention Compliance Unit Louisiana Department of Health P.O. Box 91030 Baton Rouge, LA 70821

2.16. Louisiana Division of Administrative Law (DAL)

Formerly LDH Bureau of Appeals.

Main:	1-225-342-5800
Main Fax:	1-225-219-9823
Online:	http://www.adminlaw.state.la.us/
Mailing Address:	**Division of Administrative Law** P.O. Box 4189 Baton Rouge, LA 70821

2.17. Louisiana Department of Children and Family Services (DCFS)

Main:	1-855-4LA-KIDS (1-855-452-5437)
Online:	www.dcfs.la.gov

3. Revision History

Version	Date	Revision Information
1.6	10/11/2016	Clarification for emergency dental services.
1.5	7/26/2016	Updated the pre-authorization time frame to remain valid for 180 days rather than 90 days. Revised the claims timely filing time frame from 180 days to 365 days from the date of service. Noted in the Third Party Liability section that all claims must be finalized in 24 months. Clarified the prompt payment standard is business rather than calendar days. Added contact number for Case Management Department. Extended date to file reconsideration from 60 to 365 days. Included language about ability to file consolidated complaints and in person complaints. Clarified that replacement and recementation of space maintainers is the provider's responsibility for the first 12 months. Added language about cutback for restorations.
1.4	1/28/2015	Edits to timely filing requirements and reconsideration timeframe. Clarification to the requirement for recementation of space maintainers.
1.3	9/15/2014	Edits to emergency treatment authorizations.
1.2	7/2/2014	Change to Radiographs section in Adult Denture Program Covered Services.
1.1	6/30/2014	Update to Pediatric Dentistry Conscious Sedation Form.
1.0	6/20/2014	Initial Version.

4. Program Overview

Dental programs are governed by regulations found in the Code of Federal Regulations 42CFR 440.40 and 42CFR 440.50 that describe the services available through the programs, including the required services for children under the age of 21.

The Louisiana Medicaid Dental Services include the following programs:

- EPSDT Dental
- Adult Denture Program

Louisiana Medicaid refers to Children's Medicaid and LaCHIP together as the "EPSDT Dental Program."

5. Criteria for Network Participation

The Dentist Participation Criteria lists a variety of requirements that a participating provider must meet. These requirements include standards regarding dental office physical attributes, practice coverage, member access, office procedures, office records, insurance and professional qualifications, and staff work history. The criteria are used in our credentialing and re-credentialing process and a full listing is attached to our current Provider Agreement.

5.1. Applicability

The participation criteria apply to each new applicant for participation in MCNA's network, and to all providers currently participating. They shall be enforced by MCNA as required by the EPSDT Dental and/or the Adult Denture program(s). Any provider applying to join MCNA's network must be licensed in the State of Louisiana from the Louisiana State Board of Dentistry and must adhere to the Louisiana State Board of Dentistry Requirements concerning the delivery of dental services.

An applicant must satisfactorily document evidence meeting the criteria listed for at least six (6) months prior to application unless that provider has entered clinical practice or completed a residency or a fellowship program within the past six (6) months, or currently participates with Louisiana EPSDT Dental and/or the Adult Denture program.

The following additional requirements for continued participation in MCNA's network apply to all participating providers:

- All MCNA participating providers in a group practice must meet MCNA credentialing criteria. If one or more of the providers in the group fail to meet the criteria, the entire group cannot participate.
- All MCNA participating providers must be credentialed, execute a Provider Agreement, and agree to provide all services to EPSDT Dental and/or Adult Denture members as set forth by the EPSDT Dental and Adult Denture programs. Providers who offer only diagnostic and preventive services do not meet the necessary criteria for participation.
- All MCNA participating providers must apply for re-credentialing every three (3) years.

5.2. On-Site Office Survey

On-site office surveys are conducted on an ongoing basis for participating offices. These surveys focus on essential areas of office management and dental care delivery. During the survey, which may or may not be scheduled in advance, the following areas are evaluated:

1. **General Information** – the name of the practice, address, name of principal owner and all associates, license numbers, staffing information, office hours, list of foreign languages spoken in the office, availability of appointments, method of providing 24 hour coverage (e.g., answering machine or answering services), and the name of the covering dentist when a provider is unavailable (e.g., office closed or provider on vacation).
2. **Practice History** – information regarding malpractice suits, settlements, and disciplinary actions, if applicable.
3. **Office Profile** – overview of services routinely performed.

4. **Facility Information** – description of location, accessibility (including handicap accessibility), interior office and the reception area, operatories and lab, type of infection control, general equipment, and radiographic equipment.
5. **Risk Management** – review of personal protective equipment (e.g., gloves, masks, equipment to handle waste disposal, equipment and methods to handle sterilization and disinfection), training programs for staff, radiographic procedures and safety, occupational hazard control regarding amalgam, nitrous oxide, and hazardous chemicals, and medical emergency preparedness training and equipment.
6. **Recall System** – review of procedures for assuring members are scheduled for recall examinations and follow-up treatment.
7. **Provider Credentials** – verification that all MCNA participating dental providers in a group practice are credentialed by MCNA.

5.3. Credentialing/Re-Credentialing

Credentialing is the review of qualifications and other relevant information pertaining to a dental care professional who seeks acceptance into MCNA's provider network. Our Credentialing Program follows the recommended CMS categories, which include:

- **Initial Credentialing** – written application, verification of information from primary and secondary sources, confirmation of eligibility for payment under Medicaid and site visits, as appropriate.
- **Monitoring** – monitoring of lists of practitioners who have been sanctioned and/or had grievances filed against them, and of practitioners who opt-out of accepting federal reimbursement from Medicaid. Monitoring is conducted on a regular basis between credentialing and re-credentialing cycles.
- **Re-credentialing** – re-evaluation of Provider's credentials at least once every three (3) years through a process that updates the information obtained during initial credentialing. Re-credentialing considers performance indicators such as those collected through the Quality Improvement (QI) program, the Utilization Management system, the Grievance system, enrollee satisfaction surveys, and other activities of the organization.
- **Expedited Credentialing** – records for a select provider (or provider group) are given priority status.
- **Temporary Credentialing** – provisional credentialing where MCNA runs basic verifications. If no adverse information is initially found, the provider is granted network privileges while MCNA completes all the credentialing elements. If the provider does not meet the full set of credentialing criteria, network participation privileges are rescinded and recoupment efforts ensue.

Additionally, MCNA will:

- Verify Louisiana license through appropriate licensing agency
- Review state and federal sanction activity including Medicare/Medicaid services (OIG-Office of Inspector General and State Medicaid Agencies)
- Review monthly reports released by the Office of Inspector General and local Medicaid Agencies for any network providers who have been newly sanctioned or excluded from participation in Medicare/Medicaid

All providers are required to complete the Dental Credentialing Form.

MCNA's Credentialing Program establishes the selection criteria for qualification as a participating provider. The criteria are reviewed and approved by the Credentialing Committee. The full set of criteria is clearly outlined by the credentialing application.

Additionally, current copies of the following documents must be attached to an application for initial credentialing as well as for re-credentialing. These documents are required as components of the selection criteria and will be verified through primary and secondary sources.

- Louisiana Dental License
- National Provider Identifier (NPI)
- Controlled Substance Registration Certificate from the Drug Enforcement Agency (DEA)
- Professional Liability Insurance Face Sheet
- Curriculum Vitae
- Board Certificate or Evidence of adequate training
- Completed W-9 Form
- Signed Provider Agreement/Contract
- Signed Provider Application

It is the provider's responsibility to submit any renewal certification documentation or changes in information to MCNA within 10 business days of any change. MCNA encourages all eligible providers to seek applicable Board Certification.

MCNA will send a letter to a provider with a license nearing expiration, according to the most current information received from the provider.

5.4. Credentialing Committee Appeals

In the event an applicant is credentialed with restrictions or denied, the Credentialing Committee offers an opportunity to appeal. An appeal must be requested in writing and must be reviewed by the committee within 30 days of the date the committee gave notice of its decision.

A copy of MCNA's credentialing policies can be obtained by contacting the Credentialing department (See Section 2: Contact Information).

5.5. Practice Requirements

Each dentist's office must:

- Have a sign containing the names of all dentists practicing at the office. The office sign must be visible when the office is open.
- Have a mechanism for notifying members if a dental hygienist or other non-dentist dental professional may provide care.
- Be accessible to all members in all areas, including but not limited to, the entrance, parking, and bathroom facilities.
- Have offices that are clean, presentable, and professional in appearance.
- Be a non-smoking facility and have a no-smoking sign prominently displayed in the waiting room.
- Have clean and properly equipped non-staff toilet and hand-washing facilities.
- Have a waiting room that will accommodate at least four (4) members.
- Have treatment rooms that are clean, properly equipped, and contain functional, adequately supplied hand washing facilities.
- Have at least one (1) staff person (in addition to the provider) on duty during normal office hours.

- Provide a copy of current licenses and certificates for all providers, dental hygienists, and other non-dentist dental professionals practicing in the office, including state professional licenses and certificates, Federal Drug Enforcement, and State Controlled Drug Substance licenses and certification (where applicable).
- Keep a file and make available to MCNA any state-required practices and protocols or supervising agreements for dental hygienists and other non-dentist dental professionals practicing in the office.
- Have appropriate, safe x-ray equipment. Radiation protection devices including, but not limited to, lead aprons shall be available and used according to professionally recognized guidelines, such as Food and Drug Administration guidelines. Signs warning pregnant women of potential exposure must be prominently displayed.
- Use appropriate sterilization procedures for instruments and use gloves and disposable needles. All staff shall maintain the standards and techniques of safety and sterility in the dental office required by applicable federal, state, and local laws and regulations including, but not limited to, those mandated by OSHA, and as advocated by the American Dental Association (ADA) and state and local societies.
- Comply with all applicable federal, state, and local laws and regulations regarding the handling of sharps and environmental waste, including the disposal of waste and solutions.
- Make appointments in an appointment book or the electronic equivalent accepted by MCNA. Appointments should be made in a manner that will prevent undue member waiting time and in compliance with the access criteria listed in this manual.
- Have documented emergency procedures, including procedures addressing treatment, evacuation, and transportation plans to provide for the safety of members.
- Upon request, provide members with the MCNA Member Services Hotline number to receive a copy of their rights and responsibilities as listed in the Member Handbook.
- Provide translation assistance services to any member whose native language is different from English.
- Have a functional recall system in place to notify members of the need to schedule dental appointments. The recall system must meet the following requirements for all enrolled members:
    - The system must include either written or verbal notification
    - The system must have procedures for scheduling and notifying members of routine checkups, follow-up appointments, and cleaning appointments
    - The system must have procedures for the follow-up and rescheduling of missed appointments

MCNA encourages its providers to attempt to decrease the number of "no shows." Provider offices should contact the member prior to a scheduled appointment either by phone or in writing to remind them of the time and place of the appointment. Follow-up phone calls or written information should be provided encouraging the member to reschedule the appointment in the event the appointment is missed.

5.6. Sterilization and Infection Control

Members and all office staff must be protected from infectious and environmental contaminants.

The following OSHA requirements must be met, without exception:

- All personnel should wash with bacterial soap before all oral procedures.
- Dental gloves, facemask, and eye protection should be worn.
- All instruments should be thoroughly scrubbed before sterilization.

- All instruments and equipment that cannot be sterilized, including operating light chair switches, hand pieces, cabinet working surfaces, and water/air syringes and their tips, should be disinfected, using approved techniques, after each use.
- ADA-approved sterilization solutions should be utilized.
- All equipment should be monitored using process indicators with each load and spore testing on a weekly basis.
- Handling of all environmental waste, including the disposal of waste and solutions, must be completed in compliance with all applicable federal, state, and local laws and regulations.

5.7. Medical Emergencies

All office staff shall be prepared to deal with any medical emergency through the implementation of the following guidelines:

- The provider and at least one other staff member must be currently certified in CPR procedures.
- The dental office must have a formal medical emergency plan and staff members must understand their individual responsibilities. All emergency numbers must be posted.
- Members with medical risk shall be identified in advance.
- All dental offices must have a portable source of oxygen with a positive demand valve, blood pressure cuff, and stethoscope.

6. Provider Roles and Responsibilities

6.1. Provider Rights

Each MCNA contracted provider that furnishes services to MCNA members shall be assured of the following rights:

1. A dental provider, acting within the lawful scope of practice, shall not be prohibited from advising or advocating on behalf of a member who is his/her patient, for the following:
    a. Member health status, medical care, or treatment options, including any alternative treatment that may be self-administered
    b. Any information the member needs in order to decide between all relevant treatment options
    c. The risks, benefits, and consequences of treatment or non-treatment
    d. Member right to participate in decisions regarding his/her health care, including the right to refuse treatment, and to express preferences about future treatment decisions
2. The right to receive information on the Grievance, Appeal, and State Fair Hearing procedures.
3. The right to access MCNA's policies and procedures covering the authorization of services.
4. The right to be notified of any decision by MCNA to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested
5. The right to challenge, at the request of a Medicaid EPSDT member and on their behalf, the denial of coverage of, or payment for, medical assistance.
6. The right to be free from discrimination with regard to MCNA's provider selection policies and procedures based on a provider's service to high-risk populations or specialization in conditions that require costly treatment.
7. The right to be free from discrimination for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his/her license or certification under applicable state law, solely on the basis of that license or certification.

6.2. Primary Care Dentist Role and Responsibilities

Louisiana defines a Primary Care Dentist as the provider of primary dental services. Establishment of a member's Primary Care Dentist begins no later than six (6) months of age and includes referrals to dental specialists for EPSDT Dental Program members under the age of 21, when appropriate.

Please note, Adult Denture program members do not need to be assigned to a Primary Care Dentist.

Louisiana defines primary dental services as dental services and laboratory services customarily furnished by or through a Primary Care Dentist for the evaluation, diagnosis, prevention, and treatment of diseases, disorders, or conditions of the oral cavity, maxillofacial areas, or the adjacent and associated structures. Primary dental services should be delivered through direct service to the member when possible or through the appropriate referral to specialists and/or ancillary providers.

MCNA must develop a network of Primary Care Dentists consisting of general or pediatric dentists that practice in solo or group practices. Primary Care Dentists may also practice in a clinic (Federally Qualified Health Centers or Rural Health Care Clinics). They provide preventive care to EPSDT Dental members and complete referrals for specialty care as needed. When an EPSDT member does not select a Primary Care Dentist, DentalTrac™ will

auto-assign to a Primary Care Dentist (general dentist or pediatric specialist) based on the following considerations:

1. Providers who are not in good standing are not considered during the auto-assignment methodology.

2. MCNA strives to keep families together. If a member of a family is assigned to a PCD, other members of the same family will be assigned to the same PCD. However, if the PCD has age restrictions that would prevent a family member from being assigned, we will assign that family member to another PCD in the same office that meets the age restrictions if possible.

3. If there is historical claims data that identifies a dentist that performed dental services on the member, we will assign the member to such dentist, as long as the dentist is a participating PCD that meets the age restrictions and travel distance requirement for the member.

4. For each member that needs to be auto-assigned to a PCD, we will generate a pool of participating PCDs that meet the age restrictions of the member who are located near the members residence address. The search radius will be increased until a PCD is located for assignment within the time and distance requirements of the plan. Once a pool of providers is generated, members living within that radius needing auto-assignment will be assigned to PCDs from this pool in a random sequence in order to equalize the patient load amongst providers within such radius.

Louisiana's EPSDT Dental and Adult Denture program participating providers must offer the same services to a Medicaid member as those offered to a non-Medicaid patient provided these services are reimbursable by the Medicaid program. In addition, participating providers have the responsibility to develop a provider-member relationship based on trust and cooperation. Coordination of care strengthens the positive relationship between the member and provider and is a critical tool for achieving positive oral health outcomes.

Primary Care Dentists must assess the dental needs of members for referral to specialty care providers and complete referrals as needed. Referrals must be made through MCNA. Providers can send referral requests through the online Provider Portal or via mail. Please contact the Provider Hotline for assistance with submitting a referral. Primary Care Dentists are responsible for coordinating care with specialty providers after referral.

If a referral is not submitted to MCNA, the treating dentist's claims for services will be denied. In order to receive appropriate payment for services rendered, the treating dentist must include the referral number in Box 2 of the ADA Claim Form, or in the "Pre-Authorization Number" field of the form in MCNA's Provider Portal. Failure to include the referral number may result in denial of the claim.

6.3. Specialist Role and Responsibilities

The role of the specialist (Endodontist, Orthodontist, Oral Surgeon, Pedodontist, Periodontist, and Prosthodontist) is to provide covered services to members for medically necessary treatment. Once treatment is complete, the specialist discharges the member back to their Primary Care Dentist for follow-up. MCNA allows Pedodontists to serve as Primary Care Dentists for our pediatric members.

6.4. Medically Necessary Services

Medically necessary services are those healthcare services that are delivered in accordance with generally accepted, evidence-based medical standards, or are considered by most dentists (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care.

In order to be considered medically necessary, services must be:

- Deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain, or have resulted or will result in a handicap, physical deformity or malfunction.
- Those for which no equally effective, more conservative, and less costly course of treatment is available or suitable for the member.

Any such services must be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment. They may be neither more nor less than what the member requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary." Medical Necessity determinations do not apply to Adult Denture members. In the Adult Denture program all services are subject to clinical review as noted in this manual. Service limitations apply. Please refer to the Adult Denture Program Covered Services section for more detail.

6.5. Preventive Treatment

EPSDT Dental members should be encouraged to return for a recall visit as frequently as indicated by their individual oral status and within plan time parameters. It is important that each dental office has a recall procedure in place. The following should be accomplished at each recall visit:

- Update medical history
- Review of oral hygiene practices and necessary instruction provided
- Complete prophylaxis and periodontal maintenance procedures
- Topical application of fluoride, if indicated
- Sealant application, if indicated

Please refer to the Louisiana Medicaid recommendations for treatment of pediatric members by age on the next page.

6.5.1. Periodicity and Anticipatory Guidance Recommendations

LOUISIANA MEDICAID'S RECOMMENDATION FOR PEDIATRIC ORAL HEALTH ASSESSMENT, PREVENTIVE SERVICES, AND ANTICIPATORY GUIDANCE/COUNSELING

The Louisiana Department of Health and Hospitals Medicaid Program follows the American Academy of Pediatric Dentistry's (AAPD) oral health recommendations in consultation with local dental communities. These recommendations are designed for care of children who have no contributing medical conditions are developing normally. These recommendations may require modification for children with special health needs or if disease or trauma manifests variations from normal.

	AGE				
	6-12 MTHS	12-24 MTHS	2-6 YEARS	6-12 YEARS	12 YEARS AND OLDER
Clinical oral exam [1]	♦	♦	♦	♦	♦
Assess oral growth & development [2]	♦	♦	♦	♦	♦
Caries-risk assessment [3]	♦	♦	♦	♦	♦
Radiographic Assessment [4]	♦	♦	♦	♦	♦
Prophylaxis and topical fluoride [3,4]	♦	♦	♦	♦	♦
Fluoride supplementation [5]	♦	♦	♦	♦	♦
Anticipatory guidance/counseling [6]	♦	♦	♦	♦	♦
Oral hygiene counseling [7]	Parent	Parent	Patient/Parent	Patient/Parent	Patient
Dietary counseling [8]	♦	♦	♦	♦	♦
Injury prevention counseling [9]	♦	♦	♦	♦	♦
Counseling for non-nutritive habits [10]	♦	♦	♦	♦	♦
Counseling for speech/language development	♦	♦	♦	♦	♦
Assessment and treatment of developing malocclusion			♦	♦	♦
Assessment for pit and fissure sealants [11]			♦	♦	♦
Substance abuse counseling				♦	♦
Counseling for intraoral/perioral piercing				♦	♦
Assessment and/or removal of third molars					♦
Transition to adult dental care					♦

1 First examination at the eruption of the first tooth and no later than 12 months Repeat every 6 months or as indicated by child's risk status/susceptibility to disease.
2 By clinical examination
3 Must be repeated regularly and frequently to maximize effectiveness.
4 Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.
5 Consider when systemic fluoride is suboptimal, Up to at least 16 years of age.
6 Appropriate discussion and counseling should be an integral part of each visit for care.
7 Initially, responsibility of parent; as child matures, jointly with parent; then when indicated, only child.
8 At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.
9 Initially play objects, pacifiers, car seats; then when learning to walk, sports and routine playing, including the importance of mouth guards.
10 At first, discuss the need for additional sucking; digits vs. pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.
11 For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

6.6. Access Requirements

6.6.1. Availability and Accessibility

Providers must provide the same availability to MCNA members as is done for all other patients as stated in the MCNA Dental Provider Agreement.

Appropriate access to care is an essential part of MCNA's Quality Improvement Program. Access to care is monitored by the Provider Relations department. Periodically, a written inquiry or phone call may be generated by a Provider Services Representative to obtain information concerning the next available appointment.

In order to be a PCD for EPSDT Dental Program members, a provider must deliver comprehensive care. A provider who serves as a PCD to MCNA members, including a provider who delivers services at locations other than his or her physical office location such as school based or mobile dental services, shall demonstrate to the satisfaction of MCNA that he or she has the requisite skill and facilities to deliver comprehensive care to MCNA members. Comprehensive care means that the provider or group must provide all of the covered restorative and therapeutic services described in this Provider Manual. Programs that are sealant only or preventive only will not be permitted. Services in a mobile setting or school based setting must be within 20 miles of the provider's principal place of practice for urban areas, and 40 miles of the provider's principal place of practice for rural areas.

Adult Denture Program providers conducting business at locations other than their principal place of practice shall provide the physical address where services are rendered to MCNA's Credentialing Department. This address must be on file with both MCNA and the Louisiana State Board of Dentistry. Records documenting the services provided shall be maintained at this location. To be eligible for reimbursement under the Adult Denture Program, the service must be performed within 75 miles of the provider's principal place of practice.

Providers should be familiar with additional Louisiana State Board of Dentistry requirements concerning the delivery of dental services in locations other than private offices.

6.6.2. Missed Appointments

Providers cannot charge members for missed or failed appointments. For assistance with members who routinely break appointments, please use the Member Outreach Form located in the Forms section of this manual.

6.6.3. After Hours Standards

When a provider's office is closed the office should have an answering service or answering machine that offers the following information:

- Instructions for contacting someone who can render clinical decisions or someone who can reach a dentist for clinical decisions
- Instructions for emergency services (including directing the member to dial 9-1-1 if necessary)
- List of the office hours
- Instructions for the caller to leave a message so that someone can return their call

The answering service or machine must also offer all of the information listed above in any additional languages based on cultural population.

6.6.4. Appointments and Access to Care
(Routine, Therapeutic/Diagnostic, and Urgent Care Dental Services)

The Provider Agreement outlines appointment availability standards. These standards are monitored through the Quality Improvement Program:

- Urgent care – defined as the need for immediate medical service for the treatment of acute or chronic illness or injury. Urgent care, including urgent specialty care, must be provided within 24 hours of request.
- Routine or preventive care – defined as periodic comprehensive evaluation and management to include past medical and family history, complete physical exam, and screening tests. Routine preventive care must be provided within 6 weeks of request.
- Emergent care must be provided immediately upon being presented to the emergency room or dentist and as such does not require an appointment.
- Appointment availability and access to care standards do not apply to Adult Denture Program members.

6.7. Suspected Child or Adult Abuse or Neglect

Cases of suspected child or adult abuse or neglect might be uncovered during examinations.

Child abuse is the infliction of injury, sexual abuse, unreasonable confinement, intimidation, or punishment that results in physical pain or injury, including mental injury. Abuse is also an act of omission.

If suspected cases are discovered, a verbal report should immediately be made by telephone or another means to law enforcement and/or a representative of the local Department for Social Services office. Reports of suspected cases of abuse or neglect can also be made by calling the MCNA Abuse Hotline at 1-855-FWA-MCNA (1-855-392-6262).

Adult abuse is defined as "the infliction of physical pain, mental injury, or injury of an adult." An adult is defined as "(a) a person 18 years of age who because of mental or physical dysfunction is unable to manage his [her] own resources or carry out the activity of daily living or protect himself [herself] from neglect or a hazardous or abusive situation without assistance from others and who may be in need of protective services; or (b) a person without regard to age who is the victim of abuse and neglect inflicted by a spouse."

6.8. Dental Records Standards

State law and Medicaid regulations require that all services provided under the EPSDT Dental and Adult Denture programs are documented. **Services not adequately documented are considered not to have been delivered.** Providers are required to maintain radiographs and treatment records that should reflect all procedures performed during all appointments. MCNA dentists must ensure that dental records are maintained for each member enrolled. The record shall include the quality, quantity, appropriateness, and timeliness of services performed as described by the remainder of this section of the manual.

All documentation, radiographs, and/or records must be maintained for at least six (6) years after the last good, service, or supply has been provided to a member or an authorized agent of the state or federal government, or any of its authorized agents, unless those records are subject to review, audit, investigations, or subject to an administrative or judicial action brought by or on behalf of the state or federal government. It is strongly suggested that the Adult Denture program provider maintain records for at least eight (8) years as the program allows for the

provision of prosthetics once every eight (8) years. Failure to produce these records upon demand for the Medicaid program or MCNA will result in sanctions against the provider.

Records must include a detailed charting of the oral condition that is updated on each visit and a chronological (dated) narrative account of each appointment indicating what services were provided or what conditions were present during those visits. Providers should also include in the member's treatment record copies of all pre-authorization requests (including any attachments), all pre-authorization letters, all radiographs, and any additional supporting documentation. Operative reports, laboratory prescriptions, medical consultations, TMJ summaries, and sedation logs are examples of additional supporting documentation.

A checklist of codes and services billed is insufficient documentation. The claim forms or copies of the claim forms submitted for reimbursement are not considered sufficient to document the delivery of services; however, these items must also be maintained in the member's treatment record.

The following dental record standards must be followed for each member's record as appropriate:

Providers shall ensure dental records are:

- Safeguarded against loss, destruction, or unauthorized use and are maintained, in an organized fashion, for all members evaluated or treated, and are accessible for review and audit.
- Readily available for review and provide dental and other clinical data required for Quality and Utilization Management review.

MCNA shall ensure each member's dental record includes, minimally, the following:

- All pages contain member name and/or member ID.
- Biographical/personal data including address, phone number, legal guardianship, marital status, date of birth, and gender.
- Documentation of the member's race and language spoken.
- Documentation of vital signs (blood pressure and pulse) if member is 13 years of age or older.
- All necessary forms completed, signed, and present in the record. This includes procedure/treatment consent, incident reports, pre-authorization, member outreach, non-covered services, and criteria for dental therapy under General Anesthesia forms.
- Current medical and dental history (including illness, medical conditions, psychological health, and substance abuse documentation) beginning with, at a minimum, the first member visit to the dental office.
- Documentation of clinical examination including head, neck, oral cancer screening, and TMJ examination.
- Identification and history of nicotine, alcohol use, or substance abuse if the member is 12 years of age and older.
- Documentation of medication list and/or prescribed therapies including medication strength, directions, dose, and the amount and number of refills given.
- Progress notes, lab results, and imaging studies.
- Documentation of written denials for service and the reason for those denials.
- Documentation of imaging reports, initialed by the provider to indicate they have been reviewed.
- Documentation of allergies (e.g., medications or latex) and all known adverse reactions. If no allergies are known, "NKA" or "NKDA" is clearly indicated.
- Documentation of advance directives, as appropriate.

- Indication of the chief complaint or purpose of each visit, objective findings, diagnosis, and proposed treatment.
- The record is legible, accurate, and maintained in detail. (Staff can read the record)
- All entries dated and signed by the provider who rendered services, including credentials (DDS, DMD, RDH).
- Documentation of all dental examinations.
- Documentation of emergency and/or after-hours encounters, as well as follow-up for emergency services.
- Documentation of working diagnosis consistent with clinical findings and treatment plan.
- Documentation of schedule for return visit(s) following the AAPD Periodicity Schedule.
- Documentation that unresolved problems from previous visits achieve resolution. This includes diagnostic tests, referral forms, and the outcomes of referrals.
- Evidence of appropriateness and timeliness of care.
- Documentation of outcomes of studies and evidence that they were appropriately ordered.
- Documentation of any known member comments/dissatisfaction.
- Documentation of service site.
- Documentation of each visit, which must include:
    - Date and beginning/ending times of service
    - Chief complaint or purpose of the visit
    - Diagnoses or dental impression
    - Objective findings
    - Member assessment findings
    - Studies ordered and results of those studies (e.g. laboratory, x-ray, EKG)
    - Medications prescribed
    - Health education provided
    - Name and credentials of the provider rendering services (e.g., DDS) and the signature or initials of that provider (initials of providers must be identified with correlating signatures)

6.9. Access to Dental Records

As an MCNA participating provider, you are required to ensure that an accurate and complete member dental record is established and maintained. On-site access to these dental records must be made available to MCNA's authorized personnel, its designated representatives, review organizations, and government agencies during regular business hours. If requested, you must provide MCNA with member dental records according to timelines, definitions, formats, and instructions specified by MCNA.

A request from MCNA may be for any information required under the Provider Agreement including, but not limited to, dental records, reports, and other information related to the performance of your obligations under the agreement. You are required to provide the following entities or their designees with prompt, reasonable, and adequate access to the Participating Provider Agreement and any records, books, documents, and papers that are related to the agreement and/or your performance of responsibilities under the agreement:

- MCNA authorized personnel
- State of Louisiana and/or federal regulatory agencies
- LDH authorized personnel

You must also provide access to the location or facility where such records, books, documents, and papers are maintained, along with the furnishings, equipment, and other conveniences necessary to fulfill any of the following described purposes within reasonable comfort:

- Audits and investigations
- Contract administration
- The making of copies, excerpts, or transcripts
- Any other purpose MCNA deems necessary for contract enforcement or to perform our regulatory functions.

6.10. Transfer of Dental Records

MCNA recommends your office request that all new members authorize the release of their dental records to you from the practitioner(s) who treated them prior to visiting your office.

There will be no charge for the copying of charts and/or radiographs subject to Louisiana State requirements and MCNA policies. All copies must be provided to the MCNA member within five (5) days of their request per MCNA's Dental Provider Agreement.

6.11. The Health Insurance Portability and Accountability Act (HIPAA) and Protected Health Information (PHI)

As a healthcare provider, your office is a covered entity as defined under HIPAA. Your office is required to comply with all aspects of the HIPAA regulations and rules that are in effect or that will go into effect as indicated in the final publications of HIPAA rules.

MCNA is a covered entity and has taken the required steps to become compliant with all aspects of the HIPAA rules and regulations. The HIPAA Privacy Rule protects all "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form of media, whether electronic, paper, or verbal. The Privacy Rule calls this information protected health information (PHI), and the requirements apply to both electronic medical records and paper medical records.

Individually identifiable health information is information, including demographic data, that relates to:

- The individual's past, present or future physical or mental health or condition
- The provision of health care to the individual
- The past, present, or future payment for the provision of health care to the individual

This is any information that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual. Individually identifiable health information (IIHI) includes many common identifiers (e.g., name, address, birth date, Social Security Number).

A central component of the Privacy Rule is the principle of "minimum necessary" use and disclosure. A covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request. A covered entity must develop and implement policies and procedures to reasonably limit uses and disclosures to the minimum necessary. When the minimum necessary standard applies to a use or disclosure, a covered entity may not use,

disclose, or request the entire medical record for a particular purpose, unless it can specifically justify the whole record as the amount reasonably needed for the purpose.

The minimum necessary requirement is not imposed in any of the following circumstances:

- disclosure to or a request by a healthcare provider for treatment
- disclosure to an individual who is the subject of the information, or the individual's personal representative
- use or disclosure made pursuant to an authorization
- disclosure to HHS for complaint investigation, compliance review, or enforcement
- use or disclosure that is required by law
- use or disclosure required for compliance with the HIPAA Transactions Rule or other HIPAA Administrative Simplification Rules

Because dental records are legal documents, providers should be familiar with additional Louisiana State Board of Dentistry requirements in the area of record keeping and of delivery of dental services in locations other than private offices.

6.12. Marketing Rules

It is a violation of the **Louisiana Dental Practice Act** and the **Louisiana Medicaid Program Integrity Act** to solicit or subsidize anyone by paying or presenting any person with money or anything of value for the purpose of securing members. Providers, however, may use lawful advertising that abides by the rules and regulations of the Louisiana State Board of Dentistry regarding advertising by dentists. Any provider found to be in violation shall be reported to the Louisiana State Board of Dentistry.

6.13. Provider Information Updates

It is important to keep MCNA informed of all information updates for your office. Providers are required to submit in writing the following information and provider changes to both MCNA and LDH:

- Immediate notification of changes in license status, board actions, practice address or name, DBA name, and tax ID
- Notification 30 days prior to the removal of a treating dentist from practice
- Notification 3 to 4 weeks prior to addition of a new treating dentist
- Notification 90 days prior to termination of participating provider from MCNA network to allow for continuity of care coordination

Please send updated provider information to MCNA at this address:

MCNA Dental
Attn: Credentialing
200 West Cypress Creek Road, Suite #500
Fort Lauderdale, Florida 33309

Phone: (855) 702-6262

Please send updated provider information to LDH at this address if you plan to continue to treat the excluded population covered by fee-for-service Medicaid:

Molina Provider Enrollment
P.O. Box 80159
Baton Rouge, LA 70898-0159

Phone: (225) 216-6370
Web: http://www.LaMedicaid.com

6.14. Termination of Dental Contract

MCNA may terminate a provider from the network for any misrepresentation(s) made on his/her credentialing application. Causes for termination with a 90-day notice include, but are not limited to:

- Failure to meet participating criteria
- Failure to provide requested dental records

Causes for immediate termination include, but are not limited to:

- Expulsion from, discipline by, or being barred from participation in any state Medicaid Program
- Loss or suspension of the provider's professional liability coverage
- Failure to satisfy any or all of the credentialing requirements of MCNA
- Failure to cooperate with or abide by MCNA's Quality Improvement Program
- Commission of one or more acts of fraud in connection with the provision of Dental Services
- Conduct injurious to MCNA's business reputation

Providers who wish to terminate participation with MCNA must provide a 90-day notice of termination in writing mailed certified return receipt that includes the final termination date.

When a provider's pending termination is identified, DentalTrac™ will auto-assign all members currently assigned to that provider to a new Primary Care Dentist (general dentist or pediatric specialist) based on the following considerations:

- Member will be assigned to a participating dental provider within the same group practice and at the same facility location, if possible
- Member will be assigned to the participating dental provider closest to the member's geographic location

7. Verification of Eligibility

Member eligibility varies daily. Therefore, each participating provider is responsible for verifying member eligibility with MCNA **before** providing services.

Eligibility can be verified 24 hours a day/7 days a week via the following methods (See Section 2: Contact Information):

- Electronically through MCNA's Online Provider Portal
- By calling the Provider Hotline
- By calling the MCNA Member Services department
- By calling LDH's Recipient Eligibility Verification System (REVS) at 1-800-776-6323 or 1-225-216-7387
- Electronically through Medicaid Eligibility Verification System (MEVS), an automated eligibility verification system using a swipe card device or PC software through vendors.
- Electronically through e-MEVS, a web application accessed through www.lamedicaid.com

You should verify member eligibility **before** providing any services. MCNA strongly recommends using our Provider Portal or the Medicaid Eligibility Systems to easily and quickly verify all member eligibility. Access your Provider Portal account at http://portal.mcna.net.

Please note that due to possible retroactive eligibility status changes, the information provided does not guarantee payment.

8. Referrals

Primary Care Dentists must assess the dental needs of EPSDT Dental members for referrals to specialty providers and provide referrals as needed; however, the member or guardian, as appropriate, must be advised of the referral. Primary Care Dentists must coordinate a member's care with specialty providers after referral.

Referrals are valid for a period of 90 days.

8.1. Referral to Specialists

Members do not have direct access to in-network specialists. A referral is necessary for EPSDT Dental members to access in-network specialists. All referrals will be processed within 72 hours of receipt by MCNA.

Emergency services do not require a referral. Please indicate any emergency services provided via a detailed narrative and/or rationale with your claim submission. All submissions will be evaluated for medical necessity and compliance with plan rules.

Referrals should be requested through the MCNA Online Portal at http://portal.mcna.net. All referral determinations can be viewed on the MCNA Online Portal.

For Oral Surgery Referrals from General Dentists or Pediatric Dentists, the following information is required:

- Narrative or Office Remarks – Tooth IDs and all symptoms should be provided. Describe any symptoms such as acute pain or infection in narrative form. (The use of "cut and paste" narratives is unacceptable. They must be patient specific.)
- X-Rays – Either a pano, periapical or bitewings illustrating the issue.

8.2. Second Opinion – MCNA Generated Referral

The provider should discuss all aspects of a member's treatment plan with the member and parent/guardian prior to beginning treatment. If the member or parent/guardian indicates they would like a second opinion, let them know that MCNA will have to authorize the second opinion visit to a provider in the MCNA network.

If no appropriate provider is available within the network to provide the second opinion, MCNA will cover the cost of seeing a non-network dentist. The provider must provide copies of the chart, radiographs, and any other information to the non-network dentist performing the second opinion upon request.

8.3. Out-of-Network Referrals

8.3.1. General Dental Care

If there are no contracted MCNA network general dentists or pediatric dentists available to treat MCNA members within a geographic area, MCNA will process an out-of-network referral. We will initiate the process with select dentists in the area and advise them of the guidelines for payment. All out-of-network treatment must be pre-authorized unless for emergency treatment services.

8.3.2. Specialty Care

If a required service is not available within the MCNA provider network, the EPSDT member's Primary Care Dentist may request an out-of-network referral. However, the Primary Care Dentist must obtain a pre-authorization from the MCNA Utilization Management department. They will provide the necessary guidance on a case-by-case basis to ensure that all necessary pre-authorizations and agreements are provided and successfully complete the process.

Reimbursements made for the examination, prophylaxis, bitewing radiographs, and/or fluoride to providers who routinely refer members for restorative, surgical, and other treatment services are subject to recoupment.

Please contact MCNA's Utilization Management department if you have questions (See Section 2: Contact Information).

9. Pre-Authorization of Care

We recommend using our Provider Portal (http://portal.mcna.net) to easily and quickly submit your pre-authorization requests. Pre-authorization requests will be processed by MCNA within two (2) business days of receipt. Urgent/expedited pre-authorization requests will be processed within 72 hours of receipt by MCNA.

MCNA's utilization management criteria incorporate components of dental standards from the American Academy of Pediatric Dentistry (www.aapd.org) and the American Dental Association (www.ada.org). MCNA's criteria are changed and enhanced as needed. Pre-authorization requests are reviewed against MCNA-approved criteria.

Failure to submit a request for pre-authorization and supporting documentation will result in non-payment to the provider for services that require pre-authorization. Per the Dental Provider Agreement the provider must hold MCNA, the member, and the state harmless if coverage is denied for failure to obtain pre-authorization, whether before or after service is rendered.

In addition to submitting pre-authorization requests electronically through the MCNA Provider Portal, providers may submit them through EMDEON (MCNA Payor ID: 65030) or by mail the completed 2012 ADA Claim Form (we will accept the 2006 ADA Claim Form as well, for a transitional period) to this address:

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

Approved pre-authorization requests are valid for 180 days from the date of approval. If orthodontic treatment does not begin within the valid 180-day period of the approved pre-authorization the case must be resubmitted.

Once a determination is made, the authorization will be available to view on the Provider Portal. The Utilization Management department staff will mail the authorization letter to those providers not utilizing the Provider Portal within three (3) business days of the determination for standard requests and within one (1) business day for emergency requests. Members also receive a copy of this notice.

All approvals will be assigned an authorization number for the service. This number must be submitted with the claim after services are rendered. After the provider receives approval of a pre-authorization request, they are required to contact the member to let them know of the approval and schedule the authorized services.

Please note, MCNA does not accept faxed pre-authorization requests at this time.

MCNA will not mail back x-rays, periodontal charting, or related documents submitted to us by mail. Please use a duplicate set of these documents for your submission.

9.1. Emergency Treatment Authorization

MCNA ensures that members have access to emergency care without pre-authorization, and to services and treatment as provided through the State agreement and defined in other state and federal regulations. MCNA ensures that members have the right to access emergency dental care services, consistent with the need for such services.

Should you need to refer a member on an emergency basis please contact MCNA's Provider Hotline at 1-855-701-6262 for assistance with coordination of the member's care.

Authorization prior to emergency treatment may not be possible. In those instances the provider is required to submit the same documentation with the claim post-treatment as is needed in the submission of a request for pre-authorization. Claims submitted without this documentation will be denied. All submissions will be evaluated for medical necessity and compliance with plan rules.

To submit the required documentation with a claim using MCNA's Provider Portal, please indicate in the "office remarks" section that the service was provided on an emergency basis and pre-authorization does not apply. If submitting the claim on a paper ADA claim form, please indicate this information in Box 35.

Emergency or palliative dental care services include the following:

- Procedures used to control bleeding
- Procedures used to relieve pain
- Procedures used to eliminate acute infection, opening the pulp chamber to establish drainage, and the appropriate pharmaceutical regimen
- Operative procedures that are required to prevent pulpal death and the imminent loss of teeth (e.g., excavation of decay and placement of appropriate temporary fillings)
- Palliative therapy for pericoronitis associated with partially erupted/impacted teeth

10. Covered Services

10.1. EPSDT Dental Covered Services Overview

- Preventive
- Diagnostic
- Restorative Services (Fillings and Crowns) – age limitation applies
- Oral and Maxillofacial Surgery
- Endodontic Services (Root Canals)
- Periodontal Services (Treatment of Gums)
- Removable Prosthodontics (Dentures) – age limitation applies
- Prosthodontics Fixed Services – age limitation applies
- Orthodontic Services (Braces) – based on necessity
- Adjunctive General Services

10.2. Adult Denture Covered Services Overview

- Office Visits – limited to denture services
- Oral Exams – limited to denture services
- X-Rays – limitation of services
- Removable Prosthodontics (Dentures) – limitation of services
- Prosthodontics Fixed Services – limitation of services

10.3. Continuity of Care

10.3.1. When a Member Moves Out of Service Area

Members who move out of the service area are responsible for obtaining a copy of their dental records from their current dentist to provide to their new dentist. Participating Primary Care Dentists must furnish members with copies of their records, including x-rays, free of charge.

10.3.2. When a Member has Pre-Existing Conditions

MCNA Dental does not have a pre-existing condition limitation. Regardless of any pre-existing conditions or diagnosis, members are eligible for all covered services on the effective date of their enrollment in the EPSDT Dental Program or the Adult Denture Program unless there is a periodicity limit that applies.

10.3.3. When a Member is in Active Treatment

Medicaid members will be pre-authorized to continue treatment by an out-of-network provider during the course of "active treatment" at the time of enrollment until one of the following conditions occurs, whichever comes first:

- The member's records, clinical information, and care can be transferred to an in-network provider
- The member is disenrolled
- The course of "active treatment" is completed
- A period of 30 days passes

10.4. Non-Capitated Services

The following services will continue to be provided by the member's health plan or the Medicaid fee-for-service program:

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

10.5. Emergency Dental Services

MCNA is responsible for coverage or payment of emergency dental services provided to EPSDT members in a hospital or ambulatory surgical center setting by dentists, billed on an ADA Claim Form. These services are part of the medical benefit provided by MCNA.

Emergency or palliative dental care services include the following:

- Procedures used to control bleeding
- Procedures used to relieve pain
- Procedures used to eliminate acute infection, opening the pulp chamber to establish drainage, and the appropriate pharmaceutical regimen
- Operative procedures which are required to prevent pulpal death and the imminent loss of teeth, e.g., excavation of decay and placement of appropriate temporary fillings
- Palliative therapy for pericoronitis associated with partially erupted/impacted teeth

11. Claims Administration

11.1. Claim Submission

MCNA requires all dental providers to identify a place of treatment (service) on the 2012 American Dental Association (ADA) Claim Form (MCNA will accept 2006 ADA claim forms for a transitional timeframe).

11.2. Picking and Choosing Services

Providers must bill MCNA for all covered services performed on eligible members whom the provider has accepted as a Medicaid patient. This policy prohibits MCNA providers from "picking and choosing" the services for which they agree to accept reimbursement from MCNA. Providers must accept MCNA reimbursement as payment in full for all services covered by MCNA.

11.3. Submitting Claims to MCNA

Providers may submit a claim to MCNA using any of the following three (3) methods:

- Electronically through MCNA's Provider Portal
- Electronically through a clearinghouse (MCNA Payor ID: 65030)
- Using a paper claim form sent via United States Postal Service (Use 2012 or newer ADA Claim Form). ADA claim forms can be obtained from various vendors.

Please note, MCNA does not accept faxed claims at this time.

11.4. Claims Payment

Claims are paid by MCNA. Please see the Covered Services, Fee Schedules, and Guidelines section of this manual (beginning on page 177) for a list of fees. For any claims questions please contact our Provider Hotline. (See Section 2: Contact Information).

Claims will be denied if the member is not eligible on the date of service.

Providers have 365 days of the date of service (DOS) to submit a claim. If your claim is not received within 365 days from the date of service, it will be denied for late submission. The following are exceptions to the standard 365-day timely filing submission requirement:

- If a provider files a claim erroneously with LDH's Fiscal Intermediary (Molina Medicaid Solutions) within the 365-day submission requirement and produces documentation of that, MCNA must honor the initial filing date as notification of the claim and process it without denying for timely submission. The provider must submit the claim in question to MCNA within 365 days from the date of notification by the wrong plan. If the 365-day timeframe cannot be met, the provider may file an appeal within 30 days of the date of notification by LDH's Fiscal Intermediary. The appeal submission must include the claim, all supporting documentation, and the dated documentation from LDH's Fiscal Intermediary showing the reason for the inability to meet the 365-day timeframe.
- If a claim was unable to be submitted within 365 days of the date of service due to an issue with the provider's clearinghouse, the provider must submit the claim and the supporting documentation from the clearinghouse within 365 days of the date of notification by the clearinghouse. If the 365-day timeframe

cannot be met, the provider may submit an appeal within 30 days of the date of notification from the clearinghouse. The appeal submission must include the claim, all supporting documentation, and the dated documentation from the clearinghouse showing the reason for the inability to meet the 365-day timeframe.

- If a delay in submitting a claim for payment was caused by circumstances beyond the control of the provider, MCNA may receive and process claims upon review of substantiating documentation that justifies the late submittal of a claim.
- Claims for members who have both Medicare and Medicaid coverage fall under Medicare timely filing requirements. These claims must be submitted to MCNA within 365 days from the date on the Medicare Explanation of Medicare Benefits (EOMB).
- Claims for retroactive Medicaid members must be filed within 365 days from the date of eligibility determination.
- Provider requested adjustments and voids of claims must be filed within 365 days from the date of payment.

Dental services must not be separated or performed on different dates of service solely to enhance reimbursement.

Prompt Pay: MCNA is required to adjudicate a clean claim within 15 business days of receipt.

The State of Louisiana defines a clean claim as a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in the state's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

All claims should be submitted to MCNA on a 2012 ADA claim form (MCNA will accept 2006 ADA claim forms for a transitional timeframe). The claim form must include all of the following information to be considered a clean claim:

- Member name
- Member identification number
- Member and/or guardian signature (or signature on file)
- Member date of birth
- Description of services rendered
- Provider NPI number (included with all claim submissions regardless of format)
- Provider name, state license number, and signature (included with electronic or online submissions)
- Provider address, phone number, and facility ID number (included with electronic or online submissions)
- Proper CDT coding with tooth numbers, surfaces, quadrants, and arch, when applicable.
- Full mouth x-ray series, bitewings, and/or periapical x-rays, rationale, photos, sedation time records, or other documentation, when required

Explanation of Benefits (EOB) documents will be available in the MCNA Provider Portal for all offices that receive Electronic Funds Transfer (EFT) payments. These offices may request a paper EOB be sent to their location at the time of payment. For offices receiving payment in the form of a paper check, the EOB will be included in the envelope with the check. Please contact MCNA's Credentialing department (See Section 2: Contact Information) with questions.

11.4.1. Example of a Clean Claim

ADA American Dental Association® Dental Claim Form

mcnadental

HEADER INFORMATION

1 Type of Transaction (Mark all applicable boxes)
[X] Statement of Actual Services [ ] Request for Predetermination/Preauthorization
[ ] EPSDT / Title XIX

2 Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3 Company/Plan Name, Address, City, State, Zip Code
MCNA Dental
200 West Cypress Creek Road, Suite #500
Fort Lauderdale, Florida 33309

OTHER COVERAGE (Mark applicable box and complete items 5-11 If none, leave blank.)

4 Dental? [ ] Medical? [ ] (If both, complete 5-11 for dental only.)

5 Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6 Date of Birth (MM/DD/CCYY) | 7 Gender [ ] M [ ] F | 8 Policyholder/Subscriber ID (SSN or ID#)

9 Plan/Group Number | 10 Patient's Relationship to Person named in #5 [ ] Self [ ] Spouse [ ] Dependent [ ] Other

11 Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12 Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
Johnathan A. Doe, Jr.
5500 North Birmingham Road
Baton Rouge, Louisiana 70806

13 Date of Birth (MM/DD/CCYY): 1/15/2005 | 14 Gender [X] M [ ] F | 15 Policyholder/Subscriber ID (SSN or ID#): 111-22-3333

16 Plan/Group Number | 17 Employer Name

PATIENT INFORMATION

18 Relationship to Policyholder/Subscriber in #12 Above [X] Self [ ] Spouse [ ] Dependent Child [ ] Other | 19 Reserved For Future Use

20 Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21 Date of Birth (MM/DD/CCYY) | 22 Gender [ ] M [ ] F | 23 Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24 Procedure Date (MM/DD/CCYY)	25 Area of Oral Cavity	26 Tooth System	27 Tooth Number(s) or Letter(s)	28 Tooth Surface	29 Procedure Code	29a Diag. Pointer	29b Qty.	30 Description	31 Fee
1	5/1/2014		JP			D0150		1	Comprehensive Oral Evaluation	$30.00
2										
3										
4										
5										
6										
7										
8										
9										
10										

33 Missing Teeth Information (Place an "X" on each missing tooth)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34 Diagnosis Code List Qualifier [ ] [ ] (ICD-9 = B; ICD-10 = AB)
34a Diagnosis Code(s) (Primary diagnosis in "A") A ____ B ____ C ____ D ____

31a Other Fee(s)
32 Total Fee $30.00

35 Remarks

AUTHORIZATIONS

36 I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.
X Signature on File — Patient/Guardian Signature — Date 5/1/2014

37 I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.
X Signature on File — Subscriber Signature — Date 5/1/2014

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48 Name, Address, City, State, Zip Code
National Pediatric Dental Care Associates
888 SE 10th Avenue, Suite #100
Baton Rouge, Louisiana 70815

49 NPI: 00123456789 | 50 License Number: 12345 | 51 SSN or TIN: 1234567

52 Phone Number: (225) 555-1234 | 52a Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38 Place of Treatment: 11 (e.g. 11=office, 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")
39 Enclosures (Y or N): N

40 Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42)
41 Date Appliance Placed (MM/DD/CCYY)

42 Months of Treatment Remaining
43 Replacement of Prosthesis [X] No [ ] Yes (Complete 44)
44 Date of Prior Placement (MM/DD/CCYY)

45 Treatment Resulting from [ ] Occupational illness/injury [ ] Auto accident [ ] Other accident

46 Date of Accident (MM/DD/CCYY)
47 Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53 I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
X Jessica Rivera, DDS — Signed (Treating Dentist) — Date 5/1/2014

54 NPI: 00987654321 | 55 License Number: 54321

56 Address, City, State, Zip Code: 888 SE 10th Avenue, Suite #100, Baton Rouge, Louisiana 70815 | 56a Provider Specialty Code: 122300000X

57 Phone Number: (225) 555-1234 | 58 Additional Provider ID

©2012 American Dental Association
J430D (Same as ADA Dental Claim Form – J430, J431, J432, J433, J434)

To reorder call 800 947 4746
or go online at adacatalog.org

11.5. Electronic Submission of Claims via MCNA's Provider Portal

MCNA's Provider Portal (http://portal.mcna.net) allows participating providers to easily submit claims to us and track their status. Submitting claims electronically using the Provider Portal is always free.

You have the ability to attach scanned x-rays, periodontal charting, and other documents to your claims. MCNA contracts with NEA FastAttach to allow for the electronic submission of x-rays. For those offices unable to work with digital copies of x-rays, a completed 2012 ADA claim form (MCNA will accept 2006 ADA claim forms for a transitional timeframe) along with the x-ray(s) must be sent to MCNA at the address listed in the Paper Claim Submission via Mail section.

11.6. Electronic Submission via Clearinghouse and Billing Intermediaries

Providers may submit electronic claims through clearinghouses, which transmit claims to EMDEON (WEBMD). MCNA's Payor ID code is **65030**. MCNA contracts with NEA FastAttach for the electronic submission of digital attachments.

Providers who use a billing intermediary for claims preparation and submission must notify MCNA of their billing arrangements in writing. If a billing intermediary changes or ceases to exist, you must also notify MCNA in writing. A billing intermediary is not considered to be a provider's salaried employee. A billing intermediary is an individual, partnership, or corporation contracted with the provider to bill on their behalf.

11.7. Paper Claim Submission via Mail

Paper claims must be submitted on the 2012 ADA claim form (MCNA will accept 2006 ADA claim forms for a transitional timeframe). Providers can download this form from our Provider Portal (http://portal.mcna.net), and print it. Paper claims may be submitted by mail to:

MCNA Dental
Attn: Claims Department
200 West Cypress Creek Road, Suite 500
Fort Lauderdale, Florida 33309

It is important to affix sufficient postage when mailing in bulk as MCNA does not accept postage due mail. Insufficient postage will result in the mail being returned to sender and a delay in processing your claim.

MCNA will not mail back x-rays, periodontal charting, or related documents submitted to us by mail. Please use a duplicate set of these documents for your submission.

11.8. Direct Deposit and Electronic Funds Transfer (EFT)

MCNA offers direct deposit to your bank account. To participate in direct deposit, you must complete, sign, and return the Direct Deposit EFT Form, which you can download from our website (www.mcnala.net). Please fax or mail the completed form to MCNA's Credentialing (See Section 2: Contact Information).

11.9. MCNA Processing of Deficient Claims

Providers have a total of 365 days from the date of service to submit a claim. If a claim is not received by MCNA within this 365-day timeframe it will be denied.

MCNA may also deny your claim as deficient if it does not include all supporting documentation, such as x-rays or narrative, when required. When this occurs, the Explanation of Benefits/Remittance Advice will state the reason for the denial. For example, a procedure that has been denied is listed with reason code 48, which states "please submit x-ray(s) and narrative with this request."

MCNA sends a notification within five (5) days of claim adjudication to inform providers that a determination for the claim has been made. Active Provider Portal users will be notified via a portal alert. To view why a claim is considered non-clean, providers can log in to the Provider Portal and click on "Non-Clean Claim Notices." Providers who do not use their Provider Portal accounts will receive a letter in the mail with the same information.

Additional information may be required for a non-clean claim to be processed. The provider must send in the required information within 365 days from the date of service with a corrected ADA Claim form. Provider must indicate in the remarks section of the claim form (Item 35) the required or corrected information being submitted. Remarks should be concise and pertinent to the claim submission for review. MCNA considers the official submission date of a corrected claim to be the date that a provider electronically transfers any required additional information and documentation. If a provider mails the information, the official submission date is the date MCNA receives it.

11.10. Reconsiderations

Reconsideration requests must be filed within 365 days from the date of service. Requests for MCNA's reconsideration of a claim may be filed when a claim has been denied for an administrative reason including but not limited to the following examples:

- Timely filing
- No pre-authorization on file
- Duplicate
- Member and Provider eligibility
- Incorrect fee applied

Any supporting documentation should be included with the reconsideration request. Providers may submit their request in writing by using the Provider Reconsideration and Appeal Request form (See Section 27: Forms) or online using MCNA's Provider Portal (http://portal.mcna.net). Once you have logged into the Provider Portal, please click on support and downloads to access the Online Reconsideration/Appeal link. Please complete the electronic form titled, "*Provider Reconsideration and Appeal Request*" including all information needed to evaluate your request.

11.11. Appeals

Appeal requests must be filed within 90 days of the initial claim determination. Appeals may be filed when a claim has been denied for determinations related to medical necessity and benefit coverage. Any requested or supporting information such as x-rays or rationale should be included with the appeal submission.

Providers may submit an appeal online through MCNA's Provider Portal (http://portal.mcna.net). Once you have logged into the Provider Portal, please click on 'support and downloads' to access the Online Reconsideration/Appeal link. Please include all information needed to evaluate your request. If your original ADA claim form was completed incorrectly, you must submit a corrected ADA claim form with your appeal request.

Providers may also mail an appeal to MCNA's Grievances and Appeals department (See Section 27: Forms).

11.12. Coordination of Benefits

It is the provider's responsibility to determine if members have other dental insurance. When other insurance exists and MCNA is the secondary insurer, a copy of the primary insurance Explanation of Benefits (EOB) must be submitted with all claims for services rendered to the member. These claims may be filed electronically if an electronic copy of the EOB is attached. MCNA will deem a claim paid in full when the primary insurance payment meets or exceeds MCNA's reimbursement rates.

11.13. Third Party Liability

Medicaid is the payor of last resort. Providers must bill third-party insurance carriers prior to requesting reimbursement from Medicaid. A third party insurance carrier is an individual or company who is responsible for the payment of medical or dental services. Examples of third parties are Medicare, private health insurance, automobile, and other liability carriers. When billing MCNA after payment consideration from a third party (except Medicare), an Explanation of Benefits (EOB) from the primary insurance carrier must be attached. The six-digit state assigned carrier code for the primary insurance and the amount paid by the primary insurance carrier (including zero [$0] payment) must be entered in the appropriate places on the claim form. If the third party coverage is found to be erroneous, providers may submit a corrected claim to MCNA. In situations where third party benefits exist, the timeframe for filing a claim with MCNA begins on the date that the third party carrier resolves the claim. MCNA must finalize all claims, including appealed claims, within 24 months of the date of service.

11.14. Non-Covered Services

MCNA will not pay a provider for non-covered services. According to the MCNA's Provider Agreement, the provider will hold harmless members, the plan, MCNA, and the State for payment of non-covered dental services.

No additional charges may be assessed to covered MCNA members. The MCNA Provider Agreement states that the only circumstance in which a provider may bill for non-covered services is when a member has signed a form or letter of understanding agreeing to the fees.

The following services are considered non-covered services:

- Services that are not medically necessary to the member's dental health
- Dental care for cosmetic reasons
- Experimental procedures
- Plaque control
- Certain types of x-rays
- General Anesthesia
- Routine post-operative services - these services are covered as part of the fee for initial treatment provided
- Treatment of incipient or non-carious lesions (other than covered sealants and fluoride)
- Services that 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
- Prescriptions or drugs
- Administration of in-office pre-medication

11.14.1. Non-Covered Services Private Payment Agreement Form

MCNA only reimburses for services that are medically necessary or benefits of special preventive and screening programs, such as EPSDT Dental. The provider may bill a member only if a specific service or item is provided at the member's request.

The provider must obtain and keep a written Non-Covered Services Form that is signed by the member and/or responsible party prior to the services being rendered. It must be filled out completely with the following information:

- A statement that the member is financially responsible for the described services
- A complete description of the dental services to be rendered. A statement that the Plan, MCNA, and the State will not be responsible for payment of the described dental services.

11.15. Balance Billing

MCNA network providers may not bill or otherwise attempt to recover from members the difference between the agreed upon contract allowable rate for a service and the provider's billed charge(s). This practice is called balance billing and is not permitted under your MCNA Provider Agreement.

11.16. Fraud Reporting

Providers are expected to bill only for medically necessary covered services delivered to members in accordance with MCNA's policies and procedures. MCNA and the appropriate governmental agencies actively investigate all suspected cases of fraud and abuse. In our commitment to prevent fraud and abuse in the Medicaid Program, MCNA has implemented an integrity component as a part of our Compliance Program. We monitor and maintain integrity through the following activities:

- Prevention of duplicate payments
- Post-payment utilization review to detect fraud and abuse
- Internal controls to ensure payments are not issued to providers that are excluded or sanctioned under Medicare/Medicaid
- Review of alleged illegal, unethical, or unprofessional behavior
- Profiling of providers to identify over or underutilization of services
- Completion of investigations and audits

All program integrity activities are coordinated with MCNA's Compliance department and our Special Investigation Unit (SIU) as needed.

11.16.1. Program Integrity

Providers are not allowed to provide services to an EPSDT Dental member beyond the intent of Medicaid guidelines, limitations, and/or policies for purposes of maximizing payments. If this practice is detected, the

provider may be subject to sanctions. Providers enrolled as a group or individual providers who are not linked to a group but are located in the same office as another provider are responsible for checking office records to assure that Medicaid established guidelines, limitations, and/or policies are not exceeded. Providers not participating in the MCNA network may not use the name and/or provider number of a participating provider in order to bill Medicaid for services rendered.

MCNA is committed to controlling fraud, waste, and abuse in the Louisiana EPSDT Dental and Adult Denture programs. Our efforts include vigilant monitoring, investigation, enforcement, training, and communication. MCNA monitors the appropriateness and quality of services provided to our members and verifies services billed by dental providers through pre- and post-payment reviews. These reviews help us to prevent or recover overpayments paid to providers. An overpayment includes any amount not authorized to be paid by state and federal programs, whether paid as a result of inaccurate or improper claims submissions, unacceptable practices, fraud, abuse, or a mistake.

When an overpayment is identified, MCNA begins payment recovery efforts. Providers will be given the opportunity to submit a refund or payment plan within a specified time period. If you fail to submit a refund within the specified time period, the overpayment amount will be automatically deducted from future EOBs. Additionally, MCNA will pursue all remedies up to and including the termination of your participation in our network.

11.16.2. Payment Suspensions

If MCNA has credible evidence of fraud, willful misrepresentation, or abuse under the requirements set forth by the Louisiana EPSDT Dental and Adult Denture programs, MCNA has the right to suspend payment of claims to a provider and/or a facility. Allegations are considered to be credible when they have indicia of reliability. MCNA carefully reviews all allegations, facts, and evidence, and acts judiciously on a case-by-case basis. The suspension of payment action will be temporary and will not continue if MCNA determines that there is insufficient evidence of fraud, willful misrepresentation, or abuse by the provider.

11.16.3. Appeal Rights

MCNA affords to any provider or person against whom it enforces payment holds or recoupment requests a right to appeal this action by requesting an informal review. A request for an informal review must be received in writing within 10 days of the date you receive a notice of the payment hold, and within 45 days of the date you receive a recoupment notice. Appeals should be mailed to MCNA to the attention of "Corporate Investigations" (See Section 2: Contact Information).

Along with your appeal, you may submit any documentary evidence that addresses whether the payment hold is warranted and any related issues. MCNA will consider your appeal and your evidence carefully. You will be contacted after that consideration is completed and a decision about your case is made.

Please contact MCNA's Provider Hotline if you have questions (See Section 2: Contact Information).

11.16.4. Laws that Govern Fraud and Abuse

The Federal False Claims Act and the Federal Administrative Remedies for False Claims and Statements Act are specifically incorporated into § 6032 of the Deficit Reduction Act. These acts outline the civil penalties and damages that are allowed to be brought against anyone who knowingly submits, causes the submission, or presents a false claim to any U.S. employee or agency for payment or approval. U. S. agency in this regard

means any reimbursement made under Medicare or Medicaid and includes this program. The False Claims Acts prohibits anyone from knowingly making or using a false record or statement to obtain approval of a claim.

"Knowingly" is defined in the statute as meaning not only actual awareness that the claim is false or fraudulent, but situations in which the person acts with his eyes shut, in deliberate ignorance or in reckless disregard of the truth or falsity of the claim.

The following are some examples of billing and coding issues that can constitute false claims and high-risk areas under this act:

- Billing for services not rendered
- Billing for services that are not medically necessary
- Billing for services that are not documented
- Up coding
- Participation in kickbacks

Penalties in addition to amount of damages may range from $5,500 to $11,000 per false claim, plus three (3) times the amount of money the government is defrauded. In addition to monetary penalties, the provider may be excluded from participation in the Medicaid or Medicare program.

11.16.5. Do You Want to Report Waste, Abuse, or Fraud?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other healthcare 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 EPSDT Dental or Adult Denture services that were not necessary or actually provided
- Making false statements about a medical condition in order to get medical treatment
- Letting someone else use Medicaid ID card
- Using another person's Medicaid ID card
- Making false statements about the amount of money or resources in order to get benefits

To report waste, abuse, or fraud, choose one of the following:

- Call the DDH Program Integrity Hotline at 1-800-488-2917
- Visit www.dhh.louisiana.gov and click on "Report Abuse" to complete the online form
- Call the MCNA Fraud, Waste, and Abuse Hotline at 1-855-FWA-MCNA (855-392-6262)

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

- Date(s) of event(s)
- 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 suspected waste, abuse or fraud

12. Provider Complaint Process

MCNA makes every effort to provide the highest quality of service to our members and providers. We understand there are times when issues or concerns need to be discussed, and our Provider Services team is ready to help. Please contact the Provider Hotline at 1-855-701-6262.

Complaints in the Louisiana EPSDT Dental and Adult Denture programs are defined as a verbal or written expression by a provider that indicates dissatisfaction or dispute with MCNA policy, procedure, claims processing and/or payment, or any aspect of MCNA functions. Provider complaints may be reported to the Provider Hotline by calling 1-855-701-6262. If the issue cannot be resolved by the Provider Hotline Representative, the call will be escalated to the Provider Relations department. Providers may also submit complaints verbally or in writing directly to their Provider Relations Representative, via mail to the address below, using the Provider Complaint form located in the back of this manual, or via email to contactus@mcna.net. Should a provider (or their representative) wish to present their case in person, please contact the Provider Hotline at 1-855-701-6262 to schedule an appointment.

If you would like to file a complaint in writing with MCNA, please send it to the following address:

MCNA Dental
Attention: Complaints Department – Provider Relations
P.O. Box 29008
San Antonio, Texas 78229
contactus@mcna.net

Upon receipt of a complaint, the Provider Relations department will review the issue and forward it to or solicit the assistance of the appropriate MCNA department(s). We will thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and provider subcontract provisions, collecting all pertinent facts from all parties while applying MCNA's written policies and procedures and resolve the complaint within 30 business days from the date we receive it. Providers may consolidate complaints of multiple claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or claims included in the bundled complaint. When submitting a consolidated complaint, please include all applicable patients and/or claims and denote that the complaint is a consolidated complaint in the submission.

Upon resolution of the complaint, the Provider Relations department will inform the provider in writing of the outcome of the investigation. Should there be extenuating circumstances and the investigation requires longer than 30 days, the Provider Relations department will inform the provider in writing of the need for an extension. Concerns related to medical necessity are not addressed through the complaint system. They can be submitted through the appeal system found in section 11.11 Appeals on behalf of a member, or the provider can utilize MCNA's peer-to-peer process to speak with one of our licensed dentists. You can find more information about our peer-to-peer process in the Utilization Management section of this manual and instructions for filing an appeal on behalf of a member can be found in section 17, Member Grievances and Appeal Process.

After a provider has exhausted MCNA's internal complaint process, if the provider is dissatisfied with the resolution they have the right to file a complaint directly with LDH/MMIS (Louisiana Medicaid Management Information Systems), including any issues or decisions that are not a unique function of MCNA. To file a complaint with LDH/MMIS after you have completed MCNA's complaint process, please visit the LDH website at www.healthy.la.gov or call (225) 342-6908.

13. Utilization Management

Utilization Management (UM) is the process of evaluating the necessity and efficiency of healthcare services and affecting member care decisions through assessments of the appropriateness of care. MCNA's UM department helps to assure prompt delivery of medically appropriate dental care services to all members and subsequently monitors the quality of care.

All participating providers are required to obtain pre-authorization from MCNA's UM department. The UM department is available Monday through Friday, 7 am to 7 pm, CST, except on weekends and designated holidays. All requests for the authorization of services may be received during these hours of operation (See Section 2: Contact Information).

MCNA provides an opportunity for the provider to discuss a decision with the Dental Director, to ask questions about a UM issue, or to seek information from a clinical reviewer about the UM process and the authorization of care. If you contact us after business hours or on a holiday, you may leave a message and a representative will return the call the next business day.

MCNA will not enter into any contractual arrangement that rewards clinical reviewers or any other individuals who may conduct utilization review activities for issuing denial of coverage of a service, or any other financial incentives for utilization decision-making. MCNA's UM department ensures that quality of care will not be affected by financial- and reimbursement-related processes and decisions.

MCNA adheres strictly to the following:

- Compensation for utilization management activities is not structured to provide inappropriate incentives for denials, limitations, or discontinuation of authorization of services.
- Compensation programs for MCNA Dental, consultants, dental directors, or staff who make clinical determinations do not include any incentives for denial of medically necessary services.
- Continuous monitoring of the potential effects of any incentive plan on access and/or quality of care is a standard procedure within the UM process.

13.1. Decision Making Criteria

MCNA's Utilization Management Criteria use components of dental standards from the American Academy of Pediatric Dentistry (www.aapd.org) and the American Dental Association (www.ada.org). MCNA's criteria are changed and enhanced as needed.

The procedure codes used by MCNA are described in the American Dental Association's Code Manual. Requirements for documentation of these codes are determined by community-accepted dental standards for authorization, such as treatment plans, narratives, radiographs, and periodontal charting.

These criteria are annually reviewed and approved by MCNA's Dental Management Committee. They are designed as guidelines for authorization and payment decisions and are not intended to be absolute.

We appreciate your input regarding the criteria used for decision-making. Please contact the Provider Hotline (See Section 2: Contact Information) to comment or make suggestions. MCNA also complies with the Center for

Medicare and Medicaid Services (CMS) national coverage decisions and written decisions of local carriers and intermediaries with jurisdiction for claims in the geographic area in which services are covered.

13.2. Peer-to-Peer Availability

MCNA offers the availability of peer-to-peer consultations with our Dental Director and specialty clinical reviewers. Louisiana-licensed general dentists, pediatric dentists, and specialty dental providers, such as orthodontists and oral surgeons, make all clinical determinations. The peer-to-peer process enables participating providers to discuss cases and clinical issues, including medical necessity denials, with MCNA clinical reviewers.

To request a peer-to-peer discussion, please contact your Provider Relations Representative or call the Provider Hotline (See Section 2: Contact Information).

13.3. Clinical Practice Guidelines

The Clinical Practice Guidelines are based on the enrolled membership and dictate the provision of dental care services to members with acute, chronic, and complex conditions to assist providers and members in making appropriate dental care decisions to improve quality of care. These guidelines are developed based on the following criteria:

- Reasonable, sound, scientific medical evidence
- Prevalence of 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
- Consideration of the needs of the members
- Strength of evidence to support best clinical practice management strategies
- Ability to achieve consensus on optional strategy

13.4. Clinical Decisions

A pre-authorization request for a service may be denied for failure to meet Clinical Practice Guidelines, clinical criteria, protocols, dental policies, or for failure to follow administrative procedures outlined in your Provider Agreement or this Provider Manual. All pre-authorization request approvals and denials are available through MCNA's Provider Portal. Providers who do not have access to the Provider Portal will receive their determinations via mail.

13.5. Medical-Necessity Denials

Utilization management uses dental policies, protocols, and industry standard guidelines to render review decisions. Licensed dentists and specialty dentists serve as clinical reviewers for the plan. All clinical requests are reviewed by an MCNA clinical reviewer who is available to discuss any decision rendered with the attending dental provider through our peer-to-peer process. The peer-to-peer process serves as MCNA's informal reconsideration process for adverse determinations. An adverse determination is any decision by MCNA to deny or partially deny an authorization request. .

14. Quality Performance

14.1. Quality Improvement Program

The goal of the MCNA Quality Improvement (QI) Program is to ensure that each member has affordable and convenient access to quality dental care delivered in a timely manner by a network of credentialed providers.

The Board of Directors of MCNA is responsible for establishing the priorities of the QI Program based on the recommendations of the MCNA Dental Management Committee.

The Quality Improvement Committee oversees the QI Program to ensure that the performance of all quality improvement functions is timely, consistent, and effective. This committee reports to the Board of Directors and carries out the following responsibilities:

- Oversees the implementation of the QI Program throughout MCNA's operational departments
- Establishes a method to measure and quantify improvements in dental care delivery to MCNA members resulting from QI initiatives
- Reviews and makes recommendations, which are identified through the QI process, for approval of all new and revised policies, procedures, and MCNA benefit designs
- Ensures that adequate resources are allocated toward the achievement of MCNA's QI Program goals
- Oversees the management of all aspects of MCNA's operations to make sure they are consistent with the goals and objectives of the QI Program
- Monitors the progress of all MCNA-initiated corrective action plans
- Monitors the integration, coordination, and supervision of Risk Management Program activities through the formal reporting of those activities
- Demonstrates compliance with regulatory requirements and delegation standards
- Assesses and confirms that quality care and services are being appropriately delivered to MCNA members
- Reports quarterly to the Board of Directors the status of MCNA QI Program

A copy of the QI Program is available to all participating providers upon request. Please contact the Provider Hotline (See Section 2: Contact Information).

14.2. Your Role in Quality

Every MCNA network provider is a participant in the Quality Improvement (QI) Program through his or her contractual agreement with MCNA. You may be asked to serve on any of the committees that are part of the QI Program or contribute to the development of audits, Clinical Practice Guidelines, member education programs, or other projects. Participation on a committee is voluntary and encouraged.

You can help us identify any issues that may directly or indirectly impact member care by reporting them on an Incident Report Form, which is located in Forms section of this manual. This can be submitted to MCNA via fax, email, or regular mail (See Section 2: Contact Information).

The MCNA Dental Director might contact your office about an incident report. Please keep a copy of any incident report you file with MCNA in the appropriate member's dental record.

14.3. Quality Enhancement Programs (Focus Studies)

MCNA monitors and evaluates the quality and appropriateness of care and service delivery (or the failure to provide care or deliver services) to members and providers through performance improvement projects (PIPs), dental record audits, performance measures, surveys, and related activities. As a provider for Medicaid, MCNA will perform no fewer than three (3) state-approved PIPs per year. The PIPs will focus on both clinical and non-clinical areas.

14.4. Quality Review of Key Clinical and Service Indicators

One of MCNA's Quality Improvement (QI) Program objectives is to perform a quality review of key clinical and service indicators through analysis of member and provider data to assess and improve member and provider satisfaction rates. These clinical and service indicators include reviews of:

- Member and provider complaints about care or service
- Sentinel events (defined as any event involving member care that warrants further investigation for quality of care concerns)
- National Committee for Quality Assurance's (NCQA's) Healthcare Effectiveness Data and Information Set (HEDIS®)
- Application of Clinical Practice Guidelines
- Application of appropriate dental record documentation, and continuity and coordination of care standards
- Health outcome intervention studies or activities
- Member claims and encounters
- Member pre-authorizations requests and referrals

In order to support the quality review activities of our QI Program, your office is required to make available upon a request from an MCNA representative the dental records of any MCNA member in your care.

14.5. Corrective Action

When Quality Improvement (QI) Program identifies specific cases of substandard quality of care during its review process, a letter requesting corrective action will be mailed to the treating provider. There are many forms of corrective action that may be recommended. Some examples of corrective action include:

- A Quality Correction Letter indicating the deficiency or deficiencies and requiring changes to be implemented within a maximum of 60 days (the severity of the deficiency or deficiencies noted will dictate the number of days that the provider has to implement the required changes)
- Special pre-authorization/claims review
- Post-treatment reviews of members by an Associate Dental Director
- Requirement for the provider to attend training sessions or participate in continuing education programs
- Restriction on the acceptance of new members until the provider becomes compliant with all standards of care for a specified amount of time
- Recoupment of sums paid where billing discrepancies are found during reviews
- Restriction on a provider's authorized scope of services.
- Referral of a case to the state Board of Dental Examiners and/or the Department of Justice, Attorney General's Office, and/or Office of Inspector General of the State
- Termination of the Provider Agreement

Where corrective action is recommended, our priority is to work with the provider to improve performance and compliance with all MCNA policies and procedures defined in the Provider Agreement and this Manual. MCNA is willing to provide support for a provider who shows sincere intent to correct deficiencies.

14.6. Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys

The CAHPS Survey is a tool that assists MCNA in rating member experience with network providers and with MCNA. The survey addresses key member issues such as level of satisfaction with MCNA, access to care, referral for specialty services, utilization, care received, and interaction with dental office staff. The survey is conducted on an annual basis. MCNA also complies with any state requirements regarding annual CAHPS surveys for its population. This information is used to develop and implement strategies to improve care and service to our members. Providers may be contacted to assist MCNA in developing improvement strategies.

The results and associated improvement strategies will be posted on MCNA's website at www.mcna.net.

14.7. Provider Satisfaction Surveys

MCNA will assess its contracted providers' satisfaction with MCNA. This activity shall include, but not be limited to, analyses of provider satisfaction with the following operational aspects:

- MCNA's response time to provider inquiries and complaints
- MCNA communications
- Claims payment process
- Authorization and referral process
- MCNA availability and effectiveness

We will use the results of our provider satisfaction surveys and any state-approved, contracted independent surveys to develop and implement plan-wide activities designed to improve provider satisfaction.

MCNA will make aggregate survey results available to providers and members upon request.

14.8. Member Records - Chart Reviews

As specified in MCNA's Provider Agreement, we are authorized to conduct reviews of member records. These treatment records are chosen randomly for periodic chart review. The chart review includes assessment of the following member elements:

- Record of medical history, dental history, and existing dental conditions
- Radiograph evaluation and diagnostic material used
- Treatment plan and timeliness of treatment plan
- Actual care delivered in relation to proposed treatment plan
- Recall protocol and utilization analysis of actual care delivered
- A signed Patient Consent Form

A chart review offers an insight into the provider's practice patterns and allows MCNA to identify deficiencies and suggest areas of improvement. The on-site review is a component of our Quality Improvement (QI) Program; all data is collected and entered into a QI database. This data allows MCNA to perform analysis of utilization and

general network and practice patterns, contributing to valuable feedback and information for network dental offices. This information will also be used as part of the re-credentialing process.

15. Member Services

15.1. Discrimination

Providers may choose whether to accept a member as a Medicaid patient. Providers are not required to accept every Medicaid member requiring treatment; however, providers must be consistent in this practice and not discriminate against a Medicaid member based on the member's race, religion, national origin, color, or impairment.

Providers must not differentiate or discriminate in the treatment of any member because of the member's race, color, national origin, ancestry, religion, health status, sex, marital status, age, political beliefs, or source of payment.

15.2. Confidentiality Policy

MCNA follows all HIPAA requirements. We require our contracted providers to also adhere to HIPAA requirements. The Provider Agreement requires that all providers maintain member information in a current, detailed, organized, and comprehensive manner, and in accordance with customary dental practices, and applicable state and federal laws and accreditation standards. Providers must have policies and procedures to implement HIPAA confidentiality requirements. In addition to complying with customary dental practices, applicable state and federal law, and accreditation standards, these policies and procedures should include, but are not limited to, protection of member confidentiality under the following circumstances:

- The release of information, using a release form, at the request of a member and in response to a legal request for information
- The storage of and restricted access to dental records in secured files
- The education of employees regarding the confidentiality of member records and other member information.

15.3. Informed Consent Requirements

Providers must understand and comply with applicable legal requirements regarding informed consent from members, as well as adhere to the policies of the dental community in which they practice. The provider must give MCNA members adequate information and be reasonably sure the member has understood it before proceeding with any proposed treatment. Consent documents should be in writing and be signed by the member and/or responsible party.

The provider must obtain and maintain a specific written informed consent form signed by the member, or the responsible party if the member is a minor or has been adjudicated incompetent, prior to the utilization of a papoose board as part of the member's treatment.

Such consent is required for the utilization of a papoose board and is strongly encouraged for all treatment plans and procedures where a reasonable possibility of complications from the proposed treatment or a procedure exists. Consent should disclose all risks or hazards that could influence a reasonable person in making a decision to give or withhold consent.

Written consent must be given prior to the services being rendered and must not have been revoked. Members or their responsible parties who can give written informed consent must receive information about the dental diagnoses, scope of proposed treatment, including risks and alternatives, anticipated results, and the need for and risks of the administration of sedation or anesthesia. Additionally, they must receive a full explanation of the treatment plan and give written informed consent before treatment is initiated. As a provider, you may consider seeking advice from an attorney to ensure the informed consent meets all applicable legal requirements.

MCNA urges all providers to comply with the AAPD's 2013 "Guideline on Protective Stabilization for Pediatric Dental Patients." You can find the guideline online at the AAPD's website (www.aapd.org).

15.4. Cultural Competence

We facilitate access to dental services for non-English speaking members. MCNA's population is culturally and linguistically diverse, and we recognize that this diversity sometimes serves as a barrier to members, affecting their willingness to access all available services. Title VI of the Civil Rights Act specifically requires that managed care organizations provide assistance to persons with limited English proficiency, where a significant number of the eligible population is affected.

MCNA has adopted the CLAS recommendations (www.minorityhealth.hhs.gov) as a guideline in the development of our Cultural Competency Program. MCNA encourages contracted providers to address the care and service provided to members with diverse values, beliefs, and backgrounds that vary according to their ethnicity, race, language, and abilities.

We want to ensure that we, along with our network providers, are meeting the communication needs of members with limited English proficiency. MCNA's Quality Improvement department monitors and evaluates the level of cultural competency throughout our network through dental services provided by our providers. MCNA encourages employees and network providers to utilize their own diverse cultural backgrounds to enhance our program and the services provided to our members.

Please contact the Provider Hotline to request a copy of our Cultural Competency Program (See Section 2: Contact Information).

15.5. Reading/Grade Level Consideration

All member materials produced by MCNA are written at a 6th-grade reading level to promote enhanced communication between the Medicaid population, providers, and MCNA. Our goal is to create plain and clearly understandable member communications.

15.6. Availability and Coordination of Linguistic Services

MCNA does not require members to provide their own interpreter when utilizing the services available to them through MCNA. We will ensure that dental care services will be presented in a culturally and linguistically appropriate manner utilizing member's primary language:

- Interpreter services are available through MCNA at no charge when assessing dental care. Please have the member contact the MCNA Member Hotline at 1-855-702-6262 for interpreter assistance.
- Member refusal of interpreter services must be documented.

- Friends and family are only used as an interpreter when specifically requested by the member. A Minor may not to be used as an interpreter.
- Member may request face-to-face or telephone interpreter services to discuss complex dental information and treatment options.
- Informative documents must be translated into and available in threshold languages.
- Member has the right to file a complaint or grievance if linguistic needs are not met.
- Dental provider offices are informed of the availability of the TTY contact number (1-800-955-8771) for members with hearing impairment.

15.7. Role of Provider's Bilingual Staff

The role of the bilingual staff in the office is to assist members to access and receive dental services and to understand the instructions they receive from the person speaking to them. If the member speaks a language not spoken by an office staff person, the telephone interpreter service should be utilized.

It is the responsibility of the provider's office to notify MCNA in writing within 30 days of a change in the linguistic capacity of the office that may affect the provider's ability to provide dental services.

To get a free copy of MCNA Cultural Competency Program, contact MCNA's Member Hotline (See Section 2: Contact Information).

15.8. Appointment Attendance Concerns

We track the appointment attendance history of members who are consistent "no shows" to their scheduled dental appointments. If you are treating an MCNA member who has a history of being a no show at your facility, please download the Member Outreach Form from the Provider Portal and submit it to us. This form can also be mailed and it is located in the Forms section of this Provider Manual.

15.9. Case Management

MCNA has dedicated Case Managers to assist members with special health care needs in coordinating dental care with their Primacy Care Dentist and specialty providers.

Members or providers may contact Case Management to initiate the assessment process for members with conditions that are medically compromising or are otherwise physically or mentally disabled. Our Case Mangers will act as a liaison between the member and provider in all aspects of arranging care, including coordinating travel arrangements, communication services, facilitating treatment pre-authorization, and assisting with scheduling follow-up while the member is in active care. Please call 855-702-6262 to refer a member to Case Management.

16. Member Eligibility, Enrollment, and Disenrollment

16.1. EPSDT Dental and Adult Denture Programs

MCNA does not perform enrollment functions for EPSDT or Adult Denture program members. All eligibility information provided by MCNA is the information that we have received from the Louisiana Department of Health (LDH) or its designee. The effective date of enrollment will be the first day of the month after eligibility is determined.

For instructions on how to verify member eligibility before providing services, please refer to Section IV: Verification of Eligibility in this manual.

To qualify for Louisiana Medicaid dental services, a child must be:

- Age 20 or younger
- A Louisiana resident
- A U.S. citizen or legal permanent resident
- Not a resident of an Intermediate Care Facility for the Developmentally Disabled (ICF/DD)

Please note that due to possible eligibility status changes, the information provided does not guarantee payment.

To qualify for Louisiana CHIP dental services, a child must be:

- Age 20 or younger
- A Louisiana resident
- A U.S. citizen or legal permanent resident
- Not a resident of an Intermediate Care Facility for the Developmentally Disabled (ICF/DD)

Louisiana Medicaid refers to both Medicaid and CHIP enrollees as members of the EPSDT Program. Please note that due to possible eligibility status changes, the information provided does not guarantee payment.

To qualify for Louisiana Medicaid Adult Denture dental services, an adult must be:

- Age 21 or older
- A Louisiana resident
- A U.S. citizen or legal permanent resident
- Missing all teeth in the maxillary and/or mandibular arches
- Not a resident of an Intermediate Care Facility for the Developmentally Disabled (ICF/DD)
- Not a Qualified Medicare Beneficiary Only (OMB Only)

Please note that due to possible eligibility status changes, the information provided does not guarantee payment.

16.2. Medicaid ID Cards

MCNA strongly recommends all provider offices require each member to present their LDH identification card and confirm eligibility at each appointment. You may quickly and easily complete eligibility verification through our

Provider Portal (http://portal.mcna.net) or through the Medicaid Eligibility Systems. You may also call our Provider Hotline to complete verification (See Section II: MCNA Contact Information).

MCNA advises that you keep a copy of each member's Medicaid ID card on file in the member's chart.

17. Member Rights and Responsibilities

17.1. EPSDT Dental and Adult Denture Programs

Members are informed of their rights and responsibilities in the MCNA Member Handbook. MCNA providers are also expected to respect and honor members' rights.

17.1.1. Member Rights as written in the MCNA Member Handbook

- You have the right to be treated with respect and with due consideration for your dignity and privacy.
- You have the right to participate in decisions regarding your healthcare, including the right to refuse treatment and the right to express preferences about future treatment decisions.
- You have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulations.
- You have the right to be able to request a copy of your medical records (one copy free of charge) and request that they be amended or corrected.
- You have the right to receive healthcare services that are easy to access. These services should be comparable in amount, duration, and scope to those provided under Medicaid Fee-for-Service. They should be sufficient in amount, duration, and scope to reasonable be expected to achieve their purpose.
- You have the right to receive services that are appropriate and are not denied or reduced because of diagnosis, type of illness, or dental condition.
- You have the right to receive all information, like enrollment notices, informational materials, instructional materials, and available treatment options and alternatives in a way that is easy to understand.
- You have the right to receive assistance from the Louisiana Department of Health in understanding the requirements and benefits of MCNA.
- You have the right to receive interpretation services for free and in all non-English languages, not just those that are the most common.
- You have the right to be notified that interpretation services are available and how to access those services.
- You have the right to receive information on MCNA's services, to include, but not be limited to:
    - Benefits covered
    - The way to use benefits, including any authorization requirements
    - Service area
    - Names, locations, telephone numbers of, and non-English language spoken by current network providers, like Primary Care Dentists, specialists, Federally Qualified Health Clinics, Rural Health Clinics, and hospitals.
    - Any restrictions on your freedom of choice among network providers
    - Providers who are not accepting new patients
    - Benefits not offered by MCNA that are available to you and how to obtain them, including transportation
- You have the right to receive a complete description of disenrollment rights at least once a year.
- You have the right to receive notice of any major changes in core benefits and services at least 30 days before the intended effective date of the change.
- You have the right to receive information on grievance, appeal, and State Fair Hearing procedures.
- You have the right to receive detailed information on emergency and after-hours coverage, to include, but not be limited to:

  - What constitutes an emergency medical condition and emergency services, and post-stabilization services
  - That emergency services do not require prior authorization
  - The process and procedures for getting emergency services
  - The locations of any emergency rooms and other places where MCNA has contracted to furnish emergency dental services and post-stabilization services
  - The right to use any hospital or other setting for emergency care
  - The rules about post-stabilization services after emergency care
- You have the right to receive MCNA's policy on referrals for specialty care and other benefits not provided by your Primary Care Dentist.
- You have the right to have your privacy protected according to legal privacy requirements.
- You have the right to exercise your rights without being treated differently by MCNA, our network providers, or the Louisiana Department of Health.

17.1.2. Member Responsibilities as written in the MCNA Member Handbook

- Present your Louisiana Department of Health issued Medicaid ID card when getting services from your dentist.
- Be familiar with MCNA's procedures to the best of your ability.
- Call or contact MCNA to obtain information and have questions answered.
- Let the dentist know any reasons your treatment cannot be followed as soon as possible.
- Live a healthy lifestyle and avoid behavior that can hurt your health.
- Follow the grievance process that MCNA provides for you if you have a disagreement with a dentist.
- Use the preventive dental services that are a part of your benefits.
- Be respectful of the dentist and their staff.
- Be respectful of the rights of other patients.
- Follow the dentist's rules and regulations about patient care and conduct while at the dental office.
- Provide the dentist and their office staff with true and complete information so they can give you proper care.
- Obtain services from only in-network Primary Care Dentists or specialists, except if you have a dental emergency.
- Ask the dentist questions about his or her instructions.
- Ask the dentist about the care you receive.
- Understand your dental problems and work with your dentist to decide treatment goals.
- Make good decisions about your dental health and avoid things that can damage it.
- Follow the plan of treatment for dental care agreed upon by you and your dentist agree and/or their staff.
- Make sure that payments for non-covered dental services are fulfilled as soon as possible.
- Report unexpected changes in your dental condition to your dentist.
- Keep all appointments and arrive on time. If you are unable to do so for any reason, call your dentist's office as soon as you can.

If you think the member has been treated unfairly or discriminated against, please call MCNA toll-free at 1-855-701-6262. You also can file a complaint on behalf of the member by email at contactus@mcna.net.

17.2. Non-Compliant Members

If your assigned member is non-compliant and would like to request that the member be reassigned, please follow these steps:

- Document all instances of non-compliance in the member record.
- Complete the Member Outreach Form (located in the Forms section of this manual) and select the following item, "Provider requests transfer of member from panel."
- Upon receipt of a provider's request to re-assign a member, the Provider Relations department will review with the Dental Director the situation and any documentation for appropriateness, and then inform the provider of the resolution.

18. Member Grievances and Appeal Process

Member grievances and appeals can be filed verbally or in writing. A verbally filed appeal must be followed by a written, signed appeal. At no time will a member be discriminated against because he or she has filed an appeal. All information contained within a grievance or appeal and anything that comes to light throughout the grievance and appeal process is kept strictly confidential. A provider acting on behalf of a member or a member's representative may submit grievances and appeals on behalf of members with their written consent. All appeals submitted by a provider on behalf of a member or by a member's representative must be submitted in writing with a signed copy of the member consent form.

If you would like to file a grievance or appeal on behalf of a member, please call or send it to MCNA's Grievance and Appeals department. Phone numbers and address are located in Section II: MCNA Contact Information in this manual.

The member must first exhaust MCNA's appeal process before requesting a State Fair Hearing. The member may request a State Fair Hearing within 30 calendar days from the date of the last decision notification by MCNA. MCNA will cooperate with any decision the State makes.

18.1. What is a Grievance?

A member grievance is any dissatisfaction expressed by a member, or a person acting on behalf of the member, either verbally or in writing, to MCNA concerning any aspect of MCNA's operation. This includes, but is not limited to, dissatisfaction with MCNA's administration or the way a service is provided. A grievance does not include a request for review of an action or a decision by MCNA related to covered services or services provided, misinformation that is resolved promptly by supplying the appropriate information, or clearing up a misunderstanding to the satisfaction of the member.

18.2. Member Grievance Process

Members have the right to file a grievance. Grievances can be filed verbally, in writing, or in person. A provider may file a grievance on a member's behalf. Grievances filed by a provider on a member's behalf require the member's written consent.

MCNA will acknowledge receipt of a grievance in writing within five (5) calendar days from the date that we receive it. MCNA will resolve and provide written resolution of all member grievances within 30 days from the date the complaint is received.

To file a grievance on behalf of a member, contact MCNA's Member Services department or send the request via mail to MCNA's Grievance and Appeals department. Phone numbers and address are located in Section II (MCNA Contact Information) in this manual.

At no time will a member be discriminated against because he or she has filed a grievance. We always respect our members' privacy. Anything said or written is kept confidential.

18.3. What is a Member Appeal?

A member has the right to file an appeal. An appeal is a request for review of an action or a decision by MCNA related to covered services or services provided. An action is defined as the denial or limited authorization of a requested service, including:

- The type or level of service
- Reduction, suspension, or termination of a previously authorized service
- Denial, in whole or in part, of payment for a service
- Failure to provide services in a timely manner
- Failure to act within specified timeframes
- Denial of a request to obtain services outside the network for specific reasons

18.4. Member Appeal Process

MCNA will notify the member and requesting provider of a decision about the request for a covered service through a Notice of Action Letter. If the member, member's representative, or provider disagrees with our decision, he or she can file an appeal. Appeals filed by a provider on behalf of a member or a member's representative require the member's written consent.

An appeal may be filed verbally or in writing within 30 calendar days of the date when the member receives the Notice of Action Letter. If there is an oral request, a written notice must be received from the member or the member's representative unless they request an expedited resolution. We will acknowledge receipt of a member appeal in writing within five (5) calendar days from the date we receive it.

MCNA or the member can request a 14 calendar-day extension if there is a need for additional information and the delay is in the member's best interest. If an extension is needed by MCNA, we will notify the member in writing of the reason.

The member's benefits will not end while we review the appeal unless the member is taken out of the EPSDT or the Adult Denture program. A member will continue to receive current authorized services until one of the following occurs:

- The member withdraws the appeal;
- Ten (10) calendar days pass after MCNA mails the Notice of Action providing the resolution of the appeal unless the member requests a State Fair hearing with continuation of benefits until a State Fair Hearing decision is reached;
- A State Fair Hearing Officer issues a hearing decision against the member; or
- The time period or service limits of a previously authorized service has been met.

The member may have to pay for the continued services if the final decision is that MCNA does not have to cover them.

The written appeal must clearly state that the member wishes to continue getting the services. Services may be continued until the appeal decision is made. If, however, the appeal decision agrees with MCNA's denial, the member may have to pay for the services.

To file an appeal on behalf of a member, contact MCNA's Member Services department or send the request via mail to MCNA's Grievance and Appeals department. Phone numbers and address are located in Section II (MCNA Contact Information) of this manual.

The member has the right to request a State Fair Hearing if they are not satisfied with the resolution provided by MCNA's appeals process. To request a State Fair Hearing please contact the MCNA Member Services department by phone or in writing.

18.5. Member Expedited Appeals

If the member's appeal is about care that is medically necessary and needed soon, a dental professional who has the relevant clinical experience and who did not render the original denial decision will review the appeal on an expedited basis. You may file an expedited review request verbally (must be followed up in writing) or in writing and you must include the member's written consent.

An expedited review process is available for a member appeal that is for pre-service medical necessity. This expedited review process may take place when MCNA determines or the provider/practitioner indicates that taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function.

MCNA will make a decision about an expedited review request no later than three (3) business days after we receive it. If MCNA denies a request for expedited resolution of an appeal, the appeal will be transferred to the standard appeals process and be resolved in 30 calendar days.

MCNA will contact the member by telephone to inform them of the decision to deny the expedited request. We will send a written notice indicating our denial of the request within two (2) calendar days.

18.6. Informal Reconsiderations

An informal reconsideration is the review of MCNA's decision about a service authorization request made at the request of a member or the member's representative. If a member is dissatisfied with MCNA's adverse determination of a service authorization request they have the right to ask for an informal reconsideration. A service authorization request is any one of the following:

- Pre-Authorization
- Referral
- Second Opinion

This process will take no more than one (1) business day from the date we receive your request. Call MCNA's Member Services Hotline (See Section 2: Contact Information) for assistance in submitting an informal reconsideration request.

You, with the member's consent, may ask for an informal reconsideration. An informal reconsideration may be requested verbally or in writing within 30 calendar days of when the member receives the Notice of Action from MCNA.

MCNA will set up a meeting between the member, you and/or their representative and the clinical reviewer who made the adverse determination within one (1) business day of receipt of the request. If the clinical reviewer who

made the determination will not be available within the specified timeframe, the Dental Director will select another clinical reviewer to meet with you. MCNA will provide its response to the informal reconsideration request at the conclusion of the meeting. This meeting can be an in-person meeting.

18.7. Member Request for a State Fair Hearing

If a member is not happy with MCNA's decision about an appeal, they have the right to ask for a State Fair Hearing within 30 days of the date of MCNA's Notice of Appeal Resolution. A provider may also request a State Fair Hearing on behalf of the member.

To request a State Fair Hearing on behalf of a member, you must first have the member complete and sign a one-page form, which you can request by calling the Provider Hotline (See Section 2: Contact Information) or download from our website (www.mcnala.net). This form is located in section 18.8 of this manual and will serve as the member's authorization for you to request a State Fair Hearing for the member.

During the hearing, a member may represent himself or herself, or be represented by any authorized individual, such as a friend, relative, dentist, legal counsel, or anyone the member names to speak on their behalf.

To request a State Fair Hearing, call or write to MCNA Member Services department. Phone numbers and address are located in Section II (MCNA Contact Information) of this manual.

Alternatively, you can also request a hearing by sending a letter to:

> **The Division of Administration – Administrative Law Judge Division**
> 654 Main Street
> PO Box 44033
> Baton Rouge, Louisiana 70804-4033

A member's benefits will not end during the State Fair Hearing unless they are taken out of the EPSDT Dental or the Adult Denture program. If the member wants to continue to receive the services that were denied, the member must inform MCNA within 10 days from the date on the Notice of Action and before the intended effective date of MCNA's action. The member may have to pay for the services if the final decision is that MCNA does not have to cover them.

Once a decision is made, all administrative remedies with the Louisiana Department of Health have been exhausted. If the member is dissatisfied with this ruling, he/she has the right to seek judicial review in accordance with Louisiana Revised Statute 46:107(C). The request for judicial review may be filed either in the 19th Judicial District Court, Parish of East Baton Rouge, or the district court of the parish of your domicile, within 30 days from the date of this certification.

18.8. Member Request for a State Fair Hearing Form

LOUISIANA DEPARTMENT OF HEALTH REQUEST FOR STATE FAIR HEARING FORM

[Recipient Name]

[Street Address]

[City, State & Zip Code]

I want to appeal the decision MCNA made on my case because: _____

_____

_____

Date: _____ Signature: _____

Recipient/Representative: _____

Your address if different from the address shown above: _____

_____

Telephone No: _____

Social Security Number: _____

Email address: _____

Name, Address and Phone number of your Authorized Representative at the Hearing, if any:

_____

Mail this complete form to:

DIVISION OF ADMINISTRATIVE LAW—HEALTH AND HOSPITALS SECTION
P.O. BOX 4189
BATON ROUGE, LA 70821-4189

The postmark showing the date you mailed your appeal will be the date of your appeal request. You may fax the completed form to **(225) 219-9823** or complete the form online at: **http://www.adminlaw.state.la.us/HH.htm**

After you ask for a State Fair Hearing, the Division of Administrative Law will send you a Notice by mail of the date, time and location of your State Fair Hearing. If you are unable to mail or fax the attached form, you may phone **(225) 342-5800** to give the information for your appeal.

***** DON'T FORGET TO INCLUDE THE NOTICE OF ADVERSE ACTION LETTER WITH THIS FORM*****

19. EPSDT Covered Services and Fee Schedules

19.1. Benefit Limits Key

A = Age range limitations
TID = Tooth ID

19.2. Initial Dental Screening and Annual Recall Visits

The dental visit, which includes the initial dental screening (Comprehensive Oral Examination) and annual recall visit (Periodic Oral Examination), must include (but is not limited to) the following diagnostic and preventive services:

- Examination of the oral cavity and all of its structures, using a mirror and explorer, periodontal probe (if required), and necessary diagnostic or vitality tests (considered part of the examination)
- Bitewing radiographic images
- Prophylaxis, including oral hygiene instructions
- Topical fluoride application (under 16 years of age)

This visit should also include preparation and/or updating the member's records, development of a current treatment plan, and the completion of reporting forms. The initial comprehensive oral examination (D0150) or the periodic oral examination (D0120), prophylaxis (D1110 or D1120), and topical application of fluoride (D1208) are limited to once per six (6) months.

19.3. Diagnostic Services

Diagnostic services should be performed for all members, starting within the first six (6) months of the eruption of the first primary tooth, but no later than one (1) year of age.

19.4. Examinations

Clinical Oral Evaluations			
Code	**Description**	**Benefit Limits**	**Fee**
D0120	Periodic oral evaluation (established patient)	A 3-20. Limited to one (1) every six (6) months as is age appropriate. NOT reimbursable if procedure code D0145 or D0150 has been reimbursed to the same billing provider, facility, or group within the prior six (6) month period for the same member.	$27.24
D0140	Limited oral evaluation- problem focused	A 0-20. This procedure is not payable when submitted in conjunction with any 2000 or 7000 series code for the same date of service.	$15.00

D0145	Oral evaluation, pt < 3yrs	A 0-35 months. **This procedure may be reimbursed once in a six (6) month period.** Procedure code D0145 is NOT reimbursable if procedure code D0120 or D0150 has been reimbursed to the same billing provider, facility, or group within the prior six (6) month period for the same member. In addition, procedure codes D0120 and D0150 are NOT reimbursable if procedure code D0145 has been reimbursed to the same billing provider, facility, or group within the prior six (6) month period for the same member.	$38.49
D0150	Comprehensive oral evaluation	A 3-20. Limited to one (1) every three (3) years by the same provider, facility, or group. However, procedure code D0150 is NOT reimbursable if procedure code D0120, D0145 or D0150 has been reimbursed to any billing provider, facility, or group within a six (6) month period for the same Member. Denied when submitted for the same DOS as D0145 by any provider. MCNA recognizes this code for a new member only. A new member is described as a member that has not been seen by this provider for at least three (3) years. This procedure code is to be used by a general dentist and/or specialist when evaluating a member comprehensively for the first time (specialists must include a detailed narrative as to why a comprehensive exam was needed and performed since most specialty care visits are for a specific, targeted reason). This would include the examination and recording of the member's dental and medical history and a general health assessment. This procedure should not be billed unless it has been at least three (3) years since the member was seen by the specified provider, facility, or group. An initial comprehensive oral examination (D0150) is limited to once per three (3) years when performed by the same billing provider, facility, or group.	$47.37

19.5. Radiographic Images

In order for the MCNA to be able to make the necessary authorization determinations, radiographic images and/or oral/facial images must be of good diagnostic quality. Requests for pre-authorization that contain radiographic images and oral/facial images that are not of good diagnostic quality will be denied.

There must be a diagnostic purpose for the taking of each radiograph. This must be documented in the member's record and be in accordance with the accepted standard of care.

Radiographs/Diagnostic Imaging (Including Interpretation)			
Code	**Description**	**Benefit Limits**	**Fee**
An alternate benefit of a full mouth series X-Ray (D0210) will be applied when an office submits any combination of periapical, panoramic, and bitewing X-Rays exceeding the reimbursable value of the full mouth series X-Ray within a 45-day period. Requirements when submitting X-Rays: • Must be of diagnostic quality • All X-rays must be marked right & left • Must include the member's name • Must include the date X-Rays were taken One full mouth series is available per member every year by provider, facility, or group. MCNA encourages the use of digital images. Please be aware that MCNA will not return hardcopy X-Rays. We require you to make two (2) sets of X-Rays and send us the duplicate set.			
D0210	Intraoral-complete series (including bitewings)	A 2-20. MCNA will pay for a full mouth series X-Ray (D0210) once every year by the same provider, facility, or group. An alternate benefit of a full mouth series X-Ray (D0210) will be applied when an office submits any combination of periapical, panoramic, and bitewing X-Rays exceeding the reimbursable value of the full mouth series X-Ray. Not allowed as an emergency service.	$60.17
D0220	Intraoral-periapical-first film	A 1-20. Limited to one (1) service a day by the same provider, facility, or group. When submitting a claim, the tooth number must be indicated. Not reimbursable when submitted on the same date of service as D3310, D3320, D3330, or D3346.	$14.69
D0230	Intraoral-periapical-each additional film	A 1-20. The total cost of periapicals and other radiographs cannot exceed the payment for a complete intraoral series. When the fee submitted for any combination of intraoral X-Rays in a series meets or exceeds the fee for a complete intraoral series, it is considered that the films are the equivalent of a complete series, procedure D0210. When submitting a claim, the tooth number must be indicated.	$12.42

D0240	Intraoral-occlusal film	A Birth-20. Requires rationale with pre-authorization submission. Limited to two (2) services per day by the same provider, facility, or group. Periapical films taken at an occlusal angle must be submitted as periapical radiograph, procedure code D0220 or D0230, if more than one code of D0240 is reported. Reimbursable for oral cavity 01 and 02. Claim must include oral cavity designator. May be submitted as an emergency service. If an occlusal film is used in the course of a routine dental exam to aid in caries detection it will be deemed to be the same as a periapical radiograph (D0220 and D0230) and will be bundled with the other films taken for routine examination and not paid separately.	$20.41
D0272	Bitewings-two films	A 1-20. Limited to one service in a 12 month period by any Provider, facility, or group. Not reimbursable when submitted within a 12 month period of a D0210 by the same Provider, facility or group.	$21.43
D0330	Panoramic film	A 3-20. Limited to one (1) service a day by any provider, facility, or group, and to one service every year by the same provider, facility, or group. Not allowed on emergency claims unless third molars or a traumatic condition is involved. Not reimbursable separately when a comprehensive orthodontic or crossbite therapy workup is performed. An alternate benefit of a full mouth series X-Ray (D0210) will be applied when an office submits any combination of periapical, panoramic, and bitewing X-Rays exceeding the reimbursable value of the full mouth series X-Ray. Not reimbursable in conjunction with D2000, D3000, or D4000 series codes unless an appropriate exam code of D0140 or D9110 was billed that day. Rationale required if member is less than age 3. Rationale required for emergency claims.	$57.05

Procedure code **D0350** must be used to submit claims for photographs, and will be accepted only when diagnostic-quality radiographs cannot be taken. Supporting documentation and photographs must be maintained in the member's dental record when medical necessity is not evident on radiographs for dental caries or the following procedure codes: D4210 and D4355. Requires pre-authorization.			
D0350	Oral/facial photographic images	A 1-20. Limited to two (2) service a day by the same provider, facility, or group. Not reimbursable separately when a comprehensive orthodontic or crossbite therapy workup is performed. Requires pre-authorization. Oral/facial photographic images are required when dental radiographic images do not adequately indicate the necessity for the requested treatment in the following situations: prior to gingivectomy; prior to frenulectomy; in conjunction with D7286; or with the presence of a fistula prior to retreatment of previous endodontic therapy, anterior. The provider should bill Medicaid for oral/facial photographic images **ONLY** when the photographs are taken under these circumstances. If post payment review discovers the billing of oral/facial images not in conjunction with these specific services, recoupment will be initiated. Oral/facial photographic images must be of good diagnostic quality and must indicate the necessity for the requested treatment. Reimbursable for oral cavities 01, 02, 10, 20, 30, and 40. Claim and Pre-Authorization must include oral cavity designator. Requires pre-authorization.	$27.42

19.6. Other Diagnostic Services

Tests and Examinations			
Code	**Description**	**Benefit Limits**	**Fee**
D0470	Diagnostic casts	A 1-20. Diagnostic casts will be covered only when MCNA requests them. Requires pre-authorization and rationale.	$47.44

Oral Pathology Laboratory			
Code	**Description**	**Benefit Limits**	**Fee**
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	A birth-20. Oral pathologists and medical pathologists may be reimbursed for histopathologic study and interpretation of oral specimens. The attending dental provider may not request pre-authorization or bill this code on the pathologist's behalf. For pre-authorization of the surgical procedure to obtain the specimen for biopsy please refer to the section on Oral Surgery Services, codes D7285 and D7286. Requires pre-authorization and rationale.	$74.49
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	A birth-20. Oral pathologists and medical pathologists may be reimbursed for histopathologic study and interpretation of oral specimens. The attending dental provider may not request pre-authorization or bill this code on the pathologist's behalf. For pre-authorization of the surgical procedure to obtain the specimen for biopsy please refer to the section on Oral Surgery Services, codes D7285 and D7286. Requires pre-authorization and rationale.	$77.09

19.7. Preventive Services

Preventive services include prophylaxis, topical fluoride treatments, sealants, fixed space maintainers, and re-cementation of space maintainer.

Dental Prophylaxis			
Code	**Description**	**Benefit Limits**	**Fee**
D1110	Dental prophylaxis adult	A 13-20. Limited to one (1) prophylaxis per member per six-month period (includes oral health instructions). If submitted on emergency claim, procedure code will be denied. If, at the initial visit, it is determined that the Adult Prophylaxis is the appropriate treatment and code D1110 (Adult Prophylaxis) is billed to and reimbursed by Medicaid or MCNA, then procedure code D4355 (Full Mouth Debridement) will not be reimbursed if it is billed within 12 months subsequent to the date of service of the D1110 (Adult Prophylaxis). If any D4000 series code is billed on the same date of service as a D1110 the D4000 series code will be denied. If submitted on an emergency claim, procedure code will be denied.	$48.01
D1120	Dental prophylaxis child	A six (6) months 0- 12 years. Limited to one (1) prophylaxis per member per six (6) month period (includes oral health instructions). If submitted on emergency claim, procedure code will be denied. If D1120 (Child Prophylaxis) is billed to and reimbursed by Medicaid or MCNA, then procedure code D4355 (Full Mouth Debridement) will not be reimbursed if it is billed within 12 months subsequent to the date of service of the D1120 (Child Prophylaxis). If any D4000 series code is billed on the same date of service as a D1120 the D4000 series code will be denied.	$35.02

Topical Fluoride Treatment (Office Procedure)			
Code	**Description**	**Benefit Limits**	**Fee**
D1206	Topical fluoride varnish	A 0-6. Includes oral health instructions. Denied when submitted for the same DOS as any D4000 series periodontal procedure code. Per the AAPD periodicity table, application of fluoride allowed once every six (6) months. Procedure code D1206 or D1208 is reimbursable by MCNA to any billing provider, facility, or group once per six (6) month period, per member. In addition, MCNA reimbursement of fluoride for Members less than six (6) years of age is limited to 2 (two) fluoride services (D1206 and/or D1208) per 12 month period.	$24.29
D1208	Topical application of fluoride	A 0-16. Includes oral health instructions. Denied when submitted for the same DOS as any D4000 series periodontal procedure. Per the AAPD periodicity table, application of fluoride allowed once every six (6) months. Procedure code D1206 or D1208 is reimbursable by MCNA to any billing provider, facility, or group once per six (6) month period, per member. Topical fluoride treatment must be provided to children less than 16 years of age in order to be reimbursed under this procedure code. **This procedure is limited to once in a six (6) month period.** In addition, MCNA reimbursement of fluoride for Members is limited to 2 fluoride services (D1206 and/or D1208) per twelve (12) month period.	$19.77

Other Preventive Services			
Code	**Description**	**Benefit Limits**	**Fee**
D1351	Dental sealant per tooth	Reimbursable once per tooth in a 24 month period. All sealants must be performed on a single date of service, unless restorations or other treatment services are necessary. If restorative or other treatment services are necessary, sealants may be performed on the same date of service as the restorative or other treatment services. Sealants are available for the occlusal surface only. In order for a tooth to be reimbursable for sealant services, it must be caries-free on the date of service. Sealants are not reimbursable for teeth that have any previous occlusal restoration. Dental sealants may only be placed by persons licensed to do so under the Dental Practice Act of the State of Louisiana. (TIDs #2, 3, 14, 15, 18, 19, 30 and 31 only). Six-year molar sealants will be paid only for Members under ten (10) years of age (TIDs #3, 14, 19, 30). Twelve (12) year molar sealants will be paid only for Members under sixteen (16) years of age (TIDs 2, 15, 18, 31).	$25.51

Space Maintenance (Passive Appliances)			
Code	**Description**	**Benefit Limits**	**Fee**
The billing Provider is responsible for replacement and recementation within the first twelve (12) months after placement of the space maintainer.			
D1510	Space maintainer-fixed unilateral	The billing provider is responsible for replacement and recementation within the first 12 months after placement of the space maintainer. Limited to fixed appliances, including unilateral and bilateral, that are passive in nature. A space maintainer will not be reimbursed if the space will be maintained for less than six (6) months. Fixed-space maintainers require pre-authorization and are limited to the necessary maintenance of a posterior space for a permanent successor to a prematurely lost deciduous tooth (teeth). Removable, maxillary anterior or active space maintainers are not provided. Procedure code D1510 is reimbursable for Oral Cavity areas 10, 20, 30, and 40.	$151.52

D1515	Space maintainer-fixed bilateral	The billing provider is responsible for replacement and recementation within the first 12 months after placement of the space maintainer. Limited to fixed appliances, including unilateral and bilateral, and be passive in nature. Fixed-space maintainers require pre-authorization and are limited to the necessary maintenance of a posterior space for a permanent successor to a prematurely lost deciduous tooth (teeth). Removable, maxillary anterior or active space maintainers are not provided. Procedure code D1515 is reimbursable for Oral Cavity areas 01 and 02.	$206.61
D1550	Recementation of space maintainer	The billing provider is responsible for replacement and recementation within the first 12 months after placement of the space maintainer. This procedure does not require authorization and is limited to one (1) recementation per appliance, in a five (5) year period. This procedure is reimbursable for Oral Cavity Designators 01, 02, 10, 20, 30 and 40. Requires pre-placement X-Rays.	$38.77
D1555	Removal of fixed space maintainer	This procedure code is reimbursable for the removal of Space Maintainer, Fixed, Unilateral (D1510) or the removal of a Space Maintainer, Fixed, Bilateral (D1515). This procedure is NOT reimbursable to the same billing provider, facility, or group that billed the original D1510 or D1515. This procedure is reimbursable for Oral Cavity Designators 01, 02, 10, 20, 30, and 40.	$38.26

19.8. Restorative Services

Local anesthesia is considered to be part of restorative services. Tooth and soft tissue preparation, all adhesives (including amalgam bonding agents), liners and bases, are included as part of amalgam restorations. Tooth and soft tissue preparation, all adhesives (including resin bonding agents), liners and bases and curing are included as part of resin-based composite restorations. Pins must be reported separately.

The surfaces that may be billed as restored can be any one or combination of five (5) of the seven (7) recognized tooth surfaces: mesial, distal, occlusal (or incisal), lingual, or facial (or buccal).

The original billing provider, group, or facility is responsible for the replacement of the original restoration within the first 12 months after initial placement. Duplicate surfaces are not payable on the same tooth in amalgam or composite restorations in a 12-month period by same provider, facility, or group. If the same tooth requires a second or subsequent restoration and the provider did not perform the initial surface(s) restoration, pre-authorization is required and provider will receive full fee for service. All restored surfaces on a single tooth shall be considered connected. The fee for any additional restorative service(s) on the same tooth will be cut back to the maximum restorative fee for the combined number of non-duplicated surfaces when performed within a 12-month period by same provider, facility, or group. Additional restorative services(s) on the same tooth within a 12-month period by the same provider or facility do not require PA.

Restorations of any type are not payable for deciduous central or lateral incisor teeth (Tooth letters D, E, F, G, N, O, P, and Q) for members who have reached the age of 5 (five).

Laboratory processed crowns are not covered. Provider payments received for restorative work performed within twelve (12) months of a crown procedure on the same tooth will be deducted from the crown procedure reimbursement except in cases of pulpal necrosis or traumatic injury.

If the tooth is decayed extensively, consideration should be given for the provision of an amalgam, four (4) or more surfaces, permanent (D2161); resin-based composite, four (4) or more surfaces, posterior (D2394); resin-based composite, four (4) or more surfaces or involving incisal angle, anterior (D2335); a resin-based composite crown, anterior (D2390); or a prefabricated stainless steel crown (D2930, D2931, D2932 or D2933).

Unless contraindicated, for encounter-based reimbursement situations all restorative and treatment services per quadrant must be performed on the same date of service. This allows the dentist to complete all restorative treatment in the area of the mouth that is anesthetized. In addition, if there is a simple restoration required in a second quadrant, the simple restorative procedure in the second quadrant must also be performed at the same appointment. If there is a circumstance that requires restorative treatment outside of this parameter, the rationale and circumstance must be clearly documented on the claim submission and will be subject to clinical review.

If two or more restorations are placed on the same tooth, a maximum restoration fee that can be reimbursed per tooth has been established such that all restored surfaces on a single tooth shall be considered connected.

19.8.1. Permanent Tooth Restorations

MCNA will reduce payment for a second or subsequent amalgam restoration (Procedure Codes D2140, D2150, D2160 and D2161); and/or a second or subsequent resin-based composite restoration (Procedure Codes D2330, D2331, D2332 and D2335) for the same Member, same permanent tooth when billed within 12 months from the date of the original restoration by the same, provider, facility, or group. In these situations, the maximum

combined fee for the two or more restorations within a 12 month period on the same permanent tooth will not exceed the maximum fee of the larger restoration. For the same provider, facility, or group, MCNA policy allows reimbursement for certain second or subsequent restorations on permanent teeth at the full Medicaid reimbursement fee for the same member, same permanent tooth when billed within 12 months from the date of the original restoration when the need for the restoration is due to pulpal necrosis (root canal) or traumatic injury to the tooth. All second and subsequent restorations that are requested as a result of pulpal necrosis (root canal) or traumatic injury, including codes D2140 and D2330, require x-rays and rationale to be included with claims submission in order to consider for payment. MCNA must be able to determine that the services are required as a result of pulpal necrosis (root canal) or traumatic injury; therefore, thorough documentation is required. The provider is required to submit X-Rays and rationale showing the presence of pulpal necrosis (root canal) or traumatic injury with subsequent claims for permanent teeth that are eligible for reimbursement at the full reimbursement fee in order to have the claim reconsidered for payment. The pre-authorization number must be entered in the appropriate block on the claim for payment.

If two or more restorations are placed on the same tooth, a maximum restoration fee that can be reimbursed per tooth has been established such that all restored surfaces on a single tooth shall be considered connected.

19.8.2. Primary Tooth Restorations

For the same provider, facility, or group, MCNA will reduce the payment of a second or subsequent amalgam restoration (Procedure Codes D2140, D2150 and D2160); and/or a second or subsequent resin-based composite restoration (Procedure Codes D2330, D2331, D2332 and D2335) for the same patient, same primary tooth when the date of service of the second restoration is within twelve (12) months from the date of the original restoration. The fee for any additional restorative service(s) on the same tooth will be reduced to the maximum fee allowed for the combined number of non-duplicated surfaces when performed within a 12-month period. In these situations, the maximum combined fee for the two (2) or more restorations within a 12-month period on the same tooth will not exceed the maximum fee of the larger restoration.

MCNA policy allows reimbursement for certain second or subsequent restorations on primary teeth at the full Medicaid reimbursement fee for the same member, same tooth when billed within 12 months from the date of the original restoration when the need for the restoration is due to pulpal necrosis (root canal) or traumatic injury to the tooth.

If two or more restorations are placed on the same tooth, a maximum restoration fee that can be reimbursed per tooth has been established such that all restored surfaces on a single tooth shall be considered connected.

19.8.3. General Information

Providers must utilize MCNA's Provider Portal or call the Provider Hotline in order to determine whether the member has received a restoration within 12 months from the date of original restoration. MCNA will reduce the payment of other second or subsequent restorations that are rendered within a 12-month period for the same member, same primary tooth. In these situations, the maximum combined fee for two (2) or more restorations within a 12-month period on the same tooth, same member will not exceed the maximum fee of the higher reimbursed restoration.

Amalgam restorations must be placed in a preparation in which the entire preparation extends through the enamel and into dentin. The restoration must follow established dental protocol in which the preparation and restoration should include all grooves and fissures on the billed surface(s). For providers to bill for a complex occlusal-buccal

or occlusal-lingual restoration, the preparation must extend the full length of the buccal or lingual groove or fully restore the buccal or lingual pit in addition to the occlusal surface. If the restoration is mesial-occlusal or distal-occlusal, the preparation must extend down the mesial or distal surface far enough for the restoration to be in a cleanable and inspectable area.

If two or more restorations are placed on the same tooth, a maximum restoration fee that can be reimbursed per tooth has been established such that all restored surfaces on a single tooth shall be considered connected.

Amalgam Restorations (Including Polishing)			
Code	**Description**	**Benefit Limits**	**Fee**
Procedure codes D2140, D2150, D2160, and D2161 represent final restorations. Procedure code D2161 is not payable for primary teeth. Duplicate surfaces are not payable on the same tooth in amalgam restorations in a 12-month period by same provider, facility, or group. If the same tooth requires a second or subsequent restoration and the provider did not perform the initial surface(s) restoration, pre-authorization is required and provider will receive full fee for service.			
D2140	Amalgam-one surface posterior - primary or permanent	A birth-20. This procedure is reimbursable for Tooth Number 1 through 32 and Tooth Letters A, B, C, H, I, J, K, L, M, R, S, and T.	$64.79
D2150	Amalgam-two surfaces posterior - primary or permanent	A birth-20. This procedure is reimbursable for Tooth Number 1 through 32 and Tooth Letters A, B, C, H, I, J, K, L, M, R, S, and T.	$82.14
D2160	Amalgam-three surfaces posterior - primary or permanent	A 1-20. This procedure is reimbursable for Tooth Number 1 through 32 and Tooth Letters A, B, C, H, I, J, K, L, M, R, S, and T.	$99.48
D2161	Amalgam-four or more surfaces posterior - permanent	A 1-20. This procedure is reimbursable for Tooth Number 1 through 32.	$117.34

19.9. Resin-Based Composite Restorations - Direct

Procedure codes D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394 represent final restorations. If two (2) restorations are placed on the same tooth, a maximum fee for resin-based composites that can be reimbursed per tooth has been established. The fee for any additional restorative service(s) on the same tooth will be reduced to the maximum fee for the combined number of surfaces when performed within a 12-month period, by the same provider, facility, or group. If the same tooth requires a second or subsequent restoration, and the provider did not perform the initial surface(s) restoration, pre-authorization is required and provider will receive full fee for service.

Procedure D2335 or D2394 is reimbursable only once per day, same tooth, any billing provider.

In these situations, the maximum combined fee for the two (2) or more restorations within a 12-month period on the same tooth will not exceed the maximum fee of the larger restoration. In addition, MCNA policy allows reimbursement for certain second or subsequent restorations on permanent teeth at the full reimbursement fee for the same member, same tooth when billed within 12 months from the date by same provider, facility, or group of

the original restoration when the need for the restoration is due to pulpal necrosis (root canal), traumatic injury to the tooth, or in the event of failed restoration.

Providers must utilize the MCNA's Provider Portal or call the Provider Hotline in order to determine whether the member has received a restoration within the 12 months from the date of original restoration. **All** composite restorations must be placed in a preparation that extends through the enamel and into the dentin. To bill for a particular surface in a complex restoration, the margins of the preparation must extend past the line angles onto the claimed surface. A Class V resin-based composite restoration is a one surface restoration. If the tooth is decayed extensively a crown should be considered.

The resin-based composite – four (4) or more surfaces or involving incisal angle (D2335 & D2394) – is a restoration in which both the lingual and facial margins extend beyond the proximal line angle and the incisal angle is involved. This restoration might also involve all four (4) surfaces of a tooth and not involve the incisal angle. To receive reimbursement for a restoration involving the incisal angle, the restoration must involve at least 1/3 of the clinical crown of the tooth.

The resin-based composite crown, anterior (D2390) is a single anterior restoration that involves full resin-based composite coverage of a tooth. Providers may request this procedure in cases where two (2) D2332 restorations would not adequately restore the tooth or in cases where two (2) D2335 would be required. Providers may also request this procedure on a tooth that has suffered a horizontal fracture resulting in the loss of the entire incisal segment.

The resin-based composite – four (4) or more surfaces (D2394) – is a single posterior restoration that involves full resin-based composite coverage of a tooth. Providers may bill this procedure in cases where two D2393 restorations would not adequately restore the tooth.

If the same tooth requires a second or subsequent restoration on the same surface(s) by a different provider, pre-authorization is required.

Resin-Based Composite Restorations - Direct			
Code	**Description**	**Benefit Limits**	**Fee**
Resin restoration includes composites or glass ionomer. Duplicate surfaces are not payable on the same tooth in restorations in resin-based restorations in a 12-month period by the same provider, facility, or group. **If the same tooth requires a second or subsequent restoration, and the provider did not perform the initial surface(s) restoration, pre-authorization is required and provider will receive full fee for service.**			
D2330	Resin-one surface, anterior	A 1-20. This procedure is reimbursable for Tooth Number 6 through 11 and 22 through 27. This procedure is reimbursable for Tooth Letter C, H, M and R for members under 21 years of age; and Tooth Letters D, E, F, G, N, O, P and Q only if the member is under five (5) years of age. Pre-authorization is not required for Tooth Letters D, E, F, G, N, O, P and Q.	$76.01

D2331	Resin-two surfaces, anterior	A 1-20. This procedure is reimbursable for Tooth Number 6 through 11 and 22 through 27. This procedure is reimbursable for Tooth Letter C, H, M and R for members under 21 years of age; and Tooth Letters D, E, F, G, N, O, P and Q only if the member is under five (5) years of age. Pre-authorization is not required for Tooth Letters D, E, F, G, N, O, P and Q.	$94.38
D2332	Resin-three surfaces, anterior	A 0-20. This procedure is reimbursable for Tooth Number 6 through 11 and 22 through 27. This procedure is reimbursable for Tooth Letter C, H, M and R for members under 21 years of age; and Tooth Letters D, E, F, G, N, Q, P and Q only if the member is under five (5) years of age. Pre-authorization is not required for Tooth Letters D, E, F, G, N, O, P and Q.	$114.79
D2335	Resin-four or more surfaces or involving incisal angle (anterior)	A 0-20. This procedure is reimbursable for Tooth Number 6 through 11 and 22 through 27. This procedure is reimbursable for Tooth Letter C, H, M and R for members under 21 years of age; and Tooth Letters D, E, F, G, N, O, P and Q only if the member is under five (5) years of age.	$143.87
D2390	Resin-based composite crown, anterior	A 1-20. This procedure is reimbursable for Tooth Number 6 through 11 and 22 through 27. All permanent teeth require prior authorization for this procedure. This procedure is reimbursable for Tooth Letter C, H, M and R for members under 21 years of age; and Tooth Letters D, E, F, G, N, O, P and Q only if the member is under five (5) years of age. Pre-authorization for Tooth Letters C, H, M and R is required only for members nine (9) years of age and older. Pre-authorization is not required for Tooth Letters D, E, F, G, N, O, P and Q.	$210.70
D2391	Resin-based composite - one surface, posterior	A 0-20. This procedure is reimbursable for Tooth Number 1 through 5, 12 through 16, 17 through 21, and 28 through 32 and Tooth Letters A, B, I, J, K, L, S and T.	$64.79
D2392	Resin-based composite - two surfaces, posterior	A 0-20. This procedure is reimbursable for Tooth Number 1 through 5, 12 through 16, 17 through 21, and 28 through 32 and Tooth Letters A, B, I, J, K, L, S and T.	$82.14

D2393	Resin-based composite - three surfaces, posterior	A 0-20. This procedure is reimbursable for Tooth Number 1 through 5, 12 through 16, 17 through 21, and 28 through 32 and Tooth Letters A, B, I, J, K, L, S and T.	$99.48
D2394	Resin-based composite - four or more surfaces, posterior	A 0-20. This procedure is reimbursable for Tooth Number 1 through 5, 12 through 16, 17 through 21, and 28 through 32 and Tooth Letters A, B, I, J, K, L, S and T.	$117.34

19.10. Non-Laboratory Crowns

Crown services require radiographic images, photographs, other imaging media or other documentation that depicts the pretreatment condition. The documentation supporting the need for crown services must be available for review by the LDH or MCNA upon request.

Other Restorative Services			
Code	**Description**	**Benefit Limits**	**Fee**
D2920	Recement crown	A 1-20. The billing provider, facility, or group is responsible for recementation within the first 12 months after placement of the crown. This procedure is reimbursable for Tooth Numbers 1 through 32 and Tooth Letter A through T.	$50.00
Procedure codes D2930, D2931, D2932, D2933 and D2934 represent final restorations. Non-laboratory or chair-side full coverage restorations such as stainless steel and polycarbonate crowns are available but should only be considered when other conventional chair-side types of restorations such as complex amalgams and composite resins are unsuitable. Crown services require radiographic images (unless contraindicated). Indications such as extensive caries, extensive cervical caries, fractured teeth, replacing a missing cusp, etc. must be radiographically evident and/or documented in the member's treatment records if radiographic images are medically contraindicated. The documentation that supports the need for crown services must be available for review by the LDH or MCNA upon request. Pre-authorization is required for all except as noted by code below.			
D2930	Prefabricated stainless steel crown - primary tooth	A birth-20. This procedure code is payable for Tooth Letters D, E, F, G, N, O, P and Q only if the member is under five (5) years of age. Pre-authorization for procedure code D2930 is required only for Tooth Letters B, I, L, and S for members nine (9) years of age and older; and for Tooth Letters A, C, H, J, K, M, R and T for members 10 years of age and older.	$127.54

D2931	Prefabricated stainless steel crown - permanent tooth	A 1-20. Requires pre-authorization. This procedure is reimbursable for Tooth Numbers 1 through 32.	$152.03
D2932	Prefabricated resin crown	A 1-20 (primary tooth). This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27 with pre-authorization; and Tooth Letters C, H, M and R for members under 21 years of age. This procedure does not require pre-authorization for Tooth Letters D, E, F, G, N, O, P, and Q only if the member is under five (5) years of age. Pre-authorization for Tooth Letters C, H, M and R is required for members nine (9) years of age and older.	$165.80
D2933	Prefabricated stainless steel crown with resin window	A birth-20. This procedure is reimbursable for Tooth Letters C, H, M and R for members under 21 years of age; and for Tooth Letters D, E, F, G, N, O, P and Q only if the member is under five (5) years of age. Pre-authorization is required for Tooth Letters C, H, M and R only for members nine (9) years of age or older. Pre-authorization is not required for Tooth Letters D, E, F, G, N, O, P and Q.	$168.86
D2934	Prefabricated esthetic coated stainless steel crown primary	A birth-20. This procedure is reimbursable for Tooth Letters C, H, M and R for members under 21 years of age; and for Tooth Letters D, E, F, G, N, O, P and Q only if the member is under five (5) years of age. Pre-authorization is required for Tooth Letters C, H, M and R only for members nine (9) years of age or older. Pre-authorization is not required for Tooth Letters D, E, F, G, N, O, P and O.	$168.86

The codes D2950 and D2954 are intermediate restorative codes for endodontically treated permanent teeth and can be billed only after receiving pre-authorization.			
D2950	Core build-up, including any pins	A 0-20. Provider payments received in excess of $45.00 for restorative work performed within six (6) months of a crown procedure on the same tooth will be deducted from the subsequent crown procedure reimbursement. Not allowed on primary teeth. Pre-authorization is required and is only available for permanent teeth that have undergone endodontic treatment. A core build-up cannot be authorized in conjunction with a post and core or for primary teeth. This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31.	$128.56
D2951	Pin retention-per tooth, in addition to restoration	A 0-20. Not allowed on primary teeth. Requires x-rays with claim submission. Reimbursement for pins is limited to one (1) per tooth, within a 12-month period and may only be billed in conjunction with the complex restoration codes D2160 or D2161. This procedure is reimbursable for Tooth Numbers 2 through 5; 12 through 15; 18 through 21; and 28 through 31.	$35.20
D2954	Prefabricated post and core in addition to crown	A 0-20. Not allowed on primary teeth. The post and core can be used on endodontically treated permanent teeth (2-15 and 18-31) when there is insufficient natural tooth structure to receive the final full coverage restoration. The post must extend at least one-third the length of the root and must closely approximate the canal walls. Pre-authorization is required and will not be authorized in combination with a core build-up. This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31.	$160.70
D2999	Unspecified restorative procedure	A 1-20. Requires pre-authorization, X-Rays, and rationale.	Manually Priced

19.11. Endodontic Therapy Services

Reimbursement for a root canal includes all appointments necessary to complete the treatment.

Pulpotomy and radiographs performed intra and postoperatively are included in the root canal reimbursement.

Documentation supporting medical necessity must be kept in the member's record and include the following: the medical necessity as documented through periapical radiographs of tooth treated showing pre-treatment, during treatment, and post-treatment status; the final size of the file to which the canal was enlarged; and the type of filling material used. Only endodontic treatment completed to an acceptable standard of care will be approved for reimbursement. Any reason that the root canal may appear radiographically unacceptable must be documented in the member's record.

Pulp Capping			
Code	**Description**	**Benefit Limits**	**Fee**
Procedure code D3110 will not be reimbursed when submitted with the following procedure codes for the same tooth, for the same DOS, by the same provider, facility, or group: D2950, D2954, D2999, D3220, D3240, D3310, D3320, or D3330.			
D3110	Pulp cap-direct (excluding final restoration)	A 1-20. Permanent teeth require x-rays with claim submission. Pulp capping is approved when calcium hydroxide or other ADA accepted pulp-capping material is placed directly on an exposed pulp. Indirect pulp caps are not covered. The program does not cover pulp caps in primary teeth. Pre-operative radiographic images must substantiate the need for this service. This procedure is reimbursable for Tooth Numbers 1 through 32.	$38.26

Pulpotomy			
Code	**Description**	**Benefit Limits**	**Fee**
D3220	Therapeutic pulpotomy (excluding final restoration) removal of pulp coronal	Procedure code D3220 is reimbursable for Tooth Letters A through T. However, this procedure code D3220 is reimbursable for Tooth Letters D, E, F, G, N, O, P and Q only if the member is under five (5) years of age. This is not to be billed as the first stage of root canal therapy. This procedure is limited to once per tooth every 24 months.	$94.38
D3222	Partial Pulpotomy for Apexogenisis – permanent tooth with incomplete root development	This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31. This procedure is not considered as the first stage of endodontic therapy and requires pre-authorization. This service is reimbursable only once a 12-month period, per tooth.	$94.38

Endodontic Therapy on Primary Teeth			
Code	**Description**	**Benefit Limits**	**Fee**
D3240	Pulpal therapy (resorbable filling)-posterior, primary tooth (excluding final restoration)	Coverage is provided for the endodontic treatment of posterior second primary molars (A, J, K or T) requiring complete extirpation of all pulpal material and filling with a resorbable filling material. If the endodontic pathology on these teeth cannot be treated with a pulpotomy, then extraction and space maintenance may be indicated. Authorization will be limited to a primary second molar in an arch (maxillary or mandibular), when the first permanent molar has not erupted and when a pulpectomy will eliminate the necessity for extraction and the placement of a distal shoe space maintainer. A pulpectomy will not be approved in cases where the primary roots are more than half resorbed or when the six (6) year molar has erupted. Intra-operative radiograph(s), which must include a post-operative radiograph, are included in the reimbursement for the pulpal therapy. This procedure is reimbursable for Tooth Letters A, J, K, and T. Requires pre-authorization. Post-operative radiograph must be submitted with claim.	$152.03

Endodontic Therapy (including Treatment Plan, Clinical Procedures, and Follow-up Care)			
Code	**Description**	**Benefit Limits**	**Fee**
Complete endodontic therapy (procedures D3310, D3320 and D3330) includes treatment plan, all appointments necessary to complete treatment, clinical procedures, all intraoperative radiographic images (which must include a post-operative radiograph) and follow-up care. Pre-authorization is required. Requests for pre-authorization must be accompanied by a treatment plan supported by sufficient, readable, most-current bitewings and current periapical radiographic images, as applicable, to judge the general oral health status of the member. Specific treatment plans for final restoration of the tooth must be submitted. In cases where multiple root canals are requested or when teeth are missing or in need of endodontic therapy in the same arch, a partial denture may be indicated. Third molar root canals are not reimbursable. Final approvals for root canals require post authorization. Request for post authorization must be accompanied by the approved pre-authorization request and post-operative radiographs prior to reimbursement. The date of service on the payment request must reflect the final treatment date. Written documentation must also include the type of filling material used as well as the notation of any complications encountered which may compromise the success of the endodontic treatment.			
D3310	Anterior (excluding final restoration)	**A** 6-20. This procedure is reimbursable for Tooth Numbers 6-11 and 22-27. Requires pre-authorization and X-Rays. When submitting claims, please include post-operative films.	$336.71
D3320	Bicuspid (excluding final restoration)	A 6-20. This procedure is reimbursable for Tooth Numbers 4, 5, 12, 13, 20, 21, 28 and 29. Requires pre-authorization and X-Rays. When submitting claims, please include post-operative films.	$395.37
D3330	Molar (excluding final restoration)	A 6-20. Permanent teeth only. This procedure is reimbursable for Tooth Numbers 2, 3, 14, 15, 18, 19, 30 and 31. Requires pre-authorization and X-Rays. When submitting claims, please include post-operative films.	$474.45

Endodontic Retreatment

Code	Description	Benefit Limits	Fee
D3346	Retreatment of root canal - anterior	**A** 6-20. Requires pre-authorization, X-Rays, and rationale. When submitting claims, please include pre-operative and post-operative films. Procedure D3346 may include the removal of post, pin(s), old root canal filling material, and the procedures necessary to prepare the canal and place the canal filing. This includes complete root canal therapy. The reimbursement for this procedure includes all appointments necessary to complete the treatment and all intra-operative radiographic images. The date of service on the payment request must reflect the final treatment date. Intra-operative radiograph(s), which must include a pre- and post-operative radiograph, are included in the reimbursement for the retreatment of the root canal and must be maintained in the member's treatment records. Not reimbursable when submitted by the same provider, facility or group that performed the original root canal therapy.	$391.29

Apexification/Recalcification Procedures

Code	Description	Benefit Limits	Fee
The following code requires pre-authorization, X-Rays, and rationale.			
D3352	Apexification/recalcification-interim medication replacement	A 6-20. Requires pre-authorization. **A**pexification is defined as the placement of medication within a root canal space to promote biological closure of the apex. This service is limited to a maximum of three (3) treatments per tooth with the root canal being billed separately. This service is available to both anterior and posterior permanent teeth and will be considered when the tooth fulfills all of the requirements for root canal authorization as well as an open apex, which cannot be sealed using conventional endodontic technique. A time period of 90 days must elapse between D3352 treatments. A time period of 90 days must elapse between the final D3352 treatment and start of the root canal. This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31. When submitting claims, please include post-operative films.	$121.42

Apicoectomy/Periradicular Services			
Code	**Description**	**Benefit Limits**	**Fee**
The following codes require pre-authorization and X-Rays.			
D3410	Apicoectomy/periradicular surgery-anterior	A 6-20. Requires pre-authorization. This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27.When submitting claims, please include post-operative films.	$323.44
D3430	Retrograde filling-per root	A 6-20. Requires pre-authorization. This procedure will be approved only in conjunction with code D3410. This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27.When submitting claims, please include post-operative films.	$128.56

Other Endodontic Procedures			
Code	**Description**	**Benefit Limits**	**Fee**
The following codes require pre-authorization, X-Rays, and rationale.			
D3999	Unspecified Endodontic procedure	A 1-20. Requires pre-authorization. When submitting claims, please include pre-operative and post-operative films.	Manually Priced

19.12. Periodontal Services

Procedure codes D4210, D4341, D4355, and D4999 require pre-authorization, X-Rays, and rationale with documentation of medical necessity. Additionally, pre-operative and post-operative photographs are required for the following procedure codes: D4210 and possibly D4999.

Documentation is required when medical necessity is not evident on radiographs for the following procedure codes: D4210 and D4355.

Claims for any D4000 series periodontal procedure codes will be denied when submitted for the same DOS as any preventive dental procedure codes D1110, D1120, D1208, D1206, and D1351.

Periodontal services include gingivectomy, periodontal scaling and root planing, full mouth debridement, and unspecified periodontal procedures. Local anesthesia is considered to be part of periodontal procedures.

Surgical Services

Code	Description	Benefit Limits	Fee
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth	A 0-20. This procedure requires pre-authorization, rationale, and pre-operative color photographs. A gingivectomy may be approved by MCNA only when the tissue growth interferes with mastication. This procedure is reimbursable for Oral Cavity Designators 10, 20, 30 and 40.	$295.38

Nonsurgical Periodontal Services

Code	Description	Benefit Limits	Fee
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	A 13-20. Requires pre-authorization, X-Rays, periodontal charting, and rationale. D4341 is denied if provided within 21 days of D4355. Denied when submitted for the same date of service as other D4000 series codes or with D1110, D1120, D1208. D1206, D1351, D1510, D1515, D1520, or D1555. Radiographic evidence of bone loss indicating a true periodontal disease state must be supplied with bitewings and/or posterior/anterior periapicals. This service is not approved for members who have not progressed beyond the mixed dentition stage of development. Only two (2) units of periodontal scaling and root planing may be reimbursed per day. For members requiring hospitalization for dental treatment, a maximum of four (4) units of procedure code D4341 may be paid on the same date of service if pre-authorized and must be billed in conjunction with D9420. When using the 2006 or 2012 ADA claim form used to request pre-authorization or reimbursement, you must identify the "Place of Treatment" (Block 38) and "Treatment Location" (Block 56) if the service was performed at a location other than the primary office. This procedure is reimbursable for Oral Cavity Designators 10, 20, 30 and 40. This service is reimbursable only once per quadrant in a 12 month period.	$128.56

D4355	Full mouth debridement	A 0-20. Requires a pre-authorization, X-Rays, and rationale. D4355 is not payable if provided within 21 days of D4341. Denied when submitted for the same DOS as any code except D0150, D0210, D0330 or D0350. May be billed with D0120 if submitted by the same Provider, facility or group that billed for a D0150 at least 18 months from the date of service (DOS). No other dental services except examination, radiographic images or oral/facial photographic images are reimbursable on the same date of service as full mouth debridement. When an exam is performed on the same date of service as a full mouth debridement the exam must be performed after completion of the full mouth debridement. Only one (1) full mouth debridement is allowed in a 12-month period. This procedure will not be reimbursed if payment has previously been made for an Adult Prophylaxis (D1110) or Child Prophylaxis (D1120) to the same billing provider, facility, or group within a 12-month period. If the pre- or post-authorization request for D4355 is denied and it has been determined that a D1110 (Adult Prophylaxis) or D1120 (Child Prophylaxis) has not been provided within the preceding 12 months for this member, the provider may render and bill MCNA for a D1110 (Adult Prophylaxis) or D1120 (Child Prophylaxis), whichever is applicable based on the member's age.	$86.73

Other Periodontal Services

Code	Description	Benefit Limits	Fee
D4999	Unspecified periodontal procedure	**A** 0-20. Requires pre-authorization, X-Rays, and rationale. Requires oral cavity designator. Reimbursable for oral cavity 10, 20, 30 or 40.	Manually Priced

19.13. Removable Prosthodontics

Removable prosthodontic services include complete dentures, partial dentures, denture repairs, and denture relines.

Documentation requirements are included to conform to state and federal regulations concerning the necessity of documentation linked to the payment for services funded by both the state and federal government.

19.13.1. Minimum Standards for Complete and Partial Denture Prosthodontics

Denture services provided to members under the Medicaid Program must follow acceptable techniques in all stages of construction, such as preliminary and final impressions, wax rim and esthetic try-in, processing, delivery, and adjustment. Although no minimum number of appointments is set, the following minimum standards must be adhered to:

The provider is required to obtain acceptance of esthetic appearance from member prior to processing. This acceptance must be documented by the member's signature in the treatment record.

- The denture should be flasked and processed under heat and pressure in a commercial or dental office laboratory using ADA certified materials. The prosthetic prescription and laboratory bill (or a copy) must be maintained in the member's treatment record.
- Upon delivery:
  - The denture bases must be stable on the lower and retentive on the upper.
  - The clasping must be appropriately retentive for partial dentures.
  - The vertical dimension of occlusion should be comfortable to the member (not over-closed or under-closed). The proper centric relation of occlusion should be established for complete dentures or partial dentures opposing full dentures. For partial dentures opposing natural dentition or another partial denture, the occlusion must be harmonious with the opposing arch.
  - The denture must be fitted and adjusted for comfort, function, and esthetics.
  - The denture must be finished in a professional manner; it must be clean, exhibit a high gloss, and be free of voids, scratches, abrasions, and rough spots.

The delivery date of the denture and/or partial dentures is the billing date of service (DOS).

The chart record with date of delivery of the dentures, including the member's signature for acceptance of the aesthetic try in, must be submitted with the claim for payment.

The dentist is responsible for all necessary adjustments for a period of six (6) months.

Records must include a chronological (dated) narrative account of each member visit indicating what treatment was provided and what conditions were present on those visits. A check list of codes for services billed as well as copies of claim forms submitted for authorization or payment is deemed insufficient documentation of services delivered.

If the member refuses delivery of the complete or partial denture it cannot be considered delivered.

Failure to deliver a minimally acceptable full or partial denture, failure to provide adequate follow-up care, or failure to document the services provided will be considered grounds for recouping the fee paid for the denture.

19.13.2. Denture Identification Information

All full and partial dentures (excluding interim partials, D5820, and D5821) reimbursed under the Medicaid EPSDT Program must have the following unique identification information processed into the acrylic base:

- The first four (4) letters of the member's last name and first initial
- The month and year (00/00) the denture was processed
- The last five (5) digits of provider's Medicaid ID number

Complete Dentures (Including Routine Post Delivery Care)			
Code	**Description**	**Benefit Limits**	**Fee**
The following codes require pre-authorization, X-Rays, and rationale.			
D5110	Dentures complete maxillary	A 3-20. Only one (1) prosthesis per member, per arch is allowed in a five (5) year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. Once the member reaches 21 years of age, the rules of the Adult Denture Program apply. All missing teeth must be marked on the claim form. Radiographic images documenting the necessity for complete denture(s) must be submitted with the request for pre-authorization. If an immediate denture is requested the provider must state the reasons for the request in the "Remarks" section of the claim form. Immediate dentures are not considered temporary. The provider must inform the member that no reline is covered within one (1) year of the denture delivery. If there will be teeth remaining on the date of denture delivery only the immediate full denture codes (D5130 and/or D5140) may be pre-authorized. Radiographic images should confirm that no more than six (6) teeth remain. If more than six (6) teeth remain, the attending provider must certify by statement in the "Remarks" section that six (6) or fewer teeth will remain when the final impression is taken. An immediate denture that is not delivered will be denied under the interruption of treatment guidelines. If submitted more than 5 years from any prior D5110 with a code of D5510, D5520, D5610, D5630, D5640, D5650, D5660 in history within the past 12 months the fee for D5110 will be reduced by the fee for the D5510, D5520, D5610, D5630, D5640, D5650, D5660 by the same Provider, facility or group.	$495.00

D5120	Dentures complete mandible	A 3-20. Only one (1) prosthesis per member, per arch is allowed in a five (5) year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. Once the member reaches 21 years of age the rules of the Adult Denture Program apply. All missing teeth must be marked on the claim form. Radiographic images documenting the necessity for complete denture(s) must be submitted with the request for pre-authorization. If an immediate denture is requested the provider must state the reasons for the request in the "Remarks" section of the claim form. Immediate dentures are not considered temporary. The provider must inform the member that no reline is covered within one (1) year of the denture delivery. If there will be teeth remaining on the date of denture delivery only the immediate full denture codes (D5130 and/or D5140) may be pre-authorized. Radiographic images should confirm that no more than six (6) teeth remain. If more than six (6) teeth remain, the attending provider must certify by statement in the "Remarks" section that six (6) or fewer teeth will remain when the final impression is taken. An immediate denture that is not delivered will be denied under the interruption of treatment guidelines. If submitted more than 5 years from any prior D5120 with a code of D5510, D5520, D5610, D5630, D5640, D5650, D5660 in history within the past 12 months the fee for D5120 will be reduced by the fee for the D5510, D5520, D5610, D5630, D5640, D5650, D5660 by the same Provider, facility or group.	$495.00
D5130	Dentures immediate maxillary	A 3-20. Only one (1) prosthesis per member, per arch is allowed in a five (5) year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. Once the member reaches 21 years of age the rules of the Adult Denture Program apply. All missing teeth must be marked on the claim form. Radiographic images documenting the necessity for complete denture(s) must be submitted with the request for pre-authorization. If an immediate denture is requested the provider must state the reasons for the request in the "Remarks"	$495.00

		section of the claim form. Immediate dentures are not considered temporary. The provider must inform the member that no reline is covered within one (1) year of the denture delivery. If there will be teeth remaining on the date of denture delivery only the immediate full denture codes (D5130 and/or D5140) may be pre-authorized. Radiographic images should confirm that no more than six (6) teeth remain. If more than six (6) teeth remain, the attending provider must certify by statement in the "Remarks" section that six (6) or fewer teeth will remain when the final impression is taken. An immediate denture that is not delivered will be denied under the interruption of treatment guidelines. If submitted more than 5 years from any prior D5130 with a code of D5510, D5520, D5610, D5630, D5640, D5650, D5660 in history within the past 12 months the fee for D5130 will be reduced by the fee for the D5510, D5520, D5610, D5630, D5640, D5650, D5660 by the same Provider, facility or group.	
D5140	Dentures immediate mandible	A 3-20. Only one (1) prosthesis per member, per arch is allowed in a five (5) year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. Once the member reaches 21 years of age the rules of the Adult Denture Program apply. All missing teeth must be marked on the claim form. Radiographic images documenting the necessity for complete denture(s) must be submitted with the request for pre-authorization. If an immediate denture is requested the provider must state the reasons for the request in the "Remarks" section of the claim form. Immediate dentures are not considered temporary. The provider must inform the member that no reline is covered within one (1) year of the denture delivery. If there will be teeth remaining on the date of denture delivery only the immediate full denture codes (D5130 and/or D5140) may be pre-authorized. Radiographic images should confirm that no more than six (6) teeth remain. If more than six (6) teeth remain, the attending provider must certify by statement in the "Remarks" section that six (6) or fewer teeth will remain when the final impression is	$495.00

		taken. An immediate denture that is not delivered will be denied under the interruption of treatment guidelines. If submitted more than 5 years from any prior D5140 with a code of D5510, D5520, D5610, D5630, D5640, D5650, D5660 in history within the past 12 months the fee for D5140 will be reduced by the fee for the D5510, D5520, D5610, D5630, D5640, D5650, D5660 by the same Provider, facility or group.	

Partial Dentures (Including Routing Post Delivery Care)

Code	Description	Benefit Limits	Fee
The following codes require pre-authorization, X-Rays, and rationale. Medicaid may provide an acrylic interim partial denture (D5820/D5821) in the mixed dentition or beyond the mixed dentition states in the following cases: • Missing one (1) or two (2) maxillary permanent anterior teeth or, • Missing two (2) mandibular permanent anterior teeth or, • Missing three (3) or more permanent teeth in the same arch (of which at least one must be anterior) • Medicaid may provide a partial denture (D5211, D5212, D5213, D5214) in cases where the recipient has matured beyond the mixed dentition stage in the following cases: • Missing three (3) or more maxillary anterior teeth, or • Missing two (2) or more mandibular anterior teeth, or • Missing at least three (3) adjacent posterior permanent teeth in a single quadrant when the prosthesis would restore masticatory function (third molars not considered for replacement), or • Missing at least two (2) adjacent posterior permanent teeth in both quadrants of the same arch when the prosthesis would restore masticatory function in at least one quadrant (third molars not considered for replacement) or, • Missing a combination of two (2) or more anterior and at least one posterior tooth (excluding wisdom teeth and the second molar) in the same arch. Cast partials (D5213 and D5214) will be considered only for those recipients who are 18 years of age or older. Only one (1) complete or partial denture per arch is allowed in a five (5) year period. The time period begins from the date the previous complete or partial denture for the same arch was delivered. The overall condition of the mouth is an important consideration in whether or not a partial denture is authorized. For partial dentures, abutment teeth must be caries-free or have been completely restored and have sound periodontal support. For those members requiring extensive restorations, periodontal services, extractions, etc., post-treatment radiographs may be requested prior to approval of an acrylic partial denture.			
D5211	Upper partial-resin base	A 3-20. Only one (1) prosthesis (excluding interim partial dentures) per member per arch is allowed in a five (5) year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. An interim partial denture cannot be authorized to replace a partial denture that was previously paid by Louisiana Medicaid or MCNA. A description of the arch receiving the prosthesis must be provided by indicating which teeth are to be	$470.00

		replaced and which are to be retained. If submitted more than 5 years from any prior D5211 with a D5760 in history with in the past 12 months the fee for D5211 will be reduced by the amount of the fee for the D5760 by the same Provider, facility or group. If code D5211 is reported more than five (5) years from any prior D5211 with a D5510, D5520, D5610, D5630, D5640, D5650, D5660 in history within the past 12 months the fee for D5211 will be reduced by the fee for the D5510, D5520, D5610, D5630, D5640, D5650, D5660 by the same Provider, facility or group. Only permanent teeth are eligible for replacement by an interim partial denture or a partial denture. Opposing partial dentures are available if each arch independently fulfills the requirements. Partial dentures that replace only posterior teeth must occlude against multiple posterior teeth in the opposing arch and must serve to increase masticatory function and stability of the entire mouth. For members requiring extensive restorations, periodontal services, extractions, etc., post-treatment radiographic images may be requested prior to approval of a partial denture.	
D5212	Lower partial-resin base	A 3-20. Only one (1) prosthesis (excluding interim partial dentures) per member per arch is allowed in a five (5) year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. An interim partial denture cannot be authorized to replace a partial denture that was previously paid by Louisiana Medicaid or MCNA. A description of the arch receiving the prosthesis must be provided by indicating which teeth are to be replaced and which are to be retained. If submitted more than 5 years from any prior D5212 with a D5760 in history with in the past 12 months the fee for D5212 will be reduced by the amount of the fee for the D5760 by the same Provider, facility or group. If code D5212 is reported more than five (5) years from any prior D5212 with a D5510, D5520, D5610, D5630, D5640, D5650, D5660 in history within the past 12 months the fee for D5212 will be reduced by the fee for the D5510, D5520, D5610, D5630,	$470.00

		D5640, D5650, D5660 by the same Provider, facility or group. Only permanent teeth are eligible for replacement by an interim partial denture or a partial denture. Opposing partial dentures are available if each arch independently fulfills the requirements. Partial dentures that replace only posterior teeth must occlude against multiple posterior teeth in the opposing arch and must serve to increase masticatory function and stability of the entire mouth. For members requiring extensive restorations, periodontal services, extractions, etc., post-treatment radiographic images may be requested prior to approval of a partial denture.	
D5213	Maxillary partial denture - cast metal framework with resin denture bases	A 18-20. Only one (1) prosthesis (excluding interim partial dentures) per member per arch is allowed in a five (5) year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. An interim partial denture cannot be authorized to replace a partial denture that was previously paid by Medicaid of Louisiana or MCNA. A description of the arch receiving the prosthesis must be provided by indicating which teeth are to be replaced and which are to be retained. If submitted more than 5 years from any prior D5213 with a D5760 in history with in the past 12 months the fee for D5213 will be reduced by the amount of the fee for the D5760 by the same Provider, facility or group. If code D5213 is reported more than five (5) years from any prior D5213 with a D5510, D5520, D5610, D5630, D5640, D5650, D5660 in history within the past 12 months the fee for D5213 will be reduced by the fee for the D5510, D5520, D5610, D5630, D5640, D5650, D5660 by the same Provider, facility or group. Only permanent teeth are eligible for replacement by an interim partial denture or a partial denture. Opposing partial dentures are available if each arch independently fulfills the requirements. Partial dentures that replace only posterior teeth must occlude against multiple posterior teeth in the opposing arch and	$688.00

		must serve to increase masticatory function and stability of the entire mouth. Radiographic images should verify that all pre-prosthetic services have been successfully completed. For members requiring extensive restorations, periodontal services, extractions, etc., post treatment radiographic images may be requested prior to approval of a cast partial denture.	
D5214	Mandibular partial denture - cast metal framework with resin denture bases	A 18-20. Only one (1) prosthesis (excluding interim partial dentures) per member per arch is allowed in a five (5) year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. An interim partial denture cannot be authorized to replace a partial denture that was previously paid by Louisiana Medicaid or MCNA. A description of the arch receiving the prosthesis must be provided by indicating which teeth are to be replaced and which are to be retained. If submitted more than 5 years from any prior D5214 with a D5760 in history with in the past 12 months the fee for D5214 will be reduced by the amount of the fee for the D5760 by the same Provider, facility or group. If code D5214 is reported more than five (5) years from any prior D5214 with a D5510, D5520, D5610, D5630, D5640, D5650, D5660 in history within the past 12 months the fee for D5214 will be reduced by the fee for the D5510, D5520, D5610, D5630, D5640, D5650, D5660 by the same Provider, facility or group. Only permanent teeth are eligible for replacement by an interim partial denture or a partial denture. Opposing partial dentures are available if each arch independently fulfills the requirements. Partial dentures that replace only posterior teeth must occlude against multiple posterior teeth in the opposing arch and must serve to increase masticatory function and stability of the entire mouth. Radiographic images should verify that all pre-prosthetic services have been successfully completed. For members requiring extensive restorations, periodontal services, extractions, etc., post treatment radiographic images may be requested prior to approval of a cast partial denture.	$688.00

Repairs to Complete Dentures			
Code	**Description**	**Benefit Limits**	**Fee**
D5510	Repair broken complete denture base	A 3-20. Requires rationale. Reimbursement for repairs of complete and partial dentures (excluding interim partial dentures) are allowed only if more than one (1) year has elapsed since denture insertion by the same billing provider, facility, or group and the repair makes the denture fully serviceable and eliminates the need for a new denture. If the same provider, facility, or group requests a complete or partial denture within the first year after a repair is paid, the repair fee for that arch will be deducted from the new prosthesis fee. A repair is allowed in conjunction with a reline on the same member as long as the repair makes the denture fully serviceable. Reimbursable only for Oral Cavity Designators 01 and 02. Must include the location and description of the fracture in the "Remarks" section of the claim form.	$125.00
D5520	Replace missing or broken teeth-complete denture (each tooth)	A 3-20. Cost of repairs cannot exceed replacement costs. Requires rationale. The fee assigned for the first tooth billed using the codes D5520 or D5640 or D5650 will reflect the base price for the first denture tooth. When multiple teeth are replaced or added to the same prosthesis on the same date of service, the same procedure code is to be used for each tooth. Requires tooth ID. This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31.	$65.00 $33.00

Repairs to Partial Dentures			
Code	**Description**	**Benefit Limits**	**Fee**
Cost of repairs cannot exceed replacement costs.			
D5610	Repair resin denture base	A 3-20. Reimbursement for repairs of complete and partial dentures (excluding interim partial dentures) are allowed only if more than one (1) year has elapsed since denture insertion by the same billing provider, facility, or group and the repair makes the denture fully serviceable and eliminates the need for a new denture. If the same provider, facility, or group requests a complete or partial denture within the first year after a repair is paid, the repair fee for that arch will be deducted from the new prosthesis fee. A repair is allowed in conjunction with a reline on the same member as long as the repair makes the denture fully serviceable. Reimbursable only for Oral Cavity Designators 01 and 02. Must include the location and description of the fracture in the "Remarks" section of the claim form.	$125.00
D5630	Repair or replace broken clasp, Partial Denture- per tooth	A 3-20. Requires Rationale. Reimbursable for Oral Cavity Designator 10, 20, 30 and 40. When requesting payment for these procedures, the side of the prosthesis involved (right or left) must be indicated in the "Remarks" section of the claim form.	$119.00
D5640	Replace broken teeth-per tooth	A 3-20. Requires rationale. The fee assigned for the first tooth billed using the codes D5520 or D5640 or D5650 will reflect the base price for the first denture tooth. When multiple teeth are replaced or added to the same prosthesis on the same date of service, the same procedure code is to be used for each tooth. Requires tooth ID. This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31.	$65.00 $33.00

D5650	Add tooth to existing partial denture	A 3-20. Requires rationale. Requires tooth ID. The fee assigned for the first tooth billed using the codes D5520 or D5640 or D5650 will reflect the base price for the first denture tooth. When multiple teeth are replaced or added to the same prosthesis on the same date of service, the same procedure code is to be used for each tooth. This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31.	$65.00 $33.00
D5660	Add clasp to existing partial denture- per tooth	A 3-20. Requires rationale. Requires tooth ID. Procedure Codes D5630 and D5660 are reimbursable for Oral Cavity Designators 10, 20, 30 and 40. When requesting payment for these procedures, the side of the prosthesis involved (right or left) must be indicated in the "Remarks" section of the claim form.	$119.00

Denture Reline Procedures

Code	Description	Benefit Limits	Fee
Allowed if the reline makes the denture serviceable. The following codes require pre-authorization and rationale. Not covered within one (1) year of initial placement of dentures.			
D5750	Reline complete maxillary denture (laboratory)	A 3-20. Reimbursement for complete and partial denture relines are allowed only if one (1) year has elapsed since the previous complete or partial denture was constructed or last relined. If billing provider requests a complete or partial denture for the same arch within one (1) year after delivery of the reline, the reline fee will be deducted from the new prosthesis fee. A combination of two (2) complete or partial denture relines or one (1) complete or partial denture and one (1) reline in the same arch are allowed in a five-year period as pre-authorized by LDH or its designee. Reline of existing dentures must be given priority over the construction of new dentures if it is judged that the existing dentures are serviceable for at least five (5) years. Chair-side relines (cold cure acrylics) are not reimbursable. The dentist is responsible for all necessary adjustments for a period of six (6) months.	$238.00

D5751	Reline complete mandibular denture (laboratory)	A 3-20. Reimbursement for complete and partial denture relines are allowed only if one (1) year has elapsed since the previous complete or partial denture was constructed or last relined. If billing provider requests a complete or partial denture for the same arch within one (1) year after delivery of the reline, the reline fee will be deducted from the new prosthesis fee. A combination of two (2) complete or partial denture relines or one (1) complete or partial denture and one (1) reline in the same arch are allowed in a five-year period as pre-authorized by LDH or its designee. Reline of existing dentures must be given priority over the construction of new dentures if it is judged that the existing dentures are serviceable for at least five (5) years. Chair-side relines (cold cure acrylics) are not reimbursable. The dentist is responsible for all necessary adjustments for a period of six (6) months.	$238.00
D5760	Reline maxillary partial denture (laboratory)	A 3-20. Reimbursement for complete and partial denture relines are allowed only if one (1) year has elapsed since the previous complete or partial denture was constructed or last relined. If billing provider requests a complete or partial denture for the same arch within one (1) year after delivery of the reline, the reline fee will be deducted from the new prosthesis fee. A combination of two (2) complete or partial denture relines or one (1) complete or partial denture and one (1) reline in the same arch are allowed in a five-year period as pre-authorized by LDH or its designee. Reline of existing dentures must be given priority over the construction of new dentures if it is judged that the existing dentures are serviceable for at least five (5) years. Chair-side relines (cold cure acrylics) are not reimbursable. The dentist is responsible for all necessary adjustments for a period of six (6) months.	$208.00

D5761	Reline mandibular partial denture (laboratory)	A 3-20. Reimbursement for complete and partial denture relines are allowed only if one (1) year has elapsed since the previous complete or partial denture was constructed or last relined. If billing provider requests a complete or partial denture for the same arch within one (1) year after delivery of the reline, the reline fee will be deducted from the new prosthesis fee. A combination of two (2) complete or partial denture relines or one (1) complete or partial denture and one (1) reline in the same arch are allowed in a five-year period as pre-authorized by LDH or its designee. Reline of existing dentures must be given priority over the construction of new dentures if it is judged that the existing dentures are serviceable for at least five (5) years. Chair-side relines (cold cure acrylics) are not reimbursable. The dentist is responsible for all necessary adjustments for a period of six (6) months.	$208.00

Interim Prosthesis

Code	Description	Benefit Limits	Fee
The following codes require pre-authorization, X-Rays, and rationale. For members requiring extensive restorations, periodontal services, extractions, etc., post-treatment radiographic images may be requested prior to approval of a partial denture.			
D5820	Interim partial denture (maxillary)	A 3-20. Only one (1) prosthesis (excluding interim partial dentures) per member per arch is allowed in a one (1) year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. An interim partial denture cannot be authorized to replace a partial denture that was previously paid by Louisiana Medicaid or MCNA. A description of the arch receiving the prosthesis must be provided by indicating in the "Remarks" section which teeth are to be replaced and which are to be retained. Only permanent teeth are eligible for replacement by an interim partial denture or a partial denture. Opposing partial dentures are available if each arch independently fulfills the requirements. Partial dentures that replace only posterior teeth must occlude against multiple posterior teeth in the opposing arch and must serve to increase masticatory function and stability of the entire mouth.	$375.00

D5821	Interim partial denture (mandibular)	A 3-20. Only one (1) prosthesis (excluding interim partial dentures) per member per arch is allowed in a one (1) year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. An interim partial denture cannot be authorized to replace a partial denture that was previously paid by Medicaid of Louisiana or MCNA. A description of the arch receiving the prosthesis must be provided by indicating in the "Remarks" section which teeth are to be replaced and which are to be retained. Only permanent teeth are eligible for replacement by an interim partial denture or a partial denture. Opposing partial dentures are available if each arch independently fulfills the requirements. Partial dentures that replace only posterior teeth must occlude against multiple posterior teeth in the opposing arch and must serve to increase masticatory function and stability of the entire mouth.	$375.00

Other Removable Prosthetic Services

Code	Description	Benefit Limits	Fee
The following codes require pre-authorization, X-Rays, and rationale.			
D5899	Unspecified removable prosthodontic procedure, by report	A 1-20. Requires pre-authorization, X-rays, and rationale. This procedure code is used for a procedure that is not adequately described by another code. Please describe the situation requiring treatment and the treatment proposed in the "Remarks" section of the claim form.	Manually Priced

Maxillofacial Prosthetics

Code	Description	Benefit Limits	Fee
D5986	Fluoride applicator	A 1-20. Requires pre-authorization, X-rays, and rationale. Oral Cavity Designator 01 and 02. Only available for member who are undergoing or who have undergone head and neck radiation therapy.	$98.76

19.14. Fixed Prosthodontics

Prosthodontic procedure codes require pre-authorization. Periapical radiographs are required for each tooth involved in the authorization request.

When a member is missing a single maxillary anterior incisor a resin-bonded fixed prosthesis (Maryland-type bridge consisting of two (2) retainers and a pontic) can be approved. The following requirements apply:

- The member must be at least 16 years of age
- The abutment teeth must be caries-free, restoration-free, and have sound periodontal support
- No other maxillary teeth are missing or require extraction
- Providers must submit with the request for pre-authorization periapical radiographic images of the abutment teeth and bitewings showing that all other treatment needs in the maxillary arch have been completed
- Providers must "X" out the missing tooth in the tooth number chart on the ADA form

The overall condition of the mouth is an important consideration in whether a fixed partial denture is authorized. A removable partial denture can be requested if multiple anterior teeth or if any posterior teeth are missing in the maxillary arch. Only one (1) Maryland-type bridge can be authorized in a five (5) year period.

Fixed Partial Dental Pontics

Code	Description	Benefit Limits	Fee
D6241	Pontic - porcelain fused to predominantly base metal	A 16-20. Requires pre-authorization, X-Rays, and rationale. This code is only reimbursable when submitted in conjunction with code D6545. Procedure code D6241 is limited to one (1) per member in a five (5) year period. This procedure is reimbursable for Tooth Numbers 7, 8, 9, or 10.	$486.69

Fixed Partial Dental Retainers - Inlays/Onlays

Code	Description	Benefit Limits	Fee
D6545	Retainer - cast metal for resin bonded fixed prosthesis	A 16-20. Requires pre-authorization, X-Rays, and rationale. This code is only reimbursable when submitted in conjunction with code D6241. Procedure code D6545 is limited to two (2) per member, in a five (5) year period. This procedure is reimbursable for Tooth Numbers 6, 7, 8, 9, 10 and 11.	$394.35

Other Fixed Partial Dental			
Code	**Description**	**Benefit Limits**	**Fee**
D6999	Unspecified fixed prosthodontic procedure	A 16-20. Requires pre-authorization, X-Rays, and rationale.	Manually Priced

19.15. Oral and Maxillofacial Surgery Services

The services listed below are the oral and maxillofacial surgery services covered under the EPSDT Dental Program.

Oral and Maxillofacial Surgery Services			
Code	**Description**	**Benefit Limits**	**Fee**
D7111	Extraction, coronal remnants - deciduous tooth	A birth-20. TIDs #A-T and AS-TS. All primary teeth within the normal exfoliation period will require an X-ray with claim submission.	$64.49
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	A birth-20. TIDs 1-32 and A-T, as well as 51-82, and AS-TS as needed. All primary teeth within the normal exfoliation period will require submission of an X-ray (or intraoral photograph if the tooth cannot be seen radiographically) and rationale. All permanent teeth require an X-ray with claim submission.	$79.07

Surgical Extractions			
Code	**Description**	**Benefit Limits**	**Fee**
The following codes require pre-authorization, X-Rays, and rationale for all teeth: 1-32, A-T, 51-82, and AS-TS.			
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	A 1-20. Includes removal of the roots of a previously erupted tooth missing its clinical crown. If the member's treatment record does not clearly demonstrate the need for the cutting of gingiva and removal of bone and/or sectioning of tooth structure, all records may be reviewed and recoupment of payment for services will be initiated.	$130.09
D7220	Removal of impacted tooth-soft tissue	A 1-20.	$150.50
D7230	Removal of impacted tooth-partially bony	A 1-20.	$188.76
D7240	Removal of impacted tooth-completely bony	A 1-20.	$232.12

D7241	Removal of impacted tooth-completely bony, with unusual surgical complications	A 1-20. Document unusual circumstance. This procedure code will only be authorized on a post-surgical basis. Which means that providers must submit post-operative X-Rays and detailed rationale on the claim submission outlining the unusual surgical complications.	$278.04
D7250	Surgical removal of residual tooth roots (cutting procedure)	A 1-20. Involves tissue incision and removal of bone to remove a permanent or primary tooth root left in the bone from a previous extraction, caries, or trauma. Usually some degree of soft or hard tissue healing has occurred.	$144.38

Other Surgical Procedures

Code	Description	Benefit Limits	Fee
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or display	A 1-20. Requires pre- and post-operative X-Rays and rationale. Pre-authorization is required. This code is reimbursable for accidental trauma involving permanent anterior teeth only. The date of service and an explanation of the circumstances and procedures performed, including the teeth involved, must be provided in the "Remarks" section of the claim form. This information must also be recorded in the member's treatment record. This procedure is not reimbursable for periodontal splinting. Oral Cavity Designators 01 and 02. An Oral Cavity Designator is required on the claim for reimbursement.	Manually Priced, Maximum Fee $255.05
D7280	Surgical access of an unerupted tooth	A 1-20. TIDs 2-15 and 18-31. Requires pre-authorization, X-Rays and rationale. This procedure no longer includes the placement of orthodontic attachment.	$229.57
D7283	Placement of device to facilitate eruption of impacted tooth	A 1-20. TIDs 2-15 and 18-31. Requires pre-authorization, X-Rays and rationale. Report the surgical exposure separately using D7280. This procedure is only reimbursable in conjunction with an MCNA-approved comprehensive orthodontic treatment plan.	$245.90

D7285	Biopsy of oral tissue hard	A 1-20. Requires pre-authorization, X-Rays, color photo, and rationale. This procedure is for the removal of specimen only. It involves the biopsy of osseous lesions and is not to be used for apicoectomy/ periradicular surgery. Oral Cavity Designator 01, 02, 10, 20, 30 or 40.	Manually Priced, Maximum Fee $194.88
D7286	Biopsy of oral tissue soft	A 1-20. Requires pre-authorization, X-Rays and rationale. For the surgical removal of an architecturally intact specimen only and is not used at the same time as codes for apicoectomy /periradicular curettage. A copy of the pathology report must be submitted with the claim. Oral Cavity Designators 01, 02, 10, 20, 30 and 40.	$152.54
D7291	Transseptal fiberotomy - by report	A 1-20. Requires pre-authorization, X-rays and rationale. This procedure is only reimbursable in conjunction with a MCNA-approved comprehensive orthodontic treatment plan. Oral Cavity Designators 01 and 02.	$152.30

Alveoloplasty - Surgical Preparation of Ridge for Dentures

Code	Description	Benefit Limits	Fee
D7310	Alveoloplasty in conjunction with extractions - per quadrant	A 1-20. Requires pre-authorization, X-rays, and rationale. A minimum of three (3) adjacent teeth must be extracted. Alveoloplasty during a surgical removal is considered integral to the procedure and will not be reimbursed. The date of service and an explanation of the circumstances and procedures performed, including the teeth involved must be provided in the "Remarks" section of the claim form. Oral Cavity Designators 01, 02, 10, 20, 30 or 40.	$140.29

Surgical Incision

Code	Description	Benefit Limits	Fee
D7510	Incision and drainage of abscess - intraoral soft tissue	A 1-20. TID 1-32. Requires X-Rays and rationale. This service is not reimbursable for primary teeth. Not payable for same tooth on the same date of service as the extraction.	$109.68

Reduction of Dislocation of Management of Other Temporomandibular Joint Dysfunctions

Code	Description	Benefit Limits	Fee
D7880	Occlusal orthotic appliance	A 1-20. Requires pre-authorization, pre-operative X-Ray and rationale. Pre-authorization must include a completed TMJ Summary Form, located in the Forms section of this manual, which must indicate whether the condition is acute or chronic and if any other services are to be provided in addition to the requested splint. Oral Cavity Designator 01, 02, 10, 20, 30 and 40.	$461.69

Repair of Traumatic Wounds

Code	Description	Benefit Limits	Fee
D7910	Suture recent small wound up to 5cm	A 1-20. Requires post-operative color photos and rationale.	$140.80

Other Procedures

Code	Description	Benefit Limits	Fee
D7960	Frenulectomy/frenulotomy	A 1-20. Requires pre-authorization, color photos, and rationale. The specific dental reason is required for authorization. If the specific reason is not dental, e.g., if a speech impediment is the reason for the request, then a written statement from a speech pathologist or physician must be submitted. Oral Cavity Designators 01, 02, 10, 20, 30 or 40.	$211.21

D7997	Appliance Removal (not by dentist who placed appliance) includes removal of arch bar	This procedure requires pre-authorization and can only be considered for the removal of appliances due to interrupted or discontinued treatment cases. This procedure is not reimbursable to the same billing provider, facility, or group that placed the appliance. This procedure is reimbursable for Oral Cavity Designators 01, 02, 10, 20, 30, and 40.	Manually Priced, Maximum Fee $240.00
D7999	Unspecified oral surgery procedure, by report	A 1-20. This procedure code is used for a procedure that is not adequately described by another code. It requires pre-authorization.	Manually Priced

19.16. Orthodontic Services

Orthodontic treatment is available to members meeting specified criteria. All orthodontic procedures must be pre-authorized. Providers are reminded that the MCNA reimbursement is payment in full for that procedure code.

Only providers qualified under Chapter 3, Section 301, Parts (C) and (D) of the Rules promulgated by the Louisiana State Board of Dentistry as an approved specialty of "orthodontics and dentofacial orthopedics" are eligible to be reimbursed for Comprehensive Orthodontic Services (procedure codes D8070, D8080, and D8090) in the Medicaid EPSDT Dental Program.

Members who have only crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions, and/or horizontal/vertical (overjet/overbite) discrepancies are not eligible to receive comprehensive orthodontic treatment.

This code is used to report the coordinated diagnosis and treatment leading to the improvement of a member's craniofacial dysfunction and/or dentofacial deformity including anatomical, functional, and esthetic relationships. Treatment usually, but not necessarily, utilizes fixed orthodontic appliances.

Comprehensive orthodontic treatment is approved by MCNA only in those instances that are related to an identifiable syndrome such as cleft lip and/or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy: other severe craniofacial deformities that result in age appropriate surgical cases as determined by an MCNA Clinical Reviewer.

The request for pre-authorization must include sufficient diagnostic material to demonstrate the syndrome and/or deformity listed above and the fee normally charged for a similar case. If approved, MCNA will authorize a maximum of three (3) units of the appropriate comprehensive orthodontic procedure code and assign a fee for each unit (please see fee schedule for total maximum allowable billable fees). The pre-authorization is valid for 180 days.

Providers are reminded that MCNA reimbursement is payment in full for the procedure code.

To receive reimbursement for comprehensive orthodontic procedure codes, the provider must submit three (3) claims with three (3) distinct dates of service. The first date of service may occur no earlier than the date that

diagnostic records were obtained; the second date of service no earlier than the date of banding; and the final date of service no earlier than 90 days after banding. MCNA reimbursement includes the brackets/appliance and all visits and adjustments.

Orthodontic Fee Schedule			
Code	**Description**	**Benefit Limits**	**Fee**
D8050	Interceptive treatment of primary dentition	Requires pre-authorization. The fee assigned for fixed appliance therapy includes the brackets/appliance, all visits and adjustments. This procedure is reimbursable for Oral Cavity Designators 01, 02, 10, 20, 30, and 40.	Manually Priced, Maximum Fee $438.00
D8060	Interceptive treatment of transitional dentition	Requires pre-authorization. The fee assigned for fixed appliance therapy includes the brackets/appliance, all visits and adjustments. This procedure is reimbursable for Oral Cavity Designators 01, 02, 10, 20, 30, and 40.	Manually Priced, Maximum Fee $438.00
D8070	Comprehensive orthodontic treatment of the transitional dentition.	Requires pre-authorization.	Manually Priced, Maximum Fee $4,182.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition.	Requires pre-authorization.	Manually Priced, Maximum Fee $4,281.00
D8090	Comprehensive orthodontic treatment of the adult dentition.	Requires pre-authorization.	Manually Priced, Maximum Fee $4,515.00

D8220	Fixed appliance therapy	The request for pre-authorization must include sufficient documentation to substantiate the need for and the utility of the appliance. For approval of procedure code D8220, the following must apply: • The child must be between the ages of five (5) years and eight (8) years • The maxillary incisors (7, 8, 9 and 10) are actively erupting • The child still displays the destructive habit • The child has evidenced a desire to stop the destructive habit	$534.71
D8999	Unspecified Orthodontic Procedure	Requires pre-authorization.	Manually Priced

19.17. Adjunctive General Services

Unclassified Treatment			
Code	**Description**	**Benefit Limits**	**Fee**
D9110	Palliative (emergency) treatment of dental pain-minor procedures	Emergency service only, limited to trauma case. Requires rationale. The type of treatment rendered and TID must be indicated. It must be a service other than a prescription or topical medication. The reason for emergency and a narrative of the procedure actually performed must be documented and the appropriate block for emergency must be checked on the claim form. On the date of service that a palliative treatment is rendered, a provider will only be reimbursed for periapical radiographic images (D0220 and D0230), occlusal radiographic images (D0240) if authorized, bitewing radiographic images (D0272), or panoramic radiographic images (D0330) if authorized, in addition to this procedure code. All codes other than those listed above for radiographs will be denied if billed for the same date of service as D9110. A maximum of two palliative treatments per member are available in a 12-month period.	$58.67

Anesthesia

Code	Description	Benefit Limits	Fee
Providers rendering sedation services for codes D9230, D9243, and D9248 must have the appropriate Permit Level for the level of sedation provided. Providers are responsible for submitting their correct Permit Level for the level of sedation to MCNA. D9243 can only be authorized in conjunction with difficult impactions or other extensive surgical procedures done in the office setting. A maximum of four (4) units of D9243 are available per member per visit. If requested, each must be listed on a separate claim line for both pre-authorization and payment.			
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	A 1-20. May not be submitted more than once per member per day. If a claim for payment is received for nitrous oxide and there are no restorative and/or surgical service(s) listed on the claim form or no Medicaid claims history record indicating that a restorative and/or surgical service was previously reimbursed for the same date of service as the nitrous oxide, the payment for nitrous oxide will be denied.	$36.73
D9243	Intravenous moderate (conscious) sedation/analgesia – each 15 minutes increment	A 1-20. Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in the continuous attendance of the recipient. Anesthesia services are considered completed when the recipient can be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients. Intravenous conscious sedation/analgesia can only be approved for those doctors who hold a valid permit from the Louisiana State Board of Dentistry for parenteral sedation. This procedure can only be authorized in conjunction with difficult impactions or other extensive surgical procedures done in the office setting. The fee assigned for the additional 15-minute increments will reflect the additional allowance as indicated. A maximum of four units of D9243 are available per recipient per visit; if requested, each must be listed on a separate claim line for both PA and payment.	$109.17 $73.98

D9248	Non-intravenous conscious sedation	A 1-5 for children with behavioral problems, and A 6-20 for individuals with physical or mental disabilities. Sedation form must be submitted with the claim. Must comply with all state rules and AAPD guidelines, including maintaining a current permit to provide non-intravenous (IV) conscious sedation. Pre-authorizations are required only for members six (6) years of age and older. A maximum of four (4) non-intravenous conscious sedation/analgesia administrations, per member, are available within a 12-month period by the same billing provider, facility, or group. Non-intravenous conscious sedation is not reimbursable on the same day by any provider as procedure codes D9230 (Nitrous Oxide) and D9920 (Behavior Management). The request for pre-authorization must document the need for extensive dental restorative or surgical treatment performed in the office setting and must document the need for this service based on prior experience attempting to treat the member. The provider must indicate in the "Remarks" section of the claim form the drug(s) anticipated to be used and route(s) of administration. A request for pre-authorization for conscious sedation indicates that the provider intends to administer drugs of a suitable type, strength, and mode of administration that necessitates constant monitoring by the provider or staff from administration through the time of discharge. The Conscious Sedation Form, located in the Forms section of this manual, must be completed by the member and sent with the claim submission. If the restorative/surgical phase of the treatment is aborted after the initiation of conscious sedation the provider must document the circumstances in the member's treatment record. Administration of oral pre-medication is not a covered service.	$125.45

Professional Visits

Code	Description	Benefit Limits	Fee
D9420	Hospital call	A 1-20. One (1) charge per hospital or ASC case. Procedure code D9420 is reimbursable once per six (6) month period, per member. Requires rationale. A hospital call is only reimbursable for dates of service on which restorative and/or surgical services (codes D2140 - D4999 and D7140 - D7999) are performed. Reimbursable when providing treatment in a hospital, an outpatient clinic, or an outpatient ambulatory surgical center. Hospitalization solely for the convenience of the member or the provider is not allowed. Reimbursement for hospital call is limited to members under the age of six (6) years, unless the child is an individual with a physical or mental disability. Pre-authorization is required only for members six (6) years of age and older. The request for pre-authorization must adequately justify the need for hospitalization in the "Remarks" section of the claim form. The provider must document the need for this service based on his experience with prior attempts to treat the patient and the severity of the procedure(s). If the child is physically or mentally disabled, the particular disability and its impact on the delivery of dental treatment in the office setting must be stated in the "Remarks" section. The request for pre-authorization must outline the entire treatment plan with the hospital code listed first. Additionally, the dental office treatment record for the member must also document the justification for hospitalization including accurate dental charting. A copy of the operative report must be maintained in the member's dental office treatment record. Denial of a hospital call request member does not prevent payment to the dental provider for any covered, pre-authorized (if required) treatment performed in the hospital. The denial is only for the code D9420 and its accompanying fee for additional reimbursement to the provider as compensation for time out of the office.	$106.18

D9440	Office visit after hours	A 1-20. Visits for routine postoperative care are included in all therapeutic and oral surgery fees. Requires rationale. Procedure code D9440 is to be used for an office visit after regularly scheduled hours for the treatment of a dental emergency. The dental office must be reopened specifically to treat this emergency. The service(s) provided must be reimbursable under the Medicaid EPSDT Dental Program and must be listed on the claim form.	$81.01

Miscellaneous Services

Code	Description	Benefit Limits	Fee
D9920	Behavior management - by report	Requires submission of the MCNA Behavior Management Report Form (located in the Forms section of this manual) with the claim. All services rendered must comply with the AAPD guidelines for the use of passive restraint if passive restraint is utilized. Additional compensation paid for behavior management is intended to help offset the additional cost of providing care to members displaying disruptive or negative behavior during restorative and surgical procedures and may be reimbursed under the following circumstances: • The management technique involved extends the time of delivering treatment an additional 33% above that required for members receiving similar treatment who do not demonstrate negative or disruptive behavior • Use of an additional dental personnel/assistant(s) • Use of restraint devices such as a papoose board Behavior management is reimbursable for members below the age of six (6), unless documentation indicates that the individual has a physical or mental disability. The particular disability and its impact on the delivery of dental treatment in the office setting must be stated in the request for pre-authorization. Sedation or anesthesia (including administration of nitrous) is not reimbursable when billed in conjunction with behavior management on the same day, by any provider.	$70.10

		Pre-authorizations are required only for members six (6) years of age and older. Providers must indicate on the request for pre-authorization which dental treatment services are scheduled to be delivered at each treatment visit for which a management fee is requested. Behavior management is only reimbursable for dates of service on which restorative and/or surgical services (codes D2140 - D4999 and D7111 - D7999) are performed. Behavior management, if provided, must be billed on the same claim form as the restorative and/or surgical service(s). A maximum of four (4) behavior management services, per member, are available annually by the same billing provider, facility, or group.	
D9940	Dental occlusal guard - by report	A 13-20. Requires pre-authorization X-Rays or color photographs, and rationale. Limited to once per year, per member, any provider, facility, or group. The member must have an occlusion that has progressed beyond the mixed dentition stage of tooth eruption. The request for pre-authorization must include a completed TMJ summary form (located in the Forms section of this manual). A copy of this form must be retained in the member's treatment record. Indicate whether the condition is acute or chronic and if any other services are to be provided in addition to the requested splint. This procedure is reimbursable for Oral Cavity Designators 01 and 02.	$285.08
D9951	Occlusal adjustment - limited	A 13-20. Full mouth procedure. Limited to once per year, per member, any provider, facility, or group. Requires pre-authorization and rationale. The member must have an occlusion that has progressed beyond the mixed dentition stage of tooth eruption. The request for pre-authorization must include a completed TMJ Summary form (located in the Forms section of this manual). A copy of this form must be retained in the member's treatment record. Indicate whether the condition is acute or chronic and if any other services are to be provided.	$87.24
D9999	Unspecified adjunctive procedure, by report	A 1-20. Requires pre-authorization, X-Rays, and rationale.	Manually Priced

20. EPSDT Non-Covered Services

Non-covered services include, but are not limited to, the following:

- Plaque control
- Treatment of incipient or non-carious lesions (other than covered sealants and fluoride)
- Routine panoramic radiographs
- Occlusal radiographs or upper and lower anterior or posterior periapical radiographs (when utilized as part of an initial examination or screening without a specific diagnostic reason why the radiograph is necessary)
- General anesthesia
- Administration of in-office pre-medication

21. EPSDT Pre-Authorizations (Prior Authorizations)

Requests for pre-authorization can be submitted electronically using MCNA's Provider Portal or by using an ADA Claim Form, the same paper claim form used for billing. Radiographs should be included with each request for authorization. MCNA will deny pre-authorizations that do not have the adequate information or radiographs necessary to make the authorization determination. Radiographs must be of diagnostic quality. If radiographs are contraindicated or unobtainable, the reason must be stated in the "Remarks" section of the electronic Provider Portal form or the paper ADA claim form submitted for the pre-authorization request. You must also document this reason in the member's record.

It is the responsibility of the provider to document the need for treatment and the actual treatments performed in the member record and provide that information to MCNA's Utilization Management department.

For ease of billing it is preferable to group services requiring authorization on a single form so that only one pre-authorization request need be issued per member.

EPSDT Dental Program procedure codes, which conform to the ADA Code on Dental Procedures and Nomenclature, are provided above. **The need for pre-authorization is noted above in the column labeled "Benefit Limits" for all covered procedure codes.**

Pre-authorization must be obtained and noted on the claim in Box 2 of the claim form before payment will be made. Pre-authorization must be obtained before rendering services. Services rendered before a pre-authorization is obtained will be denied. Pre-authorizations are valid for 180 days.

It is the provider's responsibility to utilize the appropriate procedure code in a pre-authorization request. The pre-authorization approval of a requested service does not constitute approval of the fee indicated by the provider.

When requesting a pre-authorization, the provider should list all services that are anticipated, even those not requiring authorization, in order for the clinical reviewer making a decision about the case to fully understand the general dental health and condition of the member for whom the request is being made. Explanations or reasons for treatment, if not obvious from the radiographs, should also be noted on the pre-authorization request. If submitting a pre-authorization request using the paper ADA Claim Form and the information required for a full explanation exceeds the space available, the provider should include a cover sheet outlining the information required to document the requested services.

If a cover sheet is used, please be certain it includes the date of the request, the member's name and Medicaid ID #, the provider's name, and the provider's Medicaid ID #.

A copy of this cover sheet, along with a copy of the pre-authorization request, must be kept in the member's treatment record.

21.1. Pre-Authorization Reminders

Within 72 hours of the completion of MCNA's review of a pre-authorization request, MCNA will send a pre-authorization letter to the provider detailing those services that have been pre-authorized. The letter will also list any denied services along with an explanation of those denials. A pre-authorization number will be furnished to

allow the provider to bill for services as they are completed. If a pre-authorization is required for a procedure code, your claim will be denied if you do not supply an approved pre-authorization number for the service.

The member will also receive a copy of the pre-authorization letter and in the case of a denial, the explanation of denied benefits. The letter will advise members of their appeal rights.

Pre-authorization is not a guarantee of member Medicaid eligibility. When a member loses Medicaid eligibility, any authorization of services becomes void.

22. Adult Denture Program Covered Services

The dental services that are covered under the Adult Denture Program are divided into two (2) categories: Diagnostic Services and Removable Prosthodontics.

Only those services described below are payable under the Adult Denture Program:

- Examination (only in conjunction with denture construction)
- Radiographs (only in conjunction with denture construction)
- Complete dentures
- Denture relines
- Denture repairs
- Acrylic partial dentures (only in conjunction with an opposing full denture)

Although similar services are available under the EPSDT Program, different program guidelines apply to the Adult Denture Program.

NOTE: The Adult Denture Program does not reimburse any adult restorative or surgical procedures.

22.1. Examinations

Procedure code D0150 is to be used for the comprehensive examination of the adult Medicaid member who is in need of a complete or partial denture.

Reimbursement for this procedure code requires that radiographs be taken and submitted with the request for denture pre-authorization. The comprehensive oral examination and/or radiographs can only be paid in conjunction with a pre-authorized denture or partial denture.

Procedure code D0150 should be entered on the first line of the claim form followed on the second line by the procedure code for radiographs (D0210, D0240, or D0330).

Any request that does not have the required number/type of radiographs attached will be denied.

The request for denture pre-authorization must also include all of the other procedures scheduled for the member.

Procedure code D0150 is reimbursable once every eight (8) years when performed by the same billing provider, facility, or group.

22.1.1. Examinations in Anticipation of Denture Construction

If, after verifying the member's eligibility for Medicaid, the provider perceives that the member is eligible for the services available in the Adult Denture Program (e.g. the member is edentulous in one arch or the member is going to have the remaining teeth in an arch extracted) the provider must proceed with a thorough oral examination and the necessary radiographs.

The provider must record in the member treatment record that the member is in need of a dental prosthesis and that she/he has determined that the member desires dentures. The provider must also assess for and record that the member can physically and mentally tolerate the construction of a new denture, and will be able to utilize the

denture once completed. The provider must also document the condition of any remaining teeth and any treatment required (including extractions and restorations).

22.1.2. Minimum Examination Requirements for the Clinical Examination

The member's oral cavity must be examined for abnormalities, such as tori, neoplasms, anomalies, and systemic manifestations of diseases that may be present in the mouth. Findings must be recorded in the member treatment record and appropriate treatment recommendations made.

22.1.3. Examination of Ineligible Members

If the member is not eligible for Medicaid denture services or if the provider perceives that the member does not require a complete denture (e.g., the member does not have an edentulous (toothless) arch), the provider should not continue with the examination or take radiographs. In addition, the provider should not submit a claim for payment of the examination code D0150, or the code for radiographs.

22.1.4. Examination in Conjunction with a Denture Repair

Radiographs are not required in conjunction with a denture repair; therefore, the fees for the examination and radiographs are not reimbursable. Claims for eligible denture repairs should be forwarded directly to MCNA for payment.

22.1.5. Examination in Conjunction with a Denture Reline

Radiographs are not required in conjunction with a denture reline; therefore, the fees for the examination and radiographs are not reimbursable.

22.2. Radiographs

If radiographs are unobtainable (e.g. the member is physically unable to receive this service or the member is a resident of a long-term care facility where radiographic equipment is unavailable), the reason for the lack of radiographs must be recorded in the member treatment record and on all pre-authorization requests submitted. In this instance, because radiographs were not taken, the provider will not be reimbursed for the examination code D0150.

In order for MCNA to be able to make the necessary authorization determination, radiographs and/or oral/facial images must be of good diagnostic quality. Those requests for pre-authorization that contain radiographs and oral/facial images that are not of good diagnostic quality will be denied.

As the comprehensive oral examination will only be paid in conjunction with the appropriate radiographs, the comprehensive oral examination will be denied if the radiographs are denied.

Procedure code D0210 is reimbursable once every eight (8) years when performed by the same billing provider, facility, or group

22.3. Removable Prosthodontics

Removable prosthodontic services include complete dentures, partial dentures, denture repairs and denture relines.

Documentation requirements are included to conform to state and federal regulations concerning the necessity of documentation linked to the payment for services funded by both the state and federal government.

The delivery date of the denture and/or partial dentures is the billing date of service (DOS).

The chart record with date of delivery of the dentures, including the member's signature for acceptance of the aesthetic try in, must be submitted with the claim for payment.

Clinical Oral Evaluations			
Any combination of occlusal films (only for an edentulous arch), periapicals or, panoramic radiographs equal to or greater than the reimbursement allowed for the D0210 will be reimbursed as a D0210. Please check history to ensure services may be rendered. Exams and X-Rays for Adult Denture members are only reimbursed if the denture or partial denture pre-authorization request is approved. Providers should check the member's claims history in the MCNA Provider Portal to determine eligibility for dentures or partial dentures.			
Code	**Description**	**Benefit Limits**	**Fee**
D0150	Comprehensive oral evaluation	A 21 and older. **This procedure may be reimbursed once in a six (6) month period by any provider, facility or group.** Limited to one (1) every eight (8) years by the same provider, facility, or group. Must include D0210, D0240, or D0330 as well as a treatment plan for the Adult Denture Program procedures scheduled for the member by any provider. Also denied in conjunction with denture repair or reline.	$40.81
D0210	Intraoral-complete series (including bitewings)	A 21 and older. **This procedure may be reimbursed once in a six (6) month period by any provider, facility or group.** Limited to one (1) every eight (8) years by the same provider, facility, or group. Denied when radiographs and/or oral/facial images are not of good diagnostic quality. • Minimum of five (5) mounted periapical radiographs of each edentulous or partially edentulous arch for which a prosthesis is requested (three (3) periapical radiographs if the arch does not require a prosthesis); or, • Any combination of occlusal films (only for an edentulous arch), periapicals or, panoramic radiographs equal to or greater than the reimbursement allowed for the D0210. A lead apron and thyroid shield must be used when taking any radiographs. This is generally accepted standard of care practice, and is part of normal, routine, radiographic hygiene.	$60.49

D0240	Intraoral-occlusal film	A 21 and older. **This procedure may be reimbursed once per arch in a six (6) month period by any provider, facility or group.** Limited to one (1) film per arch every eight (8) years by the same provider, facility, or group. Denied when radiographs and/or oral/facial images are not of good diagnostic quality. A lead apron and thyroid shield must be used when taking any radiographs. This is generally accepted standard of care practice, and is part of normal, routine, radiographic hygiene.	$20.41
D0330	Panoramic film	A 21 and older. **This procedure may be reimbursed once in a six (6) month period by any provider, facility or group.** Limited to one (1) service every eight (8) years by the same provider, facility, or group. Denied when radiographs and/or oral/facial images are not of good diagnostic quality. A lead apron and thyroid shield must be used when taking any radiographs. This is generally accepted standard of care practice, and is part of normal, routine, radiographic hygiene.	$57.05

22.4. Complete Dentures

Only one (1) complete or partial denture per arch is allowed in an eight (8) year period. The time period begins from the date the previous complete or partial denture for the same arch was delivered. A combination of two (2) complete or partial denture relines per arch or one (1) complete or partial denture and one (1) reline per arch is allowed in an eight (8) year period as pre-authorized by Medicaid/MCNA.

All missing teeth or teeth to be extracted must be marked in Block 34 of the ADA Dental Claim Form in the following manner: "X" out missing teeth and "/" out teeth to be extracted.

Immediate dentures are not considered temporary. The provider must inform the member that no reline will be reimbursed by MCNA within one (1) year of the denture delivery.

If there will be teeth remaining on the date of denture delivery, only the immediate full denture codes (D5130 and/or D5140) may be pre-authorized. Radiographs must confirm that no more than six (6) teeth remain. If more than six (6) teeth remain, the attending provider must certify by statement in the "Remarks" section that six (6) or fewer teeth will remain when the final impression is taken.

An immediate denture that is not delivered cannot be reimbursed nor will Medicaid reimburse any payment under the interruption of treatment guidelines.

Since the Medicaid Adult Denture Program does not reimburse for extractions, providers must make final arrangements for the removal of the remaining teeth prior to starting an immediate denture. Failure to deliver the immediate denture because the member is not able to pay for the extractions of the remaining teeth is not an acceptable reason for not delivering the denture.

Complete Dentures (Including Routine Post Delivery Care)

Code	Description	Benefit Limits	Fee

Denture services provided to members under the Medicaid Program must follow acceptable techniques in all stages of construction, such as preliminary and final impressions, wax rim and esthetic try-in, processing, delivery and adjustment. Although no minimum number of appointments is set the following minimum standards must be adhered to:

- The provider is required to obtain acceptance of esthetic appearance from member prior to processing. This acceptance must be documented by the member's signature in the treatment record.
- The denture must be flasked and processed under heat and pressure in a commercial or dental office laboratory using American Dental Association (ADA) certified materials. The prosthetic prescription and laboratory bill (or a copy) must be maintained in the member's treatment record.
- Upon delivery:
  - The denture bases must be stable on the lower and retentive on the upper.
  - The clasping must be appropriately retentive for partial dentures.
  - The vertical dimension of occlusion must be comfortable to the member (not over or under-closed). The proper centric relation of occlusion must be established for complete dentures or partial dentures opposing full dentures. For partial dentures opposing natural dentition or another partial denture, the occlusion must be harmonious with the opposing arch.
  - The denture must be fitted and adjusted for comfort, function, and esthetics.
  - The denture must be finished in a professional manner; it must be clean, exhibit a high gloss, and be free of voids, scratches, abrasions, and rough spots.

The provider is responsible for all necessary adjustments for a period of six (6) months.

Records must include a chronological (dated) narrative account of each member's visit indicating what treatment was provided and what conditions were present on those visits. A check list of codes for services billed as well as copies of claim forms sent in for authorization or payment is deemed insufficient documentation of services delivered.

If the member refuses delivery of the complete or partial denture, it cannot be considered delivered.

Failure to deliver a minimally acceptable full or partial denture, failure to provide adequate follow-up care, or failure to document the services provided will be considered grounds for recouping the fee paid for the denture.

All full and partial dentures reimbursed under the Medicaid Adult Denture Program must have the following unique identification information processed into the acrylic base:

- The first four (4) letters of the member's last name and first initial
- The month and year (mm/yy) the denture was processed
- The last five (5) digits of the provider's Medicaid identification (ID) number

The following codes require pre-authorization, X-Rays, and rationale. The provider is required to obtain acceptance of esthetic appearance from member prior to processing. This acceptance must be documented by the member's signature in the treatment record and submitted to MCNA along with the claim for payment. Additionally the provider must complete the Adult Denture Program Clinical Condition Certification Form located in the back of the manual under Section 27 and submit with the request for pre-authorization.

D5110	Dentures complete maxillary	A 21 and older.	$495.00
D5120	Dentures complete mandible	A 21 and older.	$495.00
D5130	Dentures immediate maxillary	A 21 and older.	$495.00
D5140	Dentures immediate mandible	A 21 and older.	$495.00

22.5. Partial Dentures

The Adult Denture Program only provides for acrylic partials to oppose a full denture and does not provide for two (2) partial dentures in the same oral cavity.

Medicaid may provide an acrylic partial denture when the opposing arch has a functioning complete denture, or is having a complete denture fabricated simultaneous to the partial denture and the arch requiring the partial denture is:

- Missing two (2) or more maxillary anterior teeth
- Missing three (3) or more mandibular anterior teeth
- Missing at least four (4) posterior permanent teeth in a single quadrant when the prosthesis would restore masticatory function and balance the occlusion.

Only one (1) complete or partial denture per arch is allowed in an eight (8) year period. The time period begins from the date the previous complete or partial denture for the same arch was delivered. A combination of two (2) complete or partial denture relines per arch or one (1) complete or partial denture and one (1) reline per arch is allowed in an eight (8) year period as pre-authorized by MCNA.

For relines, at least one (1) year shall have elapsed since the complete or partial denture was delivered or last relined.

The overall condition of the mouth is an important consideration in whether or not a partial denture is authorized. For partial dentures, abutment teeth must be caries-free or have been completely restored and have sound periodontal support. For those members requiring extensive restorations, periodontal services, extractions, etc., post-treatment radiographs may be requested prior to approval of an acrylic partial denture.

A description of the arch receiving the prosthesis must be provided by indicating which teeth are to be replaced and which are to be retained. On the tooth number chart on the ADA form, "X" out missing teeth and "/" out teeth to be extracted. If only a few teeth are present, "O" teeth that are to be retained when the partial is delivered. The design of the prosthesis and materials used should be as simple as possible and consistent with basic principles of prosthodontics.

Partial Dentures (Including Routing Post Delivery Care)			
Code	**Description**	**Benefit Limits**	**Fee**
The Adult Denture Program only provides for acrylic partials to oppose a full denture and does not provide for two (2) partial dentures in the same oral cavity. Medicaid may provide an acrylic partial denture when the opposing arch has a functioning complete denture, or is having a complete denture fabricated simultaneous to the partial denture and the arch requiring the partial denture is: • Missing two (2) or more maxillary anterior teeth • Missing three (3) or more mandibular anterior teeth • Missing at least four (4) posterior permanent teeth in a single quadrant when the prosthesis would restore masticatory function and balance the occlusion The overall condition of the mouth is an important consideration in whether or not a partial denture is authorized. For partial dentures, abutment teeth must be caries free or have been completely restored and have sound periodontal support. For those members requiring extensive restorations, periodontal services, extractions, etc. post-treatment radiographs may be requested prior to approval of an acrylic partial denture. The following codes require pre-authorization, X-Rays, and rationale. The provider is required to obtain acceptance of esthetic appearance from member prior to processing. This acceptance must be documented by the member's signature in the treatment record and submitted to MCNA along with the claim for payment. Additionally the provider must complete the Adult Denture Program Clinical Condition Certification Form located in the back of the manual under Section 27.7 and submit with the request for pre-authorization.			
D5211	Upper partial-resin base	A 21 and older.	$470.00
D5212	Lower partial-resin base	A 21 and older.	$470.00

22.6. Denture Repairs

Repairs to partial dentures are covered in the Adult Denture Program only if the partial denture opposes a complete denture. Members who do not have a complete denture are not eligible for the partial denture repair services of the Adult Denture Program.

Reimbursement for repairs of complete and partial dentures are allowed only if more than one (1) year has elapsed since denture insertion by the same billing provider, facility, or group and the repair makes the denture fully serviceable, eliminating the need for a new denture unit.

If the same billing provider, facility, or group requests a complete or partial denture within the first year after a repair is paid, the repair fee for that arch will be deducted from the new prosthesis fee. A repair is allowed in conjunction with a reline on the same member as long as the repair makes the denture fully serviceable.

A $185 limit in base repair, clasp addition or replacement, or tooth addition or replacement services per arch for the same member is allowed within a single one (1) year period for the same billing provider, facility, or group.

The fee assigned for the first tooth billed using the codes D5520, D5640 or D5650 will reflect the base price for the first denture tooth. When multiple teeth are replaced or added to the same prosthesis on the same date of service, the same procedure code is to be used for each tooth. However, the fee assigned for the additional teeth will reflect the additional allowance per tooth as indicated.

Minimal procedural requirements for repair services include the following:

- The prosthesis should be repaired using appropriate materials and techniques in a commercial or dental office laboratory. If the repair is performed in a commercial dental laboratory, the prosthetic prescription and laboratory bill (or a copy) must be maintained in the member's treatment record.
- Repairs must make the prosthesis fully serviceable, retaining proper vertical dimension and centric relation of occlusion.
- The prosthesis must be finished in a workmanlike manner; clean, exhibit a high gloss, and be free of voids, scratches, abrasions, and rough spots
- The member's treatment record must specifically identify the location and extent of the breakage.

Failure to provide adequate documentation of services billed as repaired when requested by Medicaid or its authorized representative will result in recoupment of the fee paid by the program for the repair.

Repairs to Complete Dentures

Code	Description	Benefit Limits	Fee
D5510	Repair broken complete denture base	A 21 and older. A repair is allowed in conjunction with a reline on the same member as long as the repair makes the denture fully serviceable. Must include the location and description of the fracture in the "Remarks" section of the claim form. Reimbursable only for Oral Cavity Designators 01 and 02.	$125.00
D5520	Replace missing or broken teeth-complete denture (each tooth)	A 21 and older. TIDs 2-15 and 18-31. The first tooth billed will reflect the base price for the first denture tooth. When multiple teeth are replaced or added to the same prosthesis on the same date of service, the same procedure code is to be used for each tooth. However, the fee assigned for the additional teeth will reflect the additional allowance per tooth as indicated.	$65.00 $33.00

Repairs to Partial Dentures			
Code	**Description**	**Benefit Limits**	**Fee**
D5610	Repair resin denture base	A 21 and older. A repair is allowed in conjunction with a reline on the same member as long as the repair makes the denture fully serviceable. Must include the location and description of the fracture in the "Remarks" section of the claim form. Reimbursable only for Oral Cavity Designator 01, 02, 10, 20, 30, and 40. The appropriate oral cavity designator must be when requesting reimbursement for these procedures.	$125.00
D5630	Repair or replace broken clasp, Partial Denture- per tooth	A 21 and older. Reimbursable for Oral Cavity Designators 01, 02, 10, 20, 30 and 40. The appropriate oral cavity designator must be when requesting reimbursement for these procedures.	$119.00
D5640	Replace broken teeth-per tooth	A 21 and older. TIDs 2-15 and 18-31. The first tooth billed will reflect the base price for the first denture tooth. When multiple teeth are replaced or added to the same prosthesis on the same date of service, the same procedure code is to be used for each tooth. However, the fee assigned for the additional teeth will reflect the additional allowance per tooth as indicated.	$65.00 $33.00
D5650	Add tooth to existing partial denture	A 21 and older. TIDs 2-15 and 18-31. The first tooth billed will reflect the base price for the first denture tooth. When multiple teeth are replaced or added to the same prosthesis on the same date of service, the same procedure code is to be used for each tooth. However, the fee assigned for the additional teeth will reflect the additional allowance per tooth as indicated.	$65.00 $33.00
D5660	Add clasp to existing partial denture, per tooth	A 21 and older. Reimbursable for Oral Cavity Designators 01, 02, 10, 20, 30 and 40. The appropriate oral cavity designator must be when requesting reimbursement for these procedures.	$119.00

22.7. Denture Relines

Relines for partial dentures are covered in the Adult Denture Program only if the partial denture opposes a complete denture. Members who do not have a complete denture are not eligible for the partial denture reline services of the Adult Denture Program.

A combination of two (2) complete or partial denture relines per arch or one (1) complete or partial denture and one (1) reline per arch is allowed in an eight (8) year period as pre-authorized by MCNA. The time period begins from the date the previous complete or partial denture for the same arch was delivered.

Reimbursement for complete and partial denture relines are allowed only if one (1) year has elapsed since the previous complete or partial denture was constructed or last relined.

If the same billing provider, facility, or group requests a complete or partial denture for the same arch within one (1) year after delivery of the reline, the reline fee will be deducted from the new prosthesis fee. A combination of two (2) complete or partial denture relines or one (1) complete or partial denture and one (1) reline in the same arch are allowed in an eight (8) year period as pre-authorized by MCNA.

Reline of existing dentures must be given priority over the construction of new dentures if the reline will result in a serviceable denture for at least eight (8) years.

NOTE: Chair-side relines (cold cure acrylics) are not reimbursable.

Minimal procedural requirements for reline services include the following:

- All tissue bearing areas of the denture or saddle areas of the partial must be properly relieved to allow for the reline material
- Occlusal vertical dimensions and centric relationships must be retained or re-established if lost
- Relines must be flasked and processed under heat and pressure in a commercial or office laboratory
- Relines must be finished in a workmanlike manner; clean; exhibit a high gloss; and must be free of voids, scratches, abrasions, and rough spots

The denture must be fitted and adjusted for comfort and function.

The provider is responsible for all necessary adjustments for a period of six (6) months.

Failure to deliver a minimally acceptable reline, failure to provide adequate follow-up care, or failure to provide adequate documentation of services billed as relined when requested by

MCNA will result in recoupment of the fee paid for the reline.

Denture Reline Procedures			
Code	**Description**	**Benefit Limits**	**Fee**
The following codes require pre-authorization and rationale.			
D5750	Reline complete maxillary denture (laboratory)	A 21 and older. **The provider is responsible for all necessary adjustments for a period of six (6) months.**	$238.00
D5751	Reline complete mandibular denture (laboratory)	A 21 and older. **The provider is responsible for all necessary adjustments for a period of six (6) months.**	$238.00
D5760	Reline maxillary partial denture (laboratory)	A 21 and older. Reimbursable only if the partial denture opposes a complete denture. **The provider is responsible for all necessary adjustments for a period of six (6) months.**	$208.00
D5761	Reline mandibular partial denture (laboratory)	A 21 and older. Reimbursable only if the partial denture opposes a complete denture. **The provider is responsible for all necessary adjustments for a period of six (6) months.**	$208.00

22.8. Other Removable Prosthodontics

Complete Dentures (Including Routine Post-Delivery Care)			
Code	**Description**	**Benefit Limits**	**Fee**
The following codes require pre-authorization, X-Rays, and rationale.			
D5899	Unspecified removable prosthodontic procedure, by report	A 21 and older. This procedure code is used for a procedure that is not adequately described by another code. It requires pre-authorization. Please describe the situation requiring treatment and the treatment proposed in the "Remarks" section of the claim form.	Manually Priced

23. Adult Denture Program Non-Covered Services

Non-covered services in the Adult Denture Program are any codes not listed in the Adult Denture Program fee schedule located in this manual.

24. Adult Denture Program Pre-Authorizations (Prior Authorizations)

Requests for pre-authorization can be submitted electronically using MCNA's Provider Portal or by using an ADA Claim Form, the same paper claim form used for billing. Providers should with their pre-authorization requests the appropriate mounted bitewing or periapical radiographs that support the clinical findings and justify the treatment requested.

Radiographs should be included with each request for authorization. MCNA will deny pre-authorizations that do not have the adequate information or radiographs necessary to make the authorization determination. Radiographs must be of diagnostic quality. If radiographs are contraindicated or unobtainable, the reason must be stated in the "Remarks" section of the electronic Provider Portal form or the paper ADA claim form submitted for the pre-authorization request. You must also document this reason in the member's record.

It is the responsibility of the provider to document the need for treatment and the actual treatments performed in the member's record and provide that information to MCNA.

For ease of billing it is preferable to group services requiring authorization on a single claim form so that only one pre-authorization number need be issued per member.

All Adult Denture Program services (except for exam, x-rays, and repairs) require pre-authorization. Exams and x-rays are only reimbursed if the denture is approved. Check the member's claims history to ensure the member is eligible for services based on frequency guidelines. The procedure codes for services requiring pre-authorization must be authorized by MCNA before payment will be made. It is your responsibility to utilize the appropriate procedure code in a request for pre-authorization. MCNA's approval of a requested service does not constitute approval of the fee indicated by the provider.

When requesting a pre-authorization, the provider should list all services that are anticipated, even those not requiring authorization, in order for MCNA to fully understand the general dental health and condition of the member for whom the request is being made. Explanations or reasons for treatment, if not obvious from the radiographs, should also be noted on the pre-authorization request. If submitting a pre-authorization request using the paper ADA Claim Form and the information required for a full explanation exceeds the space available, the provider should include a cover sheet outlining the information required to document the requested services.

If a cover sheet is used, please be certain it includes the date of the request, the member's name and Medicaid ID #, the provider's name, and the provider's Medicaid ID or NPI #. A copy of this cover sheet, along with a copy of the pre-authorization request, must be kept in the member's treatment record.

If the provider proceeds with treatment before receiving authorization from MCNA, the provider should consider that the request might not be authorized for services rendered. However, providers may render and bill for services that do not require pre-authorization while waiting for MCNA's decision about the authorization of those services that do.

Pre-authorization is not a guarantee of member Medicaid eligibility. When a member loses Medicaid eligibility, any authorization of services becomes void.

All pre-authorization requests should be sent to MCNA using the Provider Portal or by mail.

25. Interruption of Treatment

The guidelines for the interruption of treatment apply to codes D5110, D5120, D5211, D5212, D5213, and D5214 ONLY. No other codes are eligible for payment under these guidelines.

A provider must make every effort to deliver the denture. The provider must document in the member's treatment record all attempts to deliver the denture and the reasons the denture was not delivered.

If a failure to deliver the denture was due to circumstances beyond the provider's control, such as if the member discontinues treatment or loses eligibility during the course of the construction of a denture, then under the interruption of treatment guidelines, the provider should not bill MCNA using the procedure code as originally pre-authorized.

Because the original procedure could not be completed, the case must be resubmitted to the Utilization Management department so the pre-authorization number can be reissued with the proper procedure code relating to the service attempted. The provider will then be able to bill MCNA for that portion of the treatment that has been completed using the reissued procedure code and pre-authorization number.

NOTE: An immediate denture that is not delivered cannot be reimbursed, nor will MCNA reimburse any payment under the interruption of treatment guidelines for an immediate denture.

For the purpose of determining the amount the provider will be paid for interrupted services, the denture fabrication process is divided into four (4) stages:

- Impressions (initial impression, construction of custom dental impression tray and final impressions)
- Bite registration (wax try-in with denture teeth)
- Processing
- Delivery

If treatment is interrupted after completion of Stage 1 (Impressions), 25% of the fee may be paid upon submission of the custom dental impression tray to MCNA. If treatment is interrupted after initial impression but prior to construction of custom impression tray, no reimbursement will be made.

If treatment is interrupted after Stage 2 (Bite Registration), 50% of the fee may be paid upon submission of the wax try-in with denture teeth to MCNA Dental

If treatment is interrupted after completion of Stage 3 (Processing), 75% of the reimbursement fee will be paid upon submission of the denture to MCNA.

26. Dental Guidelines

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). MCNA's criteria are changed and enhanced as needed.

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.

These criteria are approved and annually reviewed by MCNA's Utilization Management Committee. They are designed as guidelines for authorization and payment decisions and are not intended to be absolute. Please refer to the Section of this manual titled, "Covered Services and Fee Schedules," for a list of all codes covered under the program and additional limitations and requirements for coverage.

26.1. 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 (PCD). The Member may be referred to a contracted MCNA oral surgeon when it is beyond the scope of the PCD.

26.1.1. Criteria

- A tooth broken below the bone level
- 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
- Alveolplasty (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

26.1.2. Documentation Required for Authorization

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

26.1.3. Procedure Codes

- D7210, D7220, surgical removal of erupted tooth, radiographs and narrative.
- D7230, D7240, D7241, surgical removal of impacted teeth, radiographs and narrative.

- D7250, surgical removal of residual roots, radiographs and narrative.
- D7280, surgical access of unerupted tooth, radiographs and narrative.
- D7310, alveoloplasty in conjunction with extraction, radiographs and narrative.
- D7510, incision and drainage of abscess, radiographs and narrative. Will not be considered on same date with extraction of tooth related to incision and drainage.

26.1.4. Code Descriptions

- **D7140 - extractions, erupted tooth or exposed root (Elevation and/or forceps removal)**
  Includes routine removal of tooth structure, minor smoothing of socket of socket bone, and closure, as necessary.
- **D7210 - surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated**
  Includes related cutting of gingival and bone, removal of tooth structures, minor smoothing of socket bone and closure.
- **D7220 - removal of impacted - soft tissue**
  Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation.
- **D7230 - removal of impacted tooth - partially bony**
  Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.
- **D7240 - removal of impacted tooth - completely bony**
  Most or all crown covered by bone; requires mucoperiosteal flap elevation and bone removal.
- **D7241 - removal of impacted tooth-complete bony, with unusual surgical complications**
  Most or all of crown covered by bone; usually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position.
- **D7250 - surgical removal of residual tooth roots (cutting procedure)**
  Includes cutting of soft tissue and bone, removal of tooth structure, and closure.

26.2. Guidelines for Endodontics

26.2.1. Criteria

- The tooth is infected and/or abscessed.
- Trauma or fracture that damages the pulp.
- The pulp of the primary tooth is infected and the exfoliation of the deciduous tooth is not anticipated within six months. (This is for pulpotomy or pulpectomy only)
- Tooth must demonstrate at least 50% bone support and cannot have mobility grades +2 or +3.
- Root canal therapy not in anticipation of placement of an overdenture.

26.2.2. Criteria for Retreatment of Root Canal

- Overfilled canal
- Underfilled canal
- Broken instrument in canal, that is not retrievable
- Root canal filling material lying free in periapical tissues and acting as an irritant
- Perforation of the root in the apical one-third of the canal therefore this will cause a denial for a retreatment.

- Fractured root tip is not reachable therefore this will cause a denial for a retreatment

26.2.3. Criteria for Apexification

- The apex of the root is not closed and needs to be treated so closure can be achieved. (Usually after trauma)

26.2.4. Criteria for Apicoectomy and Retrograde Filling

- The apex of the tooth needs to be removed because the surrounding area is infected and/or has an abscess; it requires a filling to be placed in the apical part of the tooth to seal that part of the root canal.
- Perforation of the root in the apical one-third of the canal.

26.2.5. Documentation Required for Authorization

- Submit appropriate radiographs with authorization request: periapical or panorex.
- Emergency treatment will require a dated pre- and post-operative radiograph for claims review.
- In situations where pathology is not apparent, a written narrative justifying treatment is required.

26.2.6. Other Considerations

- Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canal(s), and progress radiographs, including a final root canal fill radiograph.
- In cases where the root canal filling does not meet MCNA's treatment standards, MCNA can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after MCNA reviews the circumstances.

26.2.7. Procedure Codes

- D3310, anterior routine endodontic therapy
- D3320, bicuspid endodontic therapy
- D3330, molar endodontic therapy
- D3220, therapeutic pulpotomy
- D3240, pupal therapy on primary teeth (resorbable filling)
- D3352 apexification / recalcification interim visit
- D3410 apicoectomy
- D3430 retrograde filling

26.3. Guidelines for Non-Intravenous and IV Sedation

26.3.1. Requirements

- Dentists providing sedation or anesthesia services must have the appropriate certification from the Louisiana State Board of Dentistry for the level of sedation or anesthesia provided.
- MCNA must have on file a copy of the certification prior to rendering sedation services.

26.3.2. Criteria

Acceptable conditions include, but are not limited to, one or more of the following:

- Documented local anesthesia toxicity.
- Severe cognitive impairment or developmental disability.
- Severe physical disability.
- Uncontrolled management problem.
- Extensive or complicated surgical procedures.
- Failure of local anesthesia.
- Documented medical complications.
- Acute infections.

26.3.3. Documentation Required for Claims Processing

- Certain procedures require submission of narrative stating medical necessity.

Note: Sedation will be restricted to two procedures within a twelve month period without prior authorization.

26.3.4. Procedure Codes

- D9230, Analgesia, anxiolysis, inhalation of nitrous oxide
- D9243, Intravenous moderate (conscious) sedation/ analgesia- 15 minute units
- D9248, Non intravenous conscious sedation

26.3.5. Criteria for Medical Immobilization Including Papoose Boards

The Provider must obtain a written informed consent from the legal guardian and documented in the Member's record prior to medical immobilization. The Provider must complete MCNA's Medicaid Behavior Management Report Form (located in the Forms section of this manual).

The Patient's record should include:

- Informed consent
- Type of immobilization used
- Indication for immobilization
- The duration of application

Goals of behavior management:

- Establish communication
- Alleviate fear and anxiety
- Deliver quality dental care
- Build a trusting relationship between dentist and child
- Promote the child's positive attitude toward oral/dental health

26.4. Guidelines for Core Build Up

26.4.1. Criteria

- The foundation of the tooth is insufficient to place a crown.
- Performed on a previously endodontic treated tooth to provide a foundation to place a crown.
- Not covered on primary teeth.

26.4.2. Documentation Required for Authorization

- Submit appropriate radiographs with authorization request: periapical or panorex
- Requires post-operative endodontic x-ray in order to approve prefabricated post & core

26.4.3. Procedure Codes

- D2950, Core build up
- D2951, Pin retention per tooth
- D2954, Prefab post and core in addition to a crown

26.5. Guidelines for Crowns

26.5.1. Criteria

- Criteria for crowns will be met only for permanent teeth needing multisurface restorations where other restorative materials have a poor prognosis.
- Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and two or more cusps.
- Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma, and should involve three or more surfaces and at least one cusp.
- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma, and must involve four or more surfaces and at least 50% of the incisal edge.

Note: To meet criteria, a crown must be opposed to a tooth or denture in the opposite arch or be an abutment for a partial denture.

Crowns will not meet criteria if:

- A lesser invasive restoration is possible
- Tooth has subosseous and/or furcation caries.
- Tooth has advanced periodontal disease
- Crowns are being planned to alter vertical dimension

26.6. Guidelines for Crowns following Root Canal Therapy

26.6.1. Criteria

- Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex.
- The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.
- The permanent tooth must be at least 50% supported in bone and cannot have mobility grades +2 or +3.

26.6.2. Documentation Required for Authorization

- Submit appropriate radiographs with authorization request: periapical or panorex
- Require submission of radiographs showing clearly the adjacent and opposing teeth submitted with the claim for review of payment
- Claims request should include a dated radiograph of RCT. If RCT was done by submitting Dentist.

26.6.3. Procedure Codes

- D2930, Prefabricated stainless steel crown primary tooth
- D2931, Prefabricated stainless steel crown permanent tooth
- D2932, Prefabricated resin crown
- D2933, Prefabricated stainless steel crown with resin window
- D2934, Prefabricated esthetic coated stainless steel crown primary

26.7. Guidelines for Periodontal Treatment

26.7.1. Criteria

- Periodontal charting indicates abnormal pocket depths in multiple sites. Probing depths must be 4mm or greater.
- Radiographic evidence of root surface calculus.
- Radiographic evidence of noticeable loss of bone support. Attachment loss with the appearance of reduction of the alveolar crest beyond 1-1 1/2mm proximity to the cement-enamel junction (CEJ) exclusive of gingival recession.

26.7.2. Criteria for Gingivectomy

- Presence of diseased malformed or excess gingival tissue due to systemic disease or pharmacological induced gingival hyperplasia.

26.7.3. Criteria for Full Mouth Debridement

- Presence of significant gingival inflammation and/or supragingival calculus

26.7.4. Documentation Required for Authorization

- Submit appropriate radiographs with authorization request: bitewings or periapical preferred.
- Complete periodontal charting
- Narrative
- Photograph is required for CDT code (4210 & 4355)

26.7.5. Procedure Codes

- D4341, periodontal scaling and root planning requiring radiographs and perio chart.
- D4355, gross debridement requiring radiographs, narrative, and photos.
- D4210, gingivectomy and/or gingivoplasty.

26.8. Guidelines for Orthodontics

Please see the "Orthodontic Services" section.

26.9. Guidelines for X-Rays

Criteria

- Must be of diagnostic quality
- All x-rays must be marked Right & Left
- Must have the Patient's name
- Must have the date x-rays were taken

26.10. Guidelines for Removable Prosthodontics (Full and Partial Dentures)

26.10.1. Criteria

- If favorable prognosis is present.
- If abutment teeth are more than 50% supported in bone.
- Adjustments, repairs and relines are allowed when there are extenuating circumstances, and/or medical necessity.
- All prosthetic appliances shall be inserted in the mouth before a claim is submitted for payment.
- If more than one posterior tooth will be replaced not including third molars.
- A denture is determined to be an initial placement if the Patient has never worn a prosthesis. This does not refer to just the time a Patient has been receiving treatment from a certain Provider

Authorizations for removable prosthesis will not meet criteria if extensive repairs are performed on marginally functional partial dentures, or when a new partial denture would be better for the health of the recipient. However, adding teeth and/or clasp to a partial denture is a covered benefit if the addition makes the dentures functional.

Please see the "Removable Prosthodontics" section.

26.10.2. Documentation Required for Authorization

- Submit appropriate radiographs with authorization request: bitewings, periapical or panorex

26.10.3. Procedure Codes

Complete Dentures

- D5110, complete denture maxillary (upper)
- D5120, complete denture mandibular (lower)
- D5130, dentures immediate maxillary
- D5140, dentures immediate mandible

Partial Dentures

- D5211, upper partial resin base
- D5212, lower partial resin base
- D5213, Maxillary partial denture - cast metal framework with resin denture base
- D5214, Mandibular partial denture - cast metal framework with resin denture base

Repairs to Complete Dentures

- D5510, Repair broken complete denture base
- D5520, Replace missing or broken teeth - complete denture (each tooth)

Repairs to Partial Dentures

- D5610, Repair resin denture base
- D5630, Repair or replace broken clasp, Partial Denture- per tooth
- D5640, Replace broken teeth - per tooth
- D5650, Add tooth to existing partial denture
- D5660, Add clasp to existing partial denture, per tooth

Denture Reline Procedures

- D5750, Reline complete maxillary denture (laboratory)
- D5751, Reline complete mandibular (laboratory)
- D5760, Reline maxillary partial denture (laboratory)
- D5761, Reline mandibular partial denture (laboratory)

Interim Prosthesis

- D5820, Interim partial denture-maxillary
- D5821, Interim partial denture-mandibula

27. Forms

The following pages contain forms that can be filled out and submitted to MCNA directly.

27.1. Member Outreach Form for Louisiana Providers

Member Outreach Form for Louisiana Providers

MCNA Dental

An MCNA representative will contact the member to provide education, assist with scheduling appointments, and assist with transportation as needed

Member Information		Provider Information	
Member Name (Last Name, First Name)		**Provider Name** (Last Name, First Name)	
Parent/Guardian Name (Last Name, First Name)		**Office Contact Name** (Last Name, First Name)	
Date of Birth (MM/DD/YYYY)	**MCNA Member ID Number**	**MCNA Provider ID Number**	
Phone Number	**Date of Last Office Visit**	**Phone Number**	**Date of Outreach Request**

Reason for Outreach	Additional Information
To help us understand more about your request for member outreach, please select the best description of the member or the member's behavior from the following:	
☐ **Has not received initial oral health exam.**	
☐ **Behind on six-month follow-up care according to AAPD Periodicity Schedule.**	
☐ **Non-compliant with treatment plan.**	
☐ **Non-compliant with office policies and/or displays unacceptable behavior in office.**	
☐ **Requires education regarding referral use.**	
☐ **Requires transfer from office/facility panel.** *Please provide reason for request for transfer in the Additional Information section*	
☐ **Chronic "no-show" for appointments or follow-up care.** (Member must be a "no-show" for two or more consecutively scheduled appointments.) *Please list dates of missed appointments along with reason for appointments in the Additional Information section.*	
☐ **Requires follow-up with MCNA representative after being referred for services.** *Please note circumstances of referral in the Additional Information section*	

Print Name **Signature** **Date** (MM/DD/YYYY)

Mail, Fax, or Email Completed Form To:

MCNA Dental
Attn: Quality Improvement Department
200 West Cypress Creek Road, Suite 500
Fort Lauderdale, Florida 33309

Fax: 954-744-5812 • **Email:** qualityprogram@mcna.net

For Questions Contact:

1-855-701-MCNA (1-855-701-6262)

Last Updated: October 13, 2015
MCNA_LA-P_MEMBER-OUTREACH-FORM[1.0]

Page 1 of 1

27.2. Behavior Management Form

Recently, this child was seen in our dental office. Because of the misbehavior of the child during the dental visit, he/she could not have been worked on without behavior management techniques. Verbal communications were insufficient in accomplishing our goals and behavior management techniques had to be employed as follows:

Member and Procedure Information

Member Last Name, First Name _____

Member Date of Birth (MM/DD/YYYY) _____

Member ID Number _____

Date of Service (MM/DD/YYYY) _____

Behavior

The child exhibited the following behavior during his/her dental treatment:

- ☐ **Crying or Fearful**
- ☐ **Defiance**
- ☐ **Thrashing Around**
- ☐ **Hitting or Kicking**
- ☐ **Apprehensive**
- ☐ **Grabbing Instruments**
- ☐ **Difficulty Getting Into Chair**
- ☐ **Uncooperative (Physical or Mental Impairment)**
- ☐ **Will Not Lean Back and/or Stay in Chair**

Techniques used to manage the behavior of the child during his/her dental treatment:

- ☐ **Tell-Show-Do**
- ☐ **Positive reinforcement of abnormal amount of time consumed**
- ☐ **Required two or more personnel to assure safety of child and staff**
- ☐ **Papoose or Pedi-wrap**

Additional Comments: (optional)

_____

_____

_____

Provider Information

Provider Last Name, First Name _____

Date (MM/DD/YYYY) _____

Provider Signature _____

27.3. Non-Covered Services Form

Non-Covered Services | Private Pay Member Commitment Form

This Section To be Completed by the Dental Office

Office Name: _____ **Provider Name:** _____

Office Phone Number: _____ **Date Treatment Plan Created:** _____

**This signed form is required to be kept as part of the member's dental chart.*

Procedure(s):	*Tooth/Arch:*	*Fee:*
		$
		$
		$
		$
		$
		$
		$
		$
	Total Fee:	$

This Section To be Completed by the Member, Parent or Guardian

PRINT:
Member ID: _____ **Member Name:** _____

PRINT:
Signed By Name ***(*Member, Parent or Guardian)*:** _____

Respond YES or NO to Each Statement Below:	YES	NO
My dentist advised me that there are NO covered services to take care of my dental concern		
My dentist advised me that there ARE covered services that would take care of my dental concern, but I am refusing covered services to select these		
I understand I have to pay the total amount for any of these services and that **MCNA will not pay** any portion of the cost		

****I agree to pay for these dental services. If I fail to make each payment I may be subject to collection action***

***Patient's Signature if over eighteen (18) or Parent or Guardian** | **Date**

27.4. Pediatric Dentistry Conscious Sedation Form

27.4.1. Page 1 of 2

Patient Selection Criteria **Date:** _____

Patient: _____ ❑ M ❑ F Age: ____yr____mo Weight: _____kg Physician: _____

Indication for sedation:
- ❑ Fearful/anxious patient for whom basic behavior guidance techniques have not been successful
- ❑ Patient unable to cooperate due to lack of psychological or emotional maturity and/or mental, physical, or medical disability
- ❑ To protect patient's developing psyche
- ❑ To reduce patient's medical risk

Medical history/review of systems (ROS)	NONE	YES*	Describe positive findings: _____
Allergies &/or previous adverse drug reactions	❑	❑	_____
Current medications (including OTC)	❑	❑	_____
Relevant diseases, physical/neurologic impairment	❑	❑	_____
Previous sedation/general anesthetics	❑	❑	_____
Snoring, obstructive sleep apnea, mouth breathing	❑	❑	_____
Other significant findings (eg, family history)	❑	❑	_____

Airway Assessment	NONE	YES*
Obesity	❑	❑
Limited neck mobility	❑	❑
Micro/retrognathia	❑	❑
Macroglossia	❑	❑
Tonsillar obstruction (___%)	❑	❑
Limited oral opening	❑	❑

ASA classification: ❑ I ❑ II ❑ III* ❑ IV* ❑ E * Medical consultation indicated? ❑ NO ❑ YES Date requested: _____

Comments: _____

Is this patient a candidate for in-office sedation? ❑ YES ❑ NO Doctor's signature: _____ Date: _____

Plan

	Name/relation to patient	Initials	Date	By
Informed consent obtained from	_____	_____	_____	_____
Pre-op instructions reviewed with	_____	_____	_____	_____
Post-op precautions reviewed with	_____	_____	_____	_____

Assessment on Day of Sedation Date: _____

Accompanied by: _____ Relationship(s) to patient: _____

Medical Hx & ROS update	NO	YES	NPO status	Airway assessment	NO	YES	Checklist
Change in medical hx/ROS	❑	❑	Clear liquids ____hrs	Upper airway clear	❑	❑	❑ Appropriate transportation home
Change in medications	❑	❑	Milk, other liquids,	Lungs clear	❑	❑	❑ Monitors functioning
Recent respiratory illness	❑	❑	&/or foods ____hrs	Tonsillar obstruction (___%)	❑	❑	❑ Emergency kit, suction, & O_2
Weight: _____kg			Medications ____hrs				available

Vital signs (If unable to obtain, check ❑ and document reason: _____)

Blood pressure: _____/_____ mmHg Resp: _____/min Pulse: _____/min Temp: _____°F SpO_2:_____%

Comments: _____

Presedation cooperation level: ❑ Unable/unwilling to cooperate ❑ Rarely follows requests ❑ Cooperates with prompting ❑ Cooperates freely

Behavioral interaction: ❑ Definitively shy and withdrawn ❑ Somewhat shy ❑ Approachable

Guardian was provided an opportunity to ask questions, appeared to understand, and reaffirmed consent for sedation? ❑ YES ❑ NO

Drug Dosage Calculations

Sedatives

Agent _____ Route _____ _____mg/kg X _____kg = _____mg ÷ _____mg/mL = _____mL

Agent _____ Route _____ _____mg/kg X _____kg = _____mg ÷ _____mg/mL = _____mL

Agent _____ Route _____ _____mg/kg X _____kg = _____mg ÷ _____mg/mL = _____mL

Emergency reversal agents

For narcotic: NALOXONE IV, IM, or subQ Dose: 0.1 mg/kg X _____kg = _____mg (Maximum dose: 2 mg; may repeat)

For benzodiazepine: FLUMAZENIL IV (preferred), IM Dose: 0.01 mg/kg X _____kg = _____mg (Maximum dose: 0.2 mg; may repeat up to 4 times)

Local anesthetics (maximum dosage based on weight)

Lidocaine 2%	(34 mg/ 1.7 mL cartridge)	4.4 mg/kg X _____kg = _____mg	(not to exceed 300 mg total dose)
Articaine 4%	(68 mg/ 1.7 mL cartridge)	7 mg/kg X _____kg = _____mg	(not to exceed 500 mg total dose)
Mepivacaine 3%	(51 mg/ 1.7 mL cartridge)	4.4 mg/kg X _____kg = _____mg	(not to exceed 300 mg total dose)
Prilocaine 4%	(68 mg/ 1.7 mL cartridge)	6 mg/kg X _____kg = _____mg	(not to exceed 400 mg total dose)
Bupivacaine 0.5%	(8.5 mg/ 1.7 mL cartridge)	1.3 mg/kg X _____kg = _____mg	(not to exceed 90 mg total dose)

27.4.2. Page 2 of 2

Intraoperative Management and Post-Operative Monitoring

EMS telephone number: _____

Monitors: ❑ Observation ❑ Pulse oximeter ❑ Precordial/pretracheal stethoscope ❑ Blood pressure cuff ❑ Capnograph ❑ EKG ❑ Thermometer
Protective stabilization/devices: ❑ Papoose ❑ Head positioner ❑ Manual hold ❑ Neck/shoulder roll ❑ Mouth prop ❑ Rubber dam ❑ _____

TIME	Baseline	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
Sedatives[1]																	
N_2O/O_2 (%)																	
Local[2] (mg)																	
O_2 sat																	
Pulse																	
BP																	
Resp																	
CO_2																	
Procedure[3]																	
Comments[4]																	
Sedation level[*]																	
Behavior[†]																	

1. Agent _____ Route _____ Dose _____ Time _____ Administered by _____
   Agent _____ Route _____ Dose _____ Time _____ Administered by _____
   Agent _____ Route _____ Dose _____ Time _____ Administered by _____
2. Local anesthetic agent _____
3. Record dental procedure start and completion times, transfer to recovery area, etc.
4. Enter letter on chart and corresponding comments (eg, complications/side effects, airway intervention, reversal agent, analgesic) below:
   A. _____ B. _____
   C. _____ D. _____

Sedation level*
- None (typical response/ cooperation for this patient)
- Mild (anxiolysis)
- Moderate (purposeful response to verbal commands ± light tactile sensation)
- Deep (purposeful response after repeated verbal or painful stimulation
- General Anesthesia (not arousable)

Behavior/ responsiveness to treatment†
- Excellent: quiet and cooperative
- Good: mild objections &/or whimpering but treatment not interrupted
- Fair: crying with minimal disruption to treatment
- Poor: struggling that interfered with operative procedures
- Prohibitive: active resistance and crying; treatment cannot be rendered

Overall effectiveness: ❑ Ineffective ❑ Effective ❑ Very effective ❑ Overly sedated
Additional comments/treatment accomplished: _____

Discharge

Criteria for discharge
- ❑ Cardiovascular function is satisfactory and stable.
- ❑ Airway patency is satisfactory and stable.
- ❑ Patient is easily arousable.
- ❑ Responsiveness is at or very near presedation level (especially if very young or special needs child incapable of the usually expected responses).
- ❑ Protective reflexes are intact.
- ❑ Patient can talk (return to presedation level).
- ❑ Patient can sit up unaided (return to presedation level).
- ❑ State of hydration is adequate.

Discharge vital signs
Pulse: _____/ min
SpO_2: _____%
BP: _____/_____ mmHg
Resp: _____/ min
Temp: _____°F

Discharge process
- ❑ Post-operative instructions reviewed with _____ by _____
  - ❑ Transportation ❑ Airway protection/observation ❑ Activity ❑ Diet ❑ Nausea/vomiting ❑ Fever ❑ Rx ❑ Anesthetized tissues
  - ❑ Dental treatment rendered ❑ Pain ❑ Bleeding ❑ _____ ❑ Emergency contact
- ❑ Next appointment on: _____ for _____

I have received and understand these discharge instructions. The patient is discharged into my care at _____ ❑ AM ❑ PM

Signature: _____ Relationship: _____ After hours number: _____

Operator Signature: _____ Chairside Assistant: _____ Monitoring Personnel signature: _____

Post-op call

Date: _____ Time: _____ By: _____ Spoke to: _____ Comments: _____

27.5. TMJ Summary Form

Patient's Name: _____ Age: _____ ☐ M ☐ F

Recipient Number: _____

<The items written in small print, in each category are not inclusive and should be used only as guides>

Chief Complaints:	Facial Pain: headaches, TMJ pain, TMJ sounds, cervical pain, Oral pain, dental pain, decrease in jaw ROM, ringing in ears, jaw locking, closed or open, duration

Clinical Findings:	Palpation of: TMJ, masticator muscles, cervical muscles; functional manipulation; jaw and neck ROM: TMJ sounds: occlusion

Radiographic Findings:

Impressions:	Myofacial Pain: masticatory muscles, cervical muscles, TMJ capsules, TMJ disc displacement or dislocation, Hyper-mobility, osteoarthritis, headaches, myofacial tension, Missing teeth, malocclusion, chronic pain, etc.

Etiology:	Trauma, Bruxism, Missing teeth, malocclusion, etc

Recommendations:

Is a splint requested? ☐ Yes ☐ No
If splint requested please indicated type: ☐ Hard Splint ☐ Soft Splint ☐ N/A

27.6. Incident Report Form

27.6.1. Page 1 of 2

INCIDENT REPORT

PRIVILEGED & CONFIDENTIAL

Incidents must be reported to Risk Management within 3 calendar days

Incident Report #: _____

Member Name:	Member #:	Plan Name:	DOB:	SEX:

Incident Date:	Incident Time:	Incident Location Name:	Phone Number:	
Provider Name:		Address:	Initial Diagnosis:	Initial ICD-9 CM Code:
IF HOSPITALIZED				
Hospital Name:		Admission Date/Time:	Admitting DX % ICD9/CPT Code:	Was a physician called?

PDP:	SDP:	Recommendations:

Witness(es):	
Witness(es) Locating Information:	
Physician Findings/Diagnosis:	

Give a clear concise description of the incident, including time, date, and exact location:

Final DX-9/CPT Codes:			
Prepared By:	Position:	Date Report to RM:	Time of Report:

PREPARER: SIGNATURE: _____

27.6.2. Page 2 of 2

MCNA DENTAL PLANS

INCIDENT REPORT | PRIVILIGED & CONFIDENTIAL | RISK MANAGEMENT USE ONLY

Complaint/Grievance Related:

_____

Risk Manager Review:

Received by: _____ Date: ___/___/___ Time: _____AM/PM

Findings:

_____

_____

_____

Chief Dental Officer Review:

_____

_____

_____

_____

Chief Dental Officer's Signature: _____ Date: ___/___/___

RM Activity:

Level: ☐ **1:** ☐ **2:** ☐ **3:**

☐ Code 15 Report ☐ Legal Department ☐ Chief Dental Officer Review ☐ Peer Review

☐ Log/Trend ☐ Education ☐ Other:_____

Final Outcome: _____ Closure Date: ___/___/___

Risk Manager's Signature: _____ Date: ___/___/___

Level 1= No quality problem identified

Level 2= Potential quality problem

Level 3= Confirmed quality problem

27.7. Adult Denture Program Clinical Condition Certification Form

This form must be submitted with all pre-authorization requests.

Member Information

Last Name, First Name	Date of Birth (MM/DD/YYYY) Age	M or F Gender (Circle One)
Member ID Number	Location of Member's Care	

Clinical Condition

Circle YES or NO for each question:			Additional notes (optional):
Patient is of sound mind?	YES	NO	
Patient is physically sound?	YES	NO	
Patient is in Hospice?	YES	NO	
Patient is on a liquid diet?	YES	NO	
Patient is on a feeding tube, enteral feedings, or parenteral feedings?	YES	NO	

Provider Information

Last Name, First Name	
Date (MM/DD/YYYY)	Signature

Last Updated: June 20, 2014
MCNA_LA-W_DENT CLIN COND-FORM_10

Page 1 of 1

27.8 Louisiana Medicaid EPSDT and Adult Denture Provider Complaint Form

Louisiana Medicaid EPSDT and Adult Denture Provider Complaint Form

This form is not to be used for initial claim submission or claims adjustments. Complete and submit this form to MCNA, along with all documents that support your complaint. Supporting documentation must be submitted within 15 days of filing your complaint.

Provider Information

Last Name, First Name

Date (MM/DD/YYYY)

Provider ID Number

Provider NPI Number

Telephone Number

Street Address

Contact Name

City State ZIP

Member Information

Last Name, First Name

Claim Number(s) (if applicable)

Date of Birth (MM/DD/YYYY)

Date of Service (MM/DD/YYYY)

MCNA Member ID Number

Complaint Reason	Desired Outcome

Signature

Date

Mail, Fax, or Email Completed Form To:

MCNA Dental, Attn: Provider Complaints
P.O. Box 29008, San Antonio, Texas 78229
Fax: 504-848-1400
Email: LA_PR_Dept@mcna.net

For Questions Contact:

1-855-701-6262
Monday - Friday, 8am - 6pm CST

MCNA Online Portal: https://portal.mcna.net/

27.9 Provider Reconsideration and Appeal Request Form

Provider Appeal and Reconsideration Form

MCNA Dental · Louisiana EPSDT and Adult Denture Programs

This form is not to be used for initial claim submission or claims adjustments (such as corrected claims). Complete and submit this form to MCNA including all documents that support your request. Appeal request must be filed within 90 days from the initial claim determination and a reconsideration request must be filed within 365 days from the date of service on the claim.

If you are submitting a BULK APPEAL, please submit a spreadsheet that includes the Member Names, Claim Numbers, Denial Reasons, and Dates of Service for each claim. Please also specify the reason(s) for the appeals.

Provider Information

Last Name, First Name

Date (MM/DD/YYYY)

Provider ID Number

Provider NPI Number

Telephone Number

Street Address

Contact Name

City State ZIP

Member Information

Last Name, First Name

Claim Number(s)

Date of Birth (MM/DD/YYYY)

Date of Service (MM/DD/YYYY)

MCNA Member ID Number

Appeal Reason

Below are reasons you can appeal a claim that has been denied. You may attach a detailed explanation for this appeal.

- ☐ **Untimely Filing**
- ☐ **No Authorization Obtained**
- ☐ **Non-Covered Benefits**
- ☐ **Medical Necessity**
- ☐ **Other Reason(s)**

Supporting Documentation

Please check all that apply

- ☐ **Chart Notes, X-Rays, Narratives, Models, Radiographs**
- ☐ **Proof of Original Submission**
- ☐ **Copy of EOB**
- ☐ **Other Documentation**

Signature

Date

Mail or Fax Completed Form To:

MCNA Dental, Attn: Provider Appeals
200 West Cypress Creek Road, Suite 500, Fort Lauderdale, Florida 33309
Fax: 954-628-3330

Do not fax requests that include x-rays or ADA claim form. Please submit via mail.

For Questions Contact:

1-855-701-MCNA (1-855-701-6262)
Monday - Friday, 8am - 6pm CST

Last Updated: July 26, 2016
MCNA_LA-P_APPEAL_FORM[1.1]

Page 1 of 1

Attachment 35-3
Iowa Provider Orientation

Provider Orientation

Iowa Dental Wellness Program

(v1.0 – June 2016)

Confidential and Proprietary

Welcome!

Training Purpose:

1. Build strong, collaborative and lasting relationships with our network providers.
2. Educate and inform our network providers about the MCNA Program guidelines and responsibilities in conjunction with the Iowa Department of Human Services (DHS).

DWP Program Goals:

1. Provide quality, medically necessary dental services to our members.
2. Improve the oral health of our members through preventive care and dental education.

Confidential and Proprietary

Overview

- About MCNA
- DHS Program Expectations
- MCNA Services
- Provider Rights
- Dental Wellness Program - Covered Services
- Member Outreach / Non-Compliant Members
- Eligibility / ID Cards
- Pre-Authorizations
- Claims
- Provider Complaints
- Appeals / Reconsiderations
- Peer to Peer
- Member Grievances & Appeals
- Practice Changes/Updates
- Balance Billing
- Dental Record Keeping
- HIPAA / Confidentiality Policy
- Fraud, Waste, and Abuse
- Quality Improvement
- DentalTrac™
- Provider Portal
- Linguistic Services
- Iowa Network / Provider Relations Team
- Questions and Answers

Confidential and Proprietary

About MCNA

MCNA is a premier dental benefits administrator that provides exceptional service to state agencies and managed care organizations for Medicaid and CHIP members. We build and maintain strong relationships with our network providers that allow us to ensure access to quality dental care and services for the unique populations we serve for adults and children. Our corporate office is located in Florida with other offices in Texas and Louisiana.

"Our mission is to deliver value to our clients and providers by providing access, quality and service excellence that improves the oral health outcomes of our members."

DHS Program Expectations

1. Coordination of Care (COC)
2. Improve dental health **outcomes** (High risk to Low risk)
3. Increase **quality** of dental care by metrics
   a. HEDIS
   b. Dental Quality Alliance (in development)
4. Increase **personal** responsibility and self-management
5. Promote healthy **behaviors** through outreach and education
6. Decrease **fraud**, abuse, and wasteful spending

Confidential and Proprietary

MCNA's Services

- Primary and Specialty Care Dental Networks
- Dental Network Management
- NCQA-Certified Credentialing Processes
- Member Services, Outreach and Education
- Provider Services, Provider Relations and Education
- Claims Processing
- Quality Improvement
- Compliance Program (including fraud, waste and abuse)
    - Online Provider Training Modules
- Utilization Management (Pre-auth and Utilization Analysis)
- Web-based Portal Available 24/7

Confidential and Proprietary

Provider Rights

Each MCNA contracted provider that furnishes services to MCNA members shall be assured of the following rights:

- Acting within the lawful scope of practice, shall not be prohibited from advising or advocating on behalf of a member who is his/her patient for member health status, medical care or treatment
- The right to receive information on the Grievance, Appeal, and Fair Hearing procedures
- Access to MCNA's policies and procedure covering the authorization of services
- Right to be notified of any decision by MCNA to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested
- The right to challenge, at the request of a DWP member on their behalf, the denial of coverage of, or payment for, medical assistance.

Refer to the Provider Manual for more information on Provider Rights

Confidential and Proprietary

Dental Wellness Program

Covered Services

Covered Services

The Dental Wellness Program (DWP) focuses on preventive care to improve the overall health for members between the ages of 19 through 64.

This program offers three (3) levels of coverage and provides dental services immediately through Core benefits which are always available to the member. Members who receives dental exams every 6 to 12 months can earn additional benefits through Enhanced and Enhanced Plus benefits. Members 19-20 always have Enhanced Plus benefits until they turn 21. Upon turning 21 their benefit level will be determined by their utilization history.

✓**Core Benefits** include diagnostic and preventive services, emergency services, and stabilization services. These benefits are available immediately.

✓**Enhanced Benefits** are earned once the member has a second exam within 6-12 months from their first exam.

✓**Enhanced Plus Benefits** are earned once the member has a third exam 6-12 months from their second exam.

Annual Benefit Maximum
- Does not apply

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Core Benefits	Enhanced Benefits	Enhanced Plus Benefits
• Diagnostic and preventive services - exams, cleanings, x-rays. • Emergency Services - problem focused exams, extractions/oral surgery and anesthesia. • Stabilization Services - restorations for large cavities, gum disease treatment for acute problems, and dentures for those without teeth or to restore function and denture adjustments and repairs.	All Core benefits plus restorative services, root canals and other endodontic care, non-surgical gum treatment, denture adjustments and repairs, certain oral surgery services, and other designated adjunctive services.	All Core and Enhanced Benefits plus crowns, onlays, tooth replacements and gum surgery. **Enhanced Plus benefits are subject to prior authorization.**

The Primary Care Dentist (PCD) must assess the dental needs of the member and refer them to specialty providers as appropriate. PCDs should advise the member of which type of dentist they need to see for specialty care. The member can use the provider directory on the MCNA website or call the Member Hotline to locate an in-network provider.

- **If a member does not go to their dental exam every 6-12 months, they revert back to the Core Benefits.**

Member Outreach

- MCNA's member outreach activities help members better understand their dental benefits and how to appropriately access services within MCNA.
- MCNA's providers can request assistance from our Member Advocate Outreach Specialists to provide additional education to members who need further explanation.
- Providers can refer non-adherent members for additional education regarding their benefits and services by completing a member Outreach Form, which can be found in the Provider Portal.

Non-Compliant Members

If a Member is non-compliant, please follow these steps:

1. Document member's chart
2. Complete the Member Outreach Form, send to MCNA
3. We will educate the member about:
   - Keeping scheduled appointments
   - Following treatment plans
   - Following Provider office rules and policies
4. We will help the member schedule another appointment
5. If a Provider wants to discharge a member from their office they must notify the member.
6. The member can use their provider directory, the MCNA online provider directory or they may call the Member Hotline for assistance in finding another PCD.

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Verification of Eligibility

1. Member eligibility varies by month
2. DHS makes all eligibility determinations
3. MCNA makes all determination on the member's benefit level coverage
4. The MCNA issued Medicaid ID card **is not** proof of eligibility
5. The **provider is responsible** for verifying member eligibility and benefit coverage level with MCNA **before** providing services

Eligibility can be verified the following ways:

- 24 hours a day/7 days a week electronically on MCNA's Provider Portal at: http://portal.mcna.net

  Member **DOB** is required and at least one of the following:

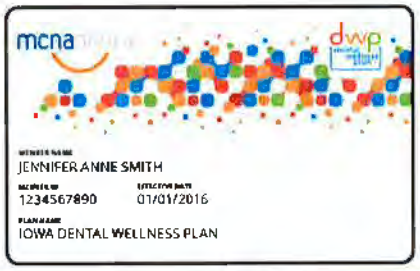
  a) Medicaid ID number

  b) Member Last name

- Calling MCNA Provider Hotline 7am-7pm CST at 855-856-6262
- Calling MCNA Member Hotline 7am-7pm CST at 855-247-6262

DWP ID Card

Members will use their MCNA issued ID card to access benefits and services covered as part of the Dental Wellness Program.



Eligibility

Visit our online tutorial to view on how to check eligibility:

http://portal.mcna.net

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Pre-Authorizations for Treatment

What is a Pre-Authorization?

The process of determining medical necessity for specific services **before** they are **rendered** and is utilized to evaluate the medical necessity of dental care services

MCNA Pre-authorization determination timeframes:

- Within fourteen (14) calendar days of receipt
- This can be extended up to fourteen (14) days if the member, provider or authorized representative requests an extension or if additional information is needed to make a determination

Requests may be submitted electronically via the MCNA Provider Portal at:

http://portal.mcna.net

Or mailed to our office at:

MCNA Utilization Dept.
200 Cypress Creek Road, Suite 500
Fort Lauderdale, FL 33309

Please contact the Utilization Management department for any questions by calling the Provider Hotline at: 1-855-856-6262

❖ **Faxed Pre- Authorizations are not accepted**

Emergency services do not require Pre- Authorization

Enter A New Pre-Authorization

Please fill out each section of the form completely to facilitate quick processing.
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: [redacted]

Subscriber ID: [redacted]

Last Name: [redacted]

First Name: [redacted]

Zip Code: [redacted]

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: * Select Provider

Treatment Location: OFFICE

Additional Information

EPSDT Procedure: Check only if Yes

NEA Fast-Attach #:

Remarks:

List of Services Provided

The **CDT Code**, and **Procedure Fee** are required as identified by a red header and asterisk. You may adjust the **Procedure Fee** if necessary. The remaining fields must be filled in only if applicable to the procedure. Multiple Tooth Numbers and Areas must be separated by commas, however, Surfaces must not include commas.

Enter each line item and then click the green **Add Additional Procedure** button to add another procedure.
If you have made an error, you can click on the **Remove** link to remove the procedure.

CDT Code *	Procedure Description	Area or Tooth Numbers/Letters	Tooth Surface	Procedure Fee *	
	Enter a Valid CDT Code			0.00	Remove
			Total	$0.00	

+ Add Additional Procedure

Submission of Claims

Providers may submit a claim to MCNA in three ways:

1. Electronically through MCNA's Provider Portal at: http://portal.mcna.net
2. Electronically through a clearinghouse (MCNA Payor ID: 65030)
3. Paper claim via United States Postal Service (Use the 2012 ADA Claim Form)

Faxed claims will not be accepted

- ✓ Claims are paid by MCNA
- ✓ Providers must file claims within 60 days from the Date of Service (DOS)
- ✓ MCNA is required to adjudicate clean claims within 30 calendar days
- ✓ MCNA runs Remittance Advice (RA) cycles on Wednesday of each week
- ✓ Providers are encouraged to register for MCNA's Electronic Funds Transfer (EFT) Program.

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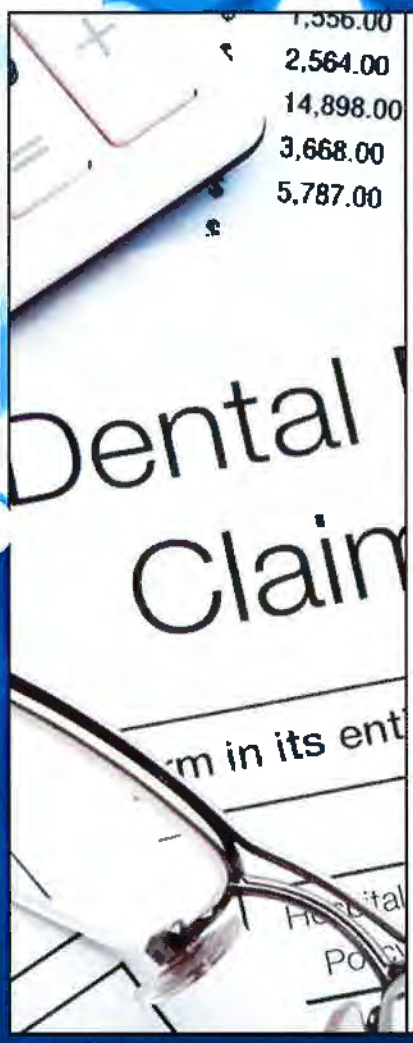

Clean Claims Definition

A claim that can be processed **without obtaining additional information from the provider** of the service or from a third party. It includes a claim with **errors originating in a state's claims system**. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

1. Member name
2. Member identification number
3. Member and/or Guardian Signature (or Signature on File)
4. Member date of birth (DOB)
5. Description of services rendered
6. Dentist NPI number (included with electronic or online submissions)
7. Group NPI number (if applicable)
8. Dentist name, state license number and signature (included with electronic or online submissions)
9. Dentist address, office ID# and phone number (included with electronic or online submissions)
10. Proper CDT coding with tooth numbers, surfaces, quadrants and arch when applicable.
11. Provider Tax Identification Number (TIN)
12. X-rays, rationale, pre-authorization or other supporting documentation as needed. (Described in Provider Manual.)

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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: 01/01/1976

Subscriber ID: [redacted]

Last Name: SMITH

First Name: [redacted]

Zip Code: [redacted]

Reset Subscriber

If you need to confirm this subscriber's current eligibility or view this subscriber's treatment history, click here.

Provider Information

Provider selection is required

Treating Provider: * Select Provider

Treatment Location: OFFICE

Additional Information

EPSDT Procedure: Check only if Yes

Pre-Authorization #:

NEA Fast-Attach #:

Check if another insurance company is involved:

Remarks:

List of Services Provided

The Procedure Date, CDT Code, and Procedure Fee are required as identified by a red header and asterisk. You may adjust the Procedure Fee if necessary. The remaining fields must be filled in only if applicable to the procedure. Multiple Tooth Numbers and Areas must be separated by commas, however, Surfaces must not include commas.

Enter each line item and then click the green Add Additional Procedure button to add another procedure.
If you have made an error, you can click on the Remove link to remove the procedure.

Procedure Date *	CDT Code *	Procedure Description	Area or Tooth Numbers/Letters	Tooth Surface	Procedure Fee *	
mm/dd/yyyy		Enter a Valid Date & CDT Code			0.00	Remove
				Total	$0.00	

Add Additional Procedure

Attachments

Please upload any attachments required for this claim, including any x-rays, oral images, or relevant documentation.
You may upload multiple files per upload box directly from your computer.

Optional Attachments

You may upload any additional relevant attachments below, up to a total number of 10 files.

File Upload: Browse... No file selected. File Type: Select File Type

Ancillary Treatment Information

These fields should only be completed if applicable to the procedures performed on this claim.

If treatment is for orthodontics:

Appliance Placement Date: mm/dd/yyyy

Months of Treatment Remaining:

If the months of treatment remaining is found to be inaccurate or in excess of the available limit, benefits will be adjusted accordingly.

If treatment is a replacement of prosthesis:

Date of Prior Placement: mm/dd/yyyy

If treatment is the result of an injury or accident:

Select One:

- Occupational Illness/Injury
- Auto Accident
- Other Accident
- None

Date of Accident: mm/dd/yyyy

State of Accident:

Sign and Submit

Please note that by submitting the claim you are digitally signing this online document on behalf of the rendering provider as of this date.

At least one procedure must be entered.

Cancel Submission | Submit Claim

Provider Complaints

MCNA maintains a provider complaint process for in and out-of-network providers in Iowa to dispute MCNA's policies, procedures, claims processing/payment or any aspect of our administrative functions.

Providers have **30 days from the date of incident to file** a complaint and MCNA must **resolve** the complaint **within 30 days of receipt of the complaint**.

Providers may use the following channels to file a complaint:

- Contact their local Provider Relations Representative
- Contact our toll free Provider Hotline at **1-855-856-6262** to speak to a Provider Services Representative
- A Provider may also submit their complaint in writing to:

MCNA Dental
Attention: Complaints – Provider Relations Department
P.O. Box 29008
San Antonio, TX 78229

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Provider Claim Appeals / Reconsiderations

An Appeal is a request for a clinical review of a claim that has been denied for determinations related to *medical necessity* and *benefit coverage*. Appeal requests must be filed within 45 days of the initial claim determination date.

Any requested or supported information such as x-rays or rational should be included with the Appeal submission.

A Reconsideration is a request for a review of a claim that has already been processed and a determination made by MCNA. If you are dissatisfied with the determination of a claim or it has been denied for an *administrative reason*, you may file a reconsideration with 45 days of the initial claim determination. The review will be conducted by the Claims department.

Administrative (non-clinical) denial can consist of any of the following but not limited to:

- ❑ **Timely Filing**
- ❑ **No Pre-Authorization on file**
- ❑ **Incorrect fee applied**
- ❑ **Duplicate**
- ❑ **Member and Provider eligibility**

Appeals or **Reconsiderations** can be submitted by the following ways:

1. Online through MCNA's Provider Portal (https://portal.mcna.net)
2. By Mail:
   MCNA Dental
   Attention: Grievances and Appeals
   200 West Cypress Creek Road, Ste 500
   Fort Lauderdale, FL 33309

❖ **Any and all supporting documentation should be included with your request for an Appeal or Reconsideration.**

Provider Peer-to-Peer

Still not satisfied?

Would you like to ask another Dentist?

MCNA offers the availability of peer-to-peer consultations with our Dental Director and Clinical Reviewers.

Licensed general dentists and specialty dental providers, such as endodontists and oral surgeons, make all clinical determinations.

To request a peer-to-peer discussion, please contact your Provider Relations Representative or call our Provider Hotline **1-855-856-6262**.

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Assisting a Member with Appeals & Grievances

Providers may submit grievances and appeals on behalf of members with their written consent.

Grievance: An expression of enrollee dissatisfaction about any matter other than an action, as action is defined. Examples of grievances include dissatisfaction with quality of care, quality of service, rudeness of a provider or a network employee and network administration practices. Administrative grievances are generally those relating to dissatisfaction with the delivery of administrative services, coverage issues, and access to care issues.

Appeal: A request for **review of an action.**

Fair Hearing: The member must first exhaust MCNA's appeal process before requesting a Fair Hearing. The member may request a Fair Hearing within thirty (30) calendar days of the date of the last decision notification by MCNA. MCNA will cooperate with any decision the State makes.

MCNA resolves appeals and grievances within 30 days.

For more information on filing an Appeal or Grievance on behalf of a member see our Provider Manual or call the Member Hotline toll free number 855-247-6262.

Practice Changes/Updates

What if you make changes to your Practice?

- All Changes are required to be submitted in writing via email or by mail
- Must be submitted to MCNA to ensure accurate updates to our Provider Directory and the Online Provider Directory.
- Please be sure that you select and submit the correct taxonomy code that is specific to your specialty

- ✓ Immediate notification to changes in license status, board actions, address or name changes, DBA or Tax ID
- ✓ Three (3) to four (4) weeks to add a new treating dentist (All dentists must be credentialed with MCNA prior to rendering treatment.)
- ✓ Ninety (90) days to terminate participation to allow for continuity of care issues
- ✓ Any covering Dentist should be credentialed with MCNA
- ✓ Your office must meet the compliance requirements

- ❖ Re-credentialing is repeated every three years

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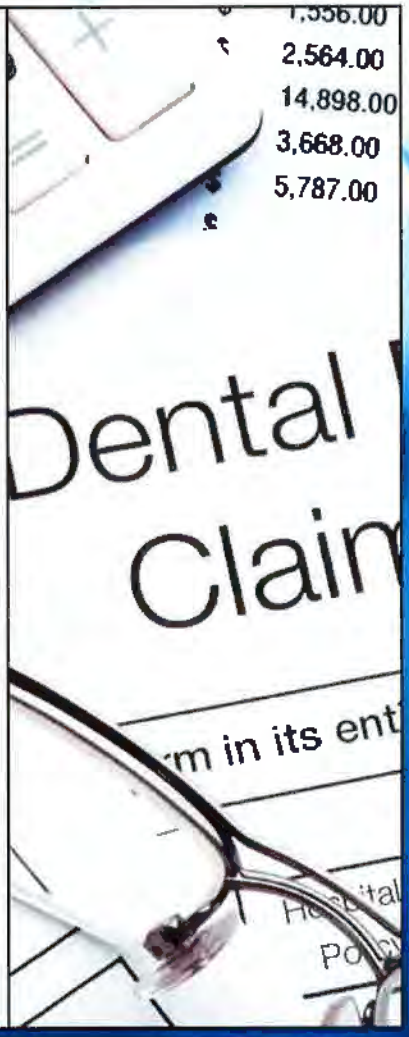
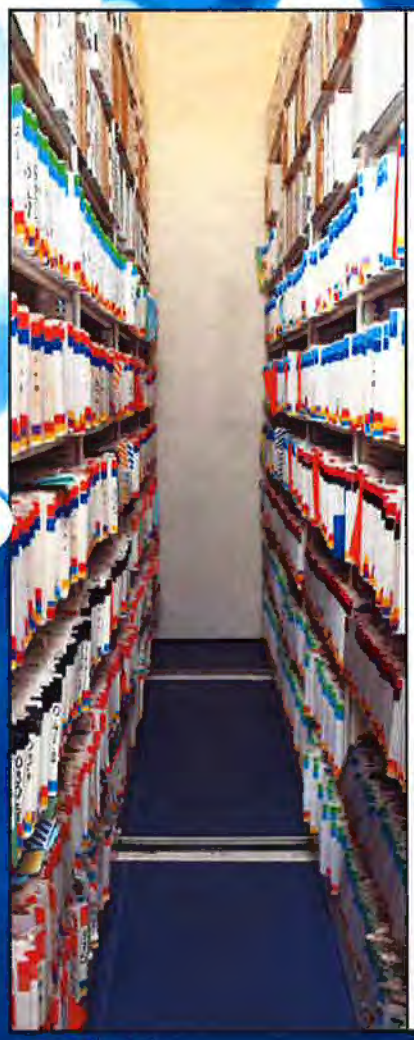
Prohibitions on Balance Billing

Providers who are contracted with MCNA may not bill members for, or otherwise attempt to recover from members, the difference between the agreed upon contract rate allowable and the provider's billed charge(s).

For example: A provider bills their usual and customary fee of $75.00 but the Dental Wellness Program only allows a maximum of $50.00 for the service. In this case MCNA will only pay $50.00 for the service rendered. The provider cannot attempt to collect the **balance** of $25.00 from the member.





Dental Record Keeping

We would like to ensure that the Dental Record Keeping standards are understood by all staff members.

This will guarantee a passing score at the time of your chart audit review.

Refer to the Provider Manual for a list of requirements and detailed instructions.

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HIPAA and Confidentiality Policy

Health Information Privacy Accountability Act

MCNA follows HIPAA requirements and requires its contracted providers to also adhere to HIPAA requirements.

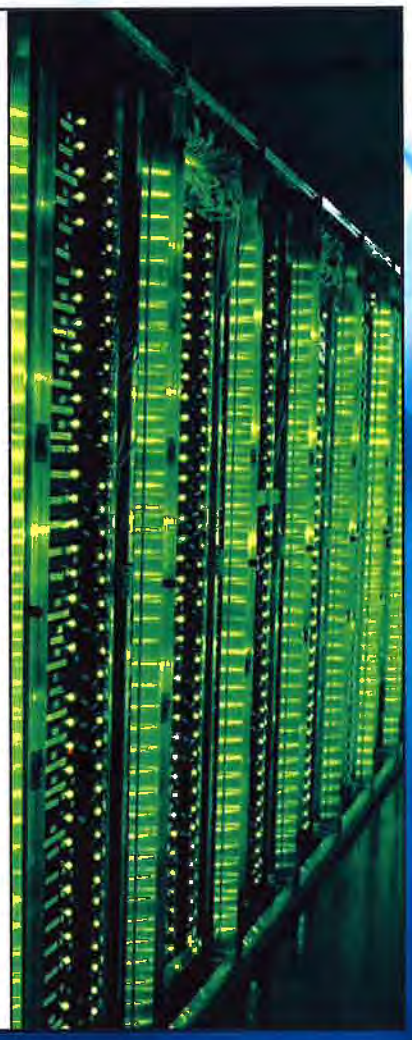
Provider agreements require that all providers maintain patient information:

1. In a current, detailed, organized and comprehensive manner

2. In accordance with the customary dental practices, applicable state and federal laws and accreditation standards.

In addition Providers must:

- Only release of information, using a release form, at the request of a member or in response to a legal request for information.
- Store and restrict access to dental records in secured files.
- Educate employees regarding confidentiality of dental records and patient information.



Fraud, Waste, and Abuse

MCNA is committed to the elimination of Fraud, Waste, and Abuse as part of the Dental Wellness Program

- Fraud - An intentional deception or misinterpretation made by a person with the knowledge that deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

- Waste - Practice that allows careless spending and/or inefficient use of resources.

- Abuse - Provider practices that are inconsistent with sound fiscal, business or dental practices and result in unnecessary program cost or in reimbursement for services that are not medically necessary or do not meet professionally recognized standards for healthcare.

✓ Falsifying claims - Altering or falsifying claim or supportive documentation, incorrect billing, double billing, regulations and statutes.

✓ Administrative/ Financial - Fraudulent/ falsified credentials, business, accounting practices or documents.

✓ Delivery of service - Denying access to service, benefits, limiting access to services, failure to refer to a specialist, under or over utilization.

✓ Abuse of Member - Physical, mental, emotional and sexual abuse, discrimination, providing substandard care, financial exploitation.

✓ Member Violations - Abuse or misuse of dental services, member ID card sharing, falsifying or concealing eligibility information.

MCNA Fraud Hotline: 1-855-FWA-MCNA (1-855-392-6262)

DHS Fraud Hotline: 1-800-831-1394

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Quality Improvement

Goals

1.To ensure that each Member has affordable and convenient access to quality dental care delivered in a timely manner by a network of credentialed Providers.

2.Have 100% of Provider participation in the following:

- HIPAA
- Dental Recording Keeping and Chart Review
- Linguistic Access for Members that may need assistance
- Provider Satisfaction Survey

Your Role in Quality

- Every MCNA network dentist is a participant in the Quality Improvement Program through his or her contractual agreement with MCNA.
- You can help us identify any issues that may directly or indirectly impact Member care by reporting them on an Incident Report Form located in the Provider Portal.
- The MCNA Director of Quality Improvement or a team member may contact your office regarding your Incident Report. Please keep a copy of the Member's Incident Report in the patient's dental record.

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DentalTrac™ Features

- ✓ Fully integrated, interactive and voice-based systems
- ✓ 24/7 access to claims and benefit information
- ✓ Real time transactions, such as EDI claim uploads
- ✓ Flexible, comprehensive reporting module
- ✓ Powerful, customizable claims engine
- ✓ HIPAA-compliant solutions
- ✓ Web-based reporting
- ✓ Secure military grade data encryption

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Provider Portal

MCNA Online Provider Portal is a tool that provides the ability to perform day-to-day activities in support of your office and members.

Using the portal will assist you with verifying member eligibility, submitting claims and pre-authorizations, viewing historical activity, and viewing and printing remittance advices.

The Portal allows you to register more than one office within a group that enables the user to have one username and manage multiple offices.

MCNA recommends that all of our providers take advantage of its features.

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Non-Discrimination

MCNA considers non-discrimination of Members essential to the health care delivery system.

Providers must not differentiate or discriminate in the treatment of any Member because of the Member's race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, physical or behavioral disability, or source of payment.

Availability and Coordination of Linguistic Services

- MCNA presents Member materials in a **culturally and linguistically appropriate** manner utilizing the Member's primary language.
- When a Member calls MCNA interpreter services via our Language Line are available through MCNA at no charge.
- Please have the Member contact our Member Hotline at **855-247-6262** to arrange Member materials in their native language.

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Would you like to join our Network?

- You may enroll online or visit our website www.MCNAIA.net
- You must sign the MCNA Participating Provider Agreement (contract).
- Complete a credentialing application via fax, email, online or mail it to:

FAX: (877) 684-5717

Email: newtwork_development@mcna.net

Online: www.MCNAIA.net

MCNA
Attn: Iowa Network Development
200 West Cypress Creek Road, Suite 500
Fort Lauderdale, FL 33309

Toll-free Provider Relations Dept.: **1-855-856-6262**

Your Iowa Network / Provider Relations Team

Rene Canales
Director of Network Development
1-855-856-6262 Ext: 591
rcanales@mcna.net

Ginger Chapman
Provider Relations Manager
1-855-856-6262 Ext: 573
gchapman@mcna.net

Christie Street
Network Development
1-855-856-6262 Ext: 883
cstreet@mcna.net

Diane Endelman
Provider Relations Rep
1-855-856-6262 Ext: 888
dendelman@mcna.net

You may also download the Provider Relations territory map on our Provider Portal at http://portal.mcna.net.

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Questions and Answers

Thank you and Welcome to MCNA!

www.mcnaia.net

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Idaho Medicaid Dental Plan Credentialing and Re-Credentialing Requirements

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When is Credentialing Needed?

- *When non participating dental providers want to join MCNA's network to provide care to Idaho Medicaid members.*
- *When a participating provider wants to add a new dentist to their existing MCNA office.*
- *If an existing credentialed provider sells their practice, the purchaser of the practice will need to become credentialed if they wish to provide dental services to MCNA members.*

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Prospective Provider Thank You Letter

mcnadental

Dear Colleague

MCNA Insurance Company (MCNA) is a leading dental benefit management company committed to providing high quality services to state agencies and managed care organizations for their Medicaid, Medicare, and Children's Health Insurance Programs (CHIP) members. We serve approximately 7 million children and adults including some of the most vulnerable members of society, with the singular mission of improving their general health by ensuring access to quality dental care.

Founded by a dentist in 1992, MCNA has one of the fastest growing dental networks in the United States. The key to our success has been our relationships with our providers in each state we serve.

We are building a new Medicaid network that will be administered by MCNA and serve Medicaid members through our affiliated health plans or if we secure an independent contract, you as the State of Idaho. We would like to see if you would be interested in joining our network.

As Idaho pediatric dentists, we recognize the dedication that Medicaid providers such as you bring to the oral health of Idaho's children and adults. We would like to extend an invitation for you to consider joining our network. Please forward a modification letter of intent as soon as possible to the fax number or email address listed below.

Fax Number: 1-208-298-3814
Email Address: Network_Development@MCNA.net

The Letter of Intent is a non-binding document that states you are interested in a possible contract with MCNA should we participate in the Medicaid dental program. At that time, we will send you a full Provider Agreement and Credentialing Application package for you to complete and register with us. If we can assist you further, please contact our Provider Services Team at (855) 235-6262 or visit our website at www.mcnaid.net

We look forward to working with you to serve the Medicaid population. Together we can make a difference, one smile at a time.

Sincerely,

Dr. Roger Singer
Idaho Executive Director
MCNA Insurance Company

Dr. John Ulrich
Idaho Dental Director
MCNA Insurance Company

When a dentist expresses an interest in joining MCNA's provider network, the dentist may download the welcome letter from the website or request one to be mailed to them. The thank you letter contains MCNA's contact information and instructions for acquiring the credentialing application, W-9 form, and EFT Form.

Documents Required for the Credentialing Process

- *Completed Current Credentialing Application*
- *Contract*
- *Amendment*
- *W9 signed by owner with current date*
- *EFT Form and voided check if the applicant desires direct deposit for payment*
- *Copy of Dental School Diploma and Training Certificates*
- *Copy of Curriculum Vitae (from Dental School to present date with dates in mm/yyyy format)*
- *Copy of Current Idaho Dental License (website printout not accepted)*
- *Copy of Current Idaho DEA License (if applicable) – (website printout not accepted)*
- *Copy of Current Controlled Substance Registration – (if applicable)*
- *Sedation Permit (if applicable)*
- *Copy of current Malpractice Insurance policy face sheet*
- *Provider Roster*

Credentialing Application

- *The Credentialing Applicatian is a 6 page, 9 section application that must be completed in its entirety for the credentialing process to begin.*
- *The application includes personal and professional information.*
- ***Any omission of information on the application will delay the initiation of the credentialing process.***
- *White out and "see attached" responses are* ***not*** *accepted on the application.*
- *A credentialing application will not be accepted until all elements are completed and submitted in their entirety.*

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Application Definitions

Multi-Specialty Group – A group of dentists with different specialties (e.g, an oral surgeon and endodontist in one practice)

Solo - One dentist in practice

Group - More than one dentist in practice

County/FQHC – Office that receives Federal Funding (see FQHC PowerPoint)

Single Specialty Group – A group of dentists with the same specialty (e.g, a group of oral surgeons)

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Application Definitions Continued

Recall System *– A system an office has in place ta track their patients for preventive care visits.*

Allied Health Professional *– Healthcare professionals who provide direct patient care and support services. Example: Dental Hygienist*

Dental /Hygienist License *– Licenses that allow professionals to practice in their scope of training.*

DEA License *– License that allows a dentist to prescribe medications. (Orthodontists are not required to have a DEA license) If a Primary care dental provider does not have a DEA license, an explanation/waiver must be provided along with the application packet.*

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Application Definitions Continued

Malpractice Insurance – *Proof of liability insurance. This document cannat expire within 30 days of credentialing. This insurance is renewed annually.*

Tax ID Number- *Also knawn as an EIN (Employer ID Number) identifies a business entity for the Internal Revenue Service (IRS). Complete a W9 with the legal name associated with the TIN issued by the IRS.*

Office NPI Number – *A 10 digit type 2 group organization National Provider Identifier number. (Not for single provider practices)*

*Individual NPI Number- A 10 digit type 1 National Provider Identifier number. Every provider **must** have an NPI number to receive Federal monies.*

Website to verify the NPI numbers:

https://nppes.cms.hhs.gov/NPPES/Welcome.do

Attestation Signature Page

- *The attestation signature page is the last page of the Credentialing Application.*
- *This must be signed by the prospective dentist to give consent so that MCNA can request verification of the information provided by the prospective dentist.*
- *This page also affirms that all information submitted on the application is complete and correct and is provided in good faith.*
- *This page must be signed and dated within 30 days of the initiation of the credentialing process.*

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W9

- *A tax form for the United States which certifies an individual's taxpayer identification number and legal name as filed by the IRS.*
- *Potential providers must submit a W9 form for each tax identification number they have.*
- *Group offices having multiple locations and multiple tax identification numbers must submit a W9 for each office with different tax identification numbers.*

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SampleW9 Form

Form **W-9**
(Rev. October 2007)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶
☐ Other (see instructions) ▶

☐ Exempt from FATCA reporting code (if any)

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I **Taxpayer Identification Number (TIN)**

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Social security number

or

Employer identification number

Note: If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Part II **Certification**

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here Signature of U.S. person ▶ Date ▶

EFT Form

- *Electronic Funds Transfer Form*
- *This form is optional if the provider wishes to have claims payments deposited directly into their bank account.*
- *A voided check or a copy of a voided check must be submitted with the completed EFT Form.*
- *Provides for faster reimbursement*

Sample EFT Form

mcnadental

PLEASE SIGN AND FAX, MAIL OR EMAIL TO
MCNA Dental
200 W Cypress Creek Rd., Suite 590
Ft. Lauderdale, FL 33309
Fax (954) 397-7441 swallen@mcna.net

Complete this form for EFT payments ONLY. If you prefer to receive your payments via regular US Mail do not complete the entire form. Check the applicable box to the right; sign & print your name, date the form and return it along with your application and documents.

EFT: ☐ YES ☐ NO

Paper EOB: ☐ YES ☐ NO

PAYEE NAME:	TAX IDENTIFICATION NUMBER:
Address:	

PAYEE E-MAIL ADDRESS FOR EOB NOTIFICATION	PAYEE PHONE NUMBER:	CONTACT'S FULL NAME & NUMBER:

BANK NAME:	NAME ON ACCT:	ROUTING NUMBER:	ACCOUNT NUMBER:
Address:			
Phone:			

PLEASE ATTACH A VOIDED CHECK HERE.

(Required)

MCNA will EFT (direct deposit) your payments **DIRECTLY** into your bank account. We will also send you an email confirmation of your EFT transaction as well as your EOB to the email address you have provided above.

If you have questions, please call Credentialing at (800) 484-6262 extension 103.

I hereby give authorization to MCNA (MCNA) to credit the account at the named financial institution above for the sole purpose of transferring payments from MCNA to my account. MCNA is also granted authorization to correct funds erroneously deposited and other non-monetary debit/credit entries. I understand that my deposit may take up to 2 business days to post to my account. This authorization is to remain in effect until notification is given to MCNA in writing (requires a minimum of 10 business days notice) or on the MCNA Direct Deposit Authorization Form advising of any change in the information on this form. I understand that the processing of changes may take up to 10 days to take effect. My signature below attests to the correctness of the information on this form and my acknowledgement of change requirements.

AUTHORIZED SIGNATURE:	PRINT YOUR NAME & TITLE:	TODAY'S DATE:

Diploma, Certificate, and Continuing Education (CE) Courses

- *Copy of the prospective provider's Dental School diploma*
- *Certificates showing training for any specialty programs completed*
- *For specialty services certificates showing training, e.g., Sedation permits*

Curriculum Vitae (Resume)

mcna dental

200 W Cypress Creek Rd • Suite 500 • Ft Lauderdale, FL 33309 • (954) 230 3131 (O) • (954) 397 7441 (F)

CURRICULUM VITAE

Name of Dentist: _____

☐ DDS ☐ DMD ☐ Specialty: _____

Email Address: _____
Phone #: _____

EDUCATION
Name of school and location: _____
_____
Month/Year of Graduation: _____ Dates Attended: _____ to _____

IF BOARD CERTIFIED
American Board of: _____
Certificate Date: _____

WORK HISTORY
Work History since Dental School "most recent position first"
(If additional space is needed for work history please attach a separate sheet)

Name/Address of Location	From MM/YYYY	To MM/YYYY

Work History Gap (please list/explain any work history gaps for more than 6 months)

Provides a detail of the prospective dentist's education, work experience and other qualifications since graduating from dental school (provide dates in mm/yyyy format please).

Completed File

Once the dentist has submitted all the necessary documents needed for credentialing to their Provider Relations Representative, Network Development Specialist, or to MCNA's Credentialing Department for verification, the credentialing file is considered complete.

PROCESSING TIME

MCNA's Credentialing Team will validate qualifications for participation. All applicants must be approved by MCNA's credentialing committee prior to participation. Upon submission of all required elements, our average turnaround time is 30-days.

Notification

- *All applicants must be approved by MCNA's credentialing committee prior to participation.*
- *Once the credentialing process is complete, the provider will be notified via a Welcome Letter from the Credentialing Department notifying them that they are credentialed, the date they are effective, and their provider and office identification numbers.*
- *If credentialing has been denied, a letter is sent via Certified Mail notifying the applicant of the reason for the denial.*

Confidential and Proprietary

Provider Orientation

Once the provider has been admitted as a participating MCNA provider, the Credentialing Department notifies the Provider Relations Department so the Provider Orientation and training can be scheduled within thirty (30) days of the effective date.

Confidential and Proprietary

Re-Credentialing

MCNA provider Re-Credentialing occurs every 3 years for all participating providers. The Credentialing Department will notify providers due for re-credentialing 120 days prior to the re-credentialing date via email, fax, and phone calls. Any provider who elects to not submit their application by their re-credentialing due date will be terminated.

Confidential and Proprietary

Additional Support

Your Provider Relations Team and Network Development Representatives are always available to provide assistance and guidance for any credentialing situation or questions that may arise.

Remember, we are here to help! We are your first point of contact.

Attachment 35-5
Provider Training Evaluation

MCNA Provider Training Evaluation Form

mcnadental

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?

_____

_____

_____

_____

_____

_____

Attachment 41-1
QI Program

2016 Quality Improvement Program Description

Nebraska Quality Assessment and Performance Improvement Program

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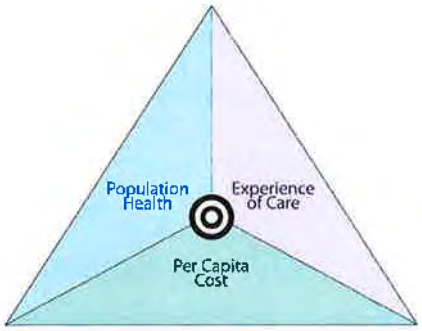
2016 Quality Improvement Program Description

The MCNA Quality Improvement Committee (QIC) has approved the 2016 Quality Assessment and Performance Improvement Program that includes the review and monitoring of internal systems, dental credentialing, management systems, and committee structures. Activities of the program fall under the direction of the Chief Dental Officer (CDO) who is a Doctor of Dental Surgery (DDS), the Nebraska Dental Director who is a DDS, and the Vice President of Dental Management and Quality Improvement. The Quality Assessment and Performance Improvement Program shall be known as the MCNA Quality Improvement Program (QI Program) and will be in compliance with state and federal requirements and laws and applicable accreditation standards.

MCNA will submit the QI Program description to the Nebraska MLTC for approval prior to implementation, and will notify the MLTC of changes in a timely manner. The ongoing QI Program is designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care, and to resolve identified problems using the prevailing professional standards of care. The QI Program is built on the foundation of the Institute for Healthcare Improvement's (IHI) Triple Aim framework approach to optimizing the U.S.'s health system and improving the quality of health care and health care delivery.



- Improving the patient experience of care (including quality and satisfaction);
- Improving the health populations;
- Reducing the per capita cost of health care.

IHI concluded that without a simultaneous focus on all three aims the U.S. would not be able to counter the predicted trends in healthcare expenditures. The National Healthcare Expenditure Projections, 2010-2020, cites the US health care system as the most costly in the world, accounting for 17% of the gross domestic product and estimates that percentage to grow to nearly 20% by 2020. MCNA is committed to the Triple Aim approach to ensure the Nebraska Medicaid recipients have a positive patient experience and improved overall oral health status while reducing the overall costs of health care delivery.

The QI Program is accompanied by a subset of written policies and procedures that describe multi-disciplinary processes to address components of effective healthcare management, and processes for ongoing monitoring and evaluation that promote quality of care. QI staff monitors key areas of dental care delivery to identify problems and achieve early recognition of opportunities to improve the delivery of quality dental care. MCNA does not delegate functions of quality assessment and performance improvement.

The QI Program includes performance improvement projects (PIPs) that are designed to enhance clinical and non-clinical efficiency. High risk and high volume areas of patient care receive priority in the selection of quality assessment and performance improvement activities. The PIPs are targeted towards improving utilization and are focused upon improving dental health outcomes, all while eliciting the highest levels of member and provider satisfaction. Specific interventions are determined and implemented based on the outcomes of PIPs, member and provider satisfaction surveys, performance measures, dental record audits, and other quality activities. Performance improvement projects that

include goals and objectives will also be implemented in response to the External Quality Review Organization's (EQRO) audit, in the event that the audit uncovers areas of opportunity. As required, MCNA will submit a separate improvement that specifically addresses the findings of the EQRO.

The QI Program provides a clear, concise statement of the mission, goals, and objectives of the plan. The ongoing internal and external review of the provision of dental care services shall include, but not be limited to, the following:

- A written statement of goals and objectives that stresses health outcomes as the principle criteria for the evaluation of the quality of care rendered to members;
- A written statement describing how state-of-the-art methodology has been applied to developing a case-orientated system for monitoring care, which when implemented, provides interpretation and analysis of patterns of care rendered to individual patients by individual providers;
- A written plan describing the program's objectives, organization, and problem-solving activities;
- A written plan describing oversight and delegation activities;
- Mechanisms to ensure the provision of policies and procedures to meet objectives; and
- Mechanisms to maintain, aggregate, and analyze information about the nature of issues raised by members, and on their resolution.

Quality Improvement Structure

The structure of the program requires the active participation of the executive leadership, contracted providers, and department leaders and managers through their involvement in the QIC in order to realize its full potential. The QIC ensures the effectiveness of the QI Program. Through interrelated QI subcommittees and structures, and a continuous flow of information, the QIC assesses information and data that measures MCNA operational and provider performance.

This structure enables MCNA to perform its core managed care processes through each of its operational departments: Utilization Management, Provider Relations, Network Management, Call Center Operations (Member Services), Quality Improvement, Grievances and Appeals and Claims (Operations). The Administration and Information Technology departments also provide support for these core processes. The framework of the QI Program ensures an ongoing process of exchanging information across organizational departments and to stakeholders to improve the quality of clinical care and services received by members. Details of the structure, processes, indicators, and outcomes are described in this QI Program and its attachments.

The QI Program ensures that findings, conclusions, recommendations, actions taken, and results of actions taken are documented and reported through the organization channels that have been established for quality assurance accountability to the QIC, Board of Directors, and relevant staff for the integration of best practices.

I. Preface

The success of the QI Program at MCNA is dependent upon a dedicated and knowledgeable group of professionals including, but not limited to, the administrative staff, committee members, department managers, and MCNA dental providers. All participants in the QI Program are committed to its objectives, processes, responsibilities, and authority. MCNA will pursue all opportunities to improve dental clinical care and services in accordance with MCNA policy and Medicaid regulations, as well as delegated requirements.

II. Purpose and Authority

The QI Program structure has been established by MCNA's Health Plan Board of Directors, who retains ultimate authority and accountability for the QI Program. The MCNA QI Program is designed to objectively initiate, monitor, and evaluate standards of dental practice that address the needs of the member. Assessment of standards, objectives, and outcomes is the mechanism by which patient care-related activities are evaluated, upgraded, and improved for the benefit of members and practitioners. The intention of the QI Program is to demonstrate accountability for the quality of dental care that is reviewed and approved by MCNA's QIC and all state and federal regulatory agencies.

The implementation, maintenance, and support of the QI Program fall under the authority of MCNA's QIC. The CDO maintains accountability for the overall function of the QI Program and serves as the chairperson of the QIC. MCNA's Nebraska Dental Director also maintains accountability for the QI Program and serves as the co-chair of the QIC and the Chair of its subcommittees. The QI Program's effectiveness is monitored and assessed by the QIC and reported to the Board of Directors. On an annual basis, the QIC reviews, assesses, makes recommendations, and approves the QI Program for the upcoming year. The Board of Directors also assesses the annual QI Program evaluation and makes recommendations as needed.

III. Roles and Responsibilities

The Board oversees and evaluates the impact and effectiveness of the QI Program, provides strategic direction, and ensures incorporation of the program into MCNA's business operations. The Board has delegated the development, implementation and review of the QI Program to the Quality Improvement Committee (QIC), chaired by MCNA's Chief Dental Officer (CDO), Dr. Ronald Ruth, and co-chaired by our Nebraska Dental Director, Dr. Scott Wieting.

The CDO is charged with the responsibility of implementing the QI Program. The CDO is responsible for the overall functioning of the QI Program and its results. The CDO, as the chair, and Dental Director as the co-chair, of the Quality Improvement Committee, are responsible for Quality Improvement, Credentialing, and Utilization Management functions. Qn an annual basis, the CDQ, Dental Director, the Vice President of Dental Management and Quality Improvement, and the Director of Quality Improvement and Risk Management develop a QI Program evaluation for the QIC's assessment and approval. The outcomes of the QI Program are reported to the Board of Directors.

MCNA's leadership is responsible for the oversight and prioritization of all individual and combined QI activities. MCNA management, staff, members, and providers are active participants in the QI Program. They are essential in assessing the quality of dental care and services provided to MCNA members and in recommending improvement strategies as needed. As part of the QI Program, these participants assist in identifying, planning, evaluating, and monitoring processes and outcomes related to member

care and services. For leadership development with quality improvement fundamentals, the CDO and Dental Director will attend quality forums and workshops throughout each calendar year that are held by healthcare quality organizations such as the Institute for Child Health Policy (ICHP), National Association for HealthCare Quality (NAHQ), and Health Care Compliance Association (HCCA).

- **Chief Executive Officer (CEO)**
  (DDS, MSD, and Board Certified Periodontist)
  Responsible for the plan's program management, financial oversight, staff management, public relations and coordination with partner organizations, and working with the Board to develop and implement a strategic vision.

- **Plan President**
  (DDS, MSD, Board Eligible Pediatric Dentist)
  Provides oversight and direction for MCNA's operations and clinical functions in the Nebraska, Iowa, Idaho, Texas, and Louisiana markets.

- **Nebraska Dental Director**
  (DDS, General Dentist)
  Provides oversight of the clinical aspects of the plan, ensures implementation of the QI Program, and monitors the dental care delivery system.

- **Nebraska Executive Director**
  (DDS, MS, Pediatric Dentist)
  Provides oversight of the administrative aspects of the plan, ensures implementation of the QI Program, and monitors the dental care delivery system.

- **Chief Operating Officer (COO)**
  Directs, coordinates, and manages the day-to-day operations of the plan and ensures that all services to members and providers are delivered in compliance with contractual requirements and in a timely manner.

- **Chief Dental Officer (CDO)**
  (DDS)
  Provides overall direction of and guidance for clinical activities of the plan, oversees the utilization management program, and monitors the utilization of dental services.

- **Chief Information and Security Officer**
  Oversees all aspects of the organization's information technology and systems. Also directs the planning and implementation of enterprise IT systems in support of business operations in order to improve cost effectiveness, service quality, and business development.

- **Chief Compliance and Privacy Officer**
  Ensures that there is an understanding of, and compliance with, MLTC regulations, and all Medicaid requirements. Coordinates and oversees new and ongoing audits, surveys, and reviews, and assures the monitoring of, responses to, reporting of and compliance with Medicaid legislation, regulatory, and policy requirements binding upon the plan.

- **Senior Vice President and General Counsel**
  Responsible for leading corporate strategic and tactical legal initiatives and providing senior management with effective advice on the plan's strategies and their implementation.

- **Vice President of External Affairs and Deputy General Counsel**
  Directs aspects of litigation of claims with General Counsel and manages in-house and outside organizational partnerships.

- **Vice President of Operations**
  Provides overall direction of and guidance for the non-clinical operational activities of the plan, with the objective of maximizing growth and profitability, as well as day-to-day leadership and management of all non-clinical company operations.

- **Vice President of Dental Management and Quality Improvement**
  Oversees all clinical functions involved in the administration of Medicaid and CHIP Dental Benefits and leads the Utilization Management, Case Management, and Quality Improvement departments.

- **Associate Vice President of Administration and Operations**
  Oversees all call center operations, provider relations, and member services, including member advocates outreach specialists, with the objective of ensuring access to care for our members and educating providers about the plan's benefit structure and business processes.

- **Director of Quality Improvement and Risk Management**
  Directs the day-to-day activities of the QI Program, and ensures compliance with regulatory agencies regarding quality management. Implements and provides ongoing oversight of the organization's internal risk management program.

- **Director of Utilization Management and Case Management**
  Provides leadership for the Utilization Management Department and oversees the Case Management Program. The Director establishes and implements workflow processes and monitors outcomes to ensure business goals and contractual requirements are met.

- **Director of Grievances and Appeals**
  Responsible for the direct oversight and administration of the grievances and appeals functions.

- **Director of Call Center Operations**
  Leads and directs the Member Hotline, Provider Hotline, and Care Connections Team. Ensures the department achieves overall quality service goals and delivers excellent levels of customer service.

- **Director of Network Development**
  Maintains networks of dental health providers throughout all regions of the states in which the plan operates.

- **Director of Credentialing**
  Ensures all network providers are fully credentialed in accordance with NCQA and URAC requirements. This includes a thorough background check to ensure providers are in good standing with all state and federal requirements.

- **Director of Claims Management**
  Leads department in all aspects of the organization's claims processing and payment activities, including claims auditing functions.

- **Director of Human Resources**
  Provides director oversight and administration of all human resource related policies and procedures, including ensuring that all MCNA clinical reviewers maintain the appropriate dental licensure.

IV. Scope

MCNA regards clinical quality of care and service performance measures (PMs) as critically important aspects of the dental managed care organization. MCNA will comply with MLTC's input and oversight regarding specific PMs to report, reporting format, and the reporting frequency. MCNA tracks PMs monthly and will comply with MLTC's reporting guidelines. The scope of the QI Program includes, without limitation, the objectives and approaches utilized in quality improvement together with measures that are quantifiable in accordance with contract performance standards and set benchmarks. The QI Program scope is comprised of actionable duties that are necessary to support and quantify demonstrable change for analyzing the successful delivery of dental services to the plan's population. In addition, the program scope details planned tasks and activities that support the QI Program's objective to initiate, monitor, and evaluate standards that impact the delivery of dental care and services to members. The identification, tracking, and trending of PMs includes:

- Evaluation of medical necessity appeals;
- Evaluation of access to services;
- Evaluation of clinical performance (peer review);
- Evaluation as to the appropriate use of tests, studies, and dental services (e.g., lab, x-ray);
- Measurement and evaluation of member satisfaction;
- Evaluation of and monitoring of call center performance measures for both the Member and Provider Hotlines that include average speed of answer, abandonment rate, and service level;
- Adherence to timeframes for claims processing;
- Evaluation of and monitoring of the timely payment of claims, and of the financial and procedural accuracy of claims processing;
- Evaluation of outcomes of care using criteria developed by dentists and other professionals to analyze patient care patterns and clinical performance for dental services provided;
- Evaluation and monitoring of the quality of provider services that includes the availability of services (access to providers, appointment procedures, etc.), the accessibility of services (telephone systems, Member Services, etc.) and member satisfaction with services;

- Establishment of a system using measurable criteria to identify, prioritize, and implement improvements to the quality of care and services;
- Compliance with the MCNA Credentialing Program (credentialing/re-credentialing) to determine that all providers meet MCNA standards;
- Analysis of the incident reporting system;
- Completion of utilization management (over-and under-utilization) analysis;
- Evaluation of case management functions;
- Completion of dental record reviews;
- Evaluation of claims data;
- Evaluation of member appeals;
- Evaluation of provider and member complaints and grievances;
- Completion of provider profiling;
- Completion of clinical focused studies performed by the quality improvement staff led by the CDO, Dental Director, Vice President of Dental Management and Quality Improvement, and the Director of Quality Improvement and Risk Management. The study topics are related to oral health objectives such as increasing the utilization of preventive dental service and access to the oral health system, and are based on MLTC's performance standards or national standards developed by the Centers for Medicare and Medicaid Services (CMS). Studies involve analyzing member data by race, sex, socioeconomics, and demographics;
- Evaluation of medical/dental records quarterly for:
    - History recording
    - Caries detection
    - Radiographic studies as appropriate
    - Written treatment plan
    - Preventive dental services
    - Indicated follow-up care;
- Evaluation of provider, member (consumer), and client satisfaction surveys; and
- Evaluation of practice office surveys.
- Evaluation of quarterly results in the Practice Site Performance Reports

All findings, conclusions, recommendations, and actions taken are documented and report through established organizational channels. All performance measures are evaluated and re-measured at least annually to monitor performance improvement.

V. Goals and Objectives

The goals of MCNA's QI Program have been established to align with, and strategically support, the National Quality Strategy (NQS) which is led by the Agency for Healthcare Research and Quality on behalf of the U.S. Department of Health and Human Services (HHS). The NQS consists of three aims, expanding on IHI's Triple Aim, six health care priorities, and nine levers/actionable items to execute their strategy. MCNA has adopted the NQS' three aims as our overarching goals to drive better, more affordable health care for Nebraska's Medicaid recipients.

- Better Care: Improve the overall quality, by making oral health care more patient-centered, reliable, accessible, and safe.
- Healthy People/Healthy Communities: Improve the health of the Nebraska population by supporting proven interventions to address behavioral, social, and environmental determinants of oral health in addition to delivering higher-quality care.
- Affordable Care: Reduce the cost of quality oral health care for individuals, families, and government.

MCNA has coupled the three aims/goals above with the national and Nebraska specific findings from the American Dental Association's report The Oral Health System: A State-by-State Analysis, 2016, to establish a defined process which:

- Achieves the optimum quality dental care through processes, structures, and data management systems in place at MCNA daily by the oversight of leadership for each operational department;
- Affirms the Quality Improvement Committee has the ultimate authority for, responsibility for, and accountability for the effectiveness of the QI Program on a quarterly basis through meetings to review the effectiveness of the QI Program's objectives and operational processes;
- Maintains a framework by which specific delegated responsibilities set for by MLTC to fulfill contractual obligations are met according to the contracted entity's delegated requirements through delegation oversight review on a quarterly basis at the QIC;
- Measures the level of accessibility, availability, and continuity/coordination of care, and facilitates Quality Improvement through appointment availability surveys, after-hours access, geo access, access related complaints, and on-site facility audits quarterly;
- Communicates all QI activities and outcomes achieved through the QI process throughout the organization, including to the providers, Board of Directors, management, staff, members, and the community through the Provider Newsletter monthly, the Quality Review newsletter quarterly, and the QIC quarterly, and weekly leadership meetings;

- Identifies and prioritizes strategies for the improvement of dental care and services utilizing the Plan-Do-Study-Act (PDSA), also called PDCA (Plan-Do-Check-Act), as a model for continuous improvement, starting new performance improvement projects, implementing change, planning data collection, and completing analysis in order to prioritize problems or root causes when conducting PIPs and measuring quarterly progress;

- Establishes thresholds and benchmarks annually, including performance indicators, through the review of the specific contract and national standard publications (i.e., American Dental Association, The Oral Health Care System: A State-by-State Analysis, 2016, Healthy People 2020, NCQA Quality Compass, National Health Interview Survey, US Centers for Disease Control and Prevention (CDC), Agency for Healthcare Research and Quality (AHRQ), and state-contracted external quality review organizations (EQROs).

- Identifies and prioritizes strategies for the improvement of dental care and services quarterly at QIC and weekly leadership meetings;

- Strives to improve and to enhance MCNA's dental care delivery system in compliance with accepted dental practices and assesses member acceptability, accessibility, and continuity of dental care and services routinely through weekly meetings with an assigned business analyst and reporting unit; and

- Cultivates a continuous quality improvement (CQI) management style that is woven throughout the organization with special emphasis on the member, measurement of key performance indicators, empowerment of employees, and a commitment to the improvement of dental care and services through quarterly QIC, subcommittee and Compliance Committee meetings, in addition to annual employee trainings and participation in company Compliance and Quality awareness activities. The CQI style is designed to meet the following objectives:

    - Educating members and providers through outreach and health education activities on a monthly or quarterly basis through community outreach and provider in-service trainings, webinars, or conferences;

    - Ensuring members are provided culturally and linguistically appropriate services with materials available in their primary language, accommodating communication assistance needs when requested, and routinely conducting office site visits;

    - Developing programs for populations with special needs through the Case Management Unit once data is analyzed and target audience is identified;

    - Conducting performance improvement projects and select studies in clinical and service areas in collaboration with state Medicaid agencies and EQROs yearly or as requested by the MLTC and EQRO;

    - Conducting satisfaction surveys for members and providers/practitioners;

- Fostering an environment that assists practitioners and providers with improving the safety of their practice by conducting monthly or quarterly office site visits;
- Conducting oversight of risk management through routine reporting at each quarterly QIC;
- Providing quarterly feedback to providers regarding opportunities for improvement both in practice management and clinical care in accordance with adopted ADA, AAPD, and EPSDT clinical practice guidelines; and
- Evaluating the effectiveness of the QI Program monthly.

VI. Compliance with MCNA, Medicaid, and Contracted Entity Requirements

The QI Program has been developed to be consistent with all federal and state Medicaid rules and regulations applicable to all MCNA-contracted entities, including providers.

VII. Conflict of Interest Statement

On an annual basis each director identifies any potential conflicts of interest that may exist in his or her role as a director of the organization. This may include, but is not limited to, relationships, associations, or business dealings with vendors, suppliers, or individuals with whom the organization may have a contractual relationship.

In the event that a director identifies a potential conflict of interest, he or she fully discloses all relevant information to the Chairman of the QIC. The Chairman, at his sole discretion, may discuss the matter with the Board of Directors or members of the corporation.

The Chairman gathers as much information as he or she feels necessary and then submits the matter to the members of the corporation for a determination. The determination of the members is final.

Any director, officer, or member of management is required to report to the Chairman any potential conflicts of interest that may exist or of which he or she may be aware.

Any director may at any time excuse himself or herself from discussions and/or determinations in connection with a conflict of interest with vendors or contractors with whom that director has a relationship.

VIII. Committee Structure

The Quality Improvement Committee has the authority to promote organizational accountability in identifying, assessing, and correcting quality of care issues, as well as in improving dental care services. Provider and organizational participation is essential in accomplishing these tasks. Membership Term: Annual, with no restrictions on member re-appointment.

The QIC and its four subcommittees are responsible for the implementation of and operation of the QI Program.

A. Quality Improvement Committee

The QIC meets on a quarterly basis. This committee is an interdisciplinary committee that includes administrative staff and dentists. The MCNA Board of Directors has delegated the implementation of and oversight of the QI Program to the QIC.

Members of the QIC are appointed by the Board of Directors. Its meetings are chaired by the CDO. All provider advisory appointments and member appointments are at the discretion of the chair.

QIC Membership

- Chaired by: Chief Dental Officer
- Co-Chairs: Nebraska Dental Director
- Plan President
- Nebraska Executive Director
- Chief Operating Officer
- Chief Information and Security Officer
- Chief Compliance and Privacy Officer
- Senior Vice President and General Counsel
- Vice President of External Affairs and Deputy General Counsel
- Vice President of Operations
- Associate Vice President of Administration and Operations
- Vice President of Dental Management and Quality Improvement
- Director of Quality Improvement and Risk Management
- Director of Utilization Management and Case Management
- Director of Grievances and Appeals
- Director of Call Center Operations
- Director of Network Development
- Director of Credentialing
- Director of Claims Management
- Director of Human Resources
- Clinical Reviewers (licensed dentists)
- Participating Network Dentists

Other departments may be represented by ad hoc members when necessary.

QIC Main Functions

The QIC is the functional means of the QI Program's implementation. The committee's main functions are:

- Providing oversight and review of the QI Program's subcommittees;
- Evaluating quality training materials prior to their dissemination, including CMS protocols;
- Implementing quality training for providers about standards for dental record keeping, utilization of preventative services (sealants, prophylaxis, and fluoride), missed appointments and continuity of care, oral hygiene instruction (brushing and flossing), and compliance with the American Academy of Pediatric Dentistry's periodicity schedule;

- Developing educational materials to teach parents and members about oral health and preventative services;
- Conducting review and giving input into strategies for targeting outreach to children with special health care needs, pregnant women, EPSDT eligible children, and adult members that have not seen a dentist in a 12-month period of time;
- Tracking indicators, reviewing studies and quarterly reports, and ensuring follow up on the resolution of opportunities for improvement;
- Suggesting and reviewing new and/or improved QI activities;
- Reviewing and approving all policies and procedures;
- Reviewing and approving the Dental Utilization Management Program and Plan;
- Assessing the quality and appropriateness of dental care furnished to members with special healthcare needs;
- Ensuring the completion of staff education and training related to QI activities;
- Providing guidance to staff on QI priorities and projects;
- Assuring the communication of necessary information with departments and services when problems or opportunities arise to improve patient care;
- Reviewing the scope, objectives, organization, and effectiveness of the QI Program at least annually, as necessary, and presenting the results to the Board of Directors;
- Determining issues and subjects for review (e.g., accessibility and availability studies);
- Approving quality indicators for each of the reporting departments;
- Approving the selection of PIPs and/or focused studies, as well as the study design procedures;
- Monitoring the QI work plan and program activities to ensure assigned tasks are initiated and completed according to schedule, and overseeing the documentation of the results of activities;
- Monitoring progress in meeting QI goals;
- Reviewing, approving, and monitoring corrective action plans;
- Researching, identifying, and removing any communication barriers that may impede members from effectively making complaints against MCNA;
- Reviewing all member complaints and grievances to identify areas for improvement, take corrective action, and assess their effectiveness;

- Ensuring a comprehensive, culturally competent network of dental services that members can readily access;
- Reviewing claims processing quality indicators on a quarterly basis;
- Conducting individual primary care dentist and primary care dentist practice quality performance measure profiling;
- Reviewing performance reporting on performance measures from delegated entities; and
- Reporting findings to the Board of Directors, relevant stakeholders, other departments, and contracted providers as required at least quarterly.

QIC Voting Rights/Procedures

- The QIC will operate by majority rule and a quorum.
- All QIC members will have voting rights on all non-clinical issues.
- Only clinical members will have voting rights for clinical issues.
- A quorum will be required when voting on dental issues.
- A quorum will consist of nine members with a minimum of five voting members.
- No member may vote if he or she is involved personally in the case.
- All matters that require the QIC's approval are reported as committee resolutions to the Board of Directors.

Each meeting will have an agenda. Minutes will be recorded and may be publicly displayed. Minutes of the previous meeting will be reviewed at each QIC meeting. They will be maintained in a locked file. Attendance will be taken at each QIC meeting. Attendance is mandatory for all members unless prior approval for an excused absence is obtained from the CDO.

2. The Credentialing Subcommittee

The Credentialing subcommittee of the QIC supports MCNA's credentialing and recredentialing efforts. This committee meets at least quarterly or as needed. During the Credentialing Committee (CC) meetings, issues and credentialing documents are examined thoroughly. Quarterly reports are presented to the QIC committee for review and action.

The Chairperson of the CC is appointed by the Board of Directors. The committee is chaired by the CDO and co-chaired by the Dental Director. All provider advisory appointments and member appointments are at the discretion of the chair and co-chair.

CC Membership

- Chaired by: Chief Dental Officer
- Co-Chaired by: Nebraska Dental Director
- Nebraska Executive Director
- Vice President of Operations
- Vice President of Dental Management and Quality Improvement
- Chief Compliance and Privacy Officer
- Clinical Reviewers
- Participating Dentists

- Director of Quality Improvement and Risk Management
- Director of Credentialing
- Associate Vice President of Administration and Operations
- Credentialing Coordinators

Other departments may be represented by ad hoc members when necessary.

CC Main Functions

- Approving or denying applicants seeking network participation.
- Reviewing and evaluating all issues, but specifically quality issues related to applicants and providers.
- Conducting ongoing monitoring and oversight of providers seeking recredentialing.

CC Objectives

The CC supports initial provider credentialing and recredentialing efforts. The CC is responsible for the evaluation of and approval of the quality of dental providers who provide services to MCNA members. The CC allows input from currently credentialed dentists regarding all credentialing review activities. The CC objectives are:

- To review and approve all dentists according to the Credentialing policies and procedures; and
- To review and make determinations on all clinical issues found during the verification process.

CC Voting Rights/Procedures

- The CC will operate by majority rule.
- All CC Committee members will have voting rights on all non-clinical issues.
- Only the provider members will have voting rights on clinical issues.
- A quorum will be required when voting on clinical issues.
- A quorum will consist of at least two of the three provider committee members.
- No member may vote if he or she is involved personally in the case.
- All final decisions and comments will be submitted to the QIC for final approval.

Each meeting will have an agenda. Minutes will be recorded and may be publicly displayed. Minutes of the previous meeting will be reviewed at each CC meeting. They will be maintained in a locked file. Attendance will be taken at each CC meeting. Attendance is mandatory for all members unless prior approval for an excused absence is obtained from the CDO.

3. The Peer Review Subcommittee

The Peer Review subcommittee of the QIC supports MCNA's efforts to provide due diligence to network providers regarding professional competence and provider disputes. It also works to ensure members receive high quality dental care according to prevailing standards of the dental care industry. The committee objectively and methodically assesses, evaluates, and resolves issues related to the quality and appropriateness of care, safety, and services.

Peer Review Membership

- Chaired by: Nebraska Dental Director
- Chief Dental Officer

- Director of Quality Improvement and Risk Management
- At least three qualified dentists, meeting the following criteria:
  - At least one of the providers must be a participating provider of MCNA who is not involved in network management and is a clinical peer of the participating provider that filed the dispute
  - One participating dentist who practices in the same specialty as the appealing provider
- Other departments may be represented by ad hoc members when necessary

Peer Review Main Functions

- Acting as the peer review component and providing resolution to provider disputes involving adverse patient incidents associated with professional competence, professional conduct, and the quality of care and services rendered to members.
- Reviewing the complaint or allegation against a provider and evaluating whether the severity of the issue requires a corrective action for that provider up to and including reduction, suspension, and termination from MCNA's participating provider network.
- Reporting the disposition of peer reviews to the QIC on a quarterly basis.

Peer Review Voting Rights/Procedures

- The Peer Review Committee will operate by majority rule.
- Only the qualified dentists will have voting rights.
- A quorum will consist of at least three qualified dentists (active license and non-excluded parties listed).
- No member may vote if he or she is involved personally in the case or if, for any reason, with or without disclosure, finds the need to recuse themselves.

Each meeting will have an agenda. Minutes will be recorded and they will be maintained in a locked file and may not be publicly displayed.

4. The Utilization Management Subcommittee

The Utilization Management subcommittee of the QIC supports the dental utilization management process for MCNA members. The Utilization Management Committee (UMC) monitors the medical appropriateness and necessity of dental care services utilizing clinical criteria and policy in addition to the effects of prior authorization utilization trends.

UMC Membership

- Chaired by: Nebraska Dental Director
- Co-Chair: Director of Utilization Management and Case Management
- Nebraska Executive Director
- Chief Dental Officer
- Clinical Reviewers
- Chief Compliance and Privacy Officer
- Vice President of Operations
- Vice President of Dental Management and Quality Improvement
- Director of Quality Improvement and Risk Management
- Director of Grievances and Appeals
- Managers of Utilization Management and Referrals

Other departments may be represented by ad hoc members when necessary.

UMC Main Functions

- Developing and assessing of the UM portion of the organizational QI Work Plan.
- Monitoring for the consistent application of medical necessity criteria and clinical practice guidelines.
- Reducing inappropriate and/or unnecessary dental services without adversely affecting the outcome of the delivery of services.
- Reviewing and assessing trends in clinical grievances and appeals and providing recommendations to the utilization review process based upon findings.
- Reviewing the effectiveness of the utilization review process and recommending changes to the process as needed.
- Reviewing effectiveness of the case management program and recommending changes to the processes and/or program as needed.

UMC Voting Rights/Procedures

- Only clinical members of the UM Committee have voting rights.
- The committee requires five members to attend for a quorum with a minimum of four voting members.

The UMC will maintain copies of all minutes, reports, and other documents in a manner ensuring strict confidentiality. Access to such documentation is restricted to regulating agencies and to those individuals who have prior authorization from the CDO. The minutes for each meeting will be maintained under the jurisdiction of the Director of Utilization Management and Case Management and may be publicly displayed.

5. The Grievances and Appeals Subcommittee

The Grievances and Appeals subcommittee of the QIC supports the continual improvement process for addressing member and provider dental complaints, grievances, and appeals, and the improvement of member and provider satisfaction. The Grievances and Appeals Committee (GAC) focuses on complaints, grievances, and appeals patterns in relation to the care and services provided to MCNA's members and providers.

GAC Membership

- Chaired by: Nebraska Dental Director
- Co-Chair: Director of Grievances and Appeals
- Nebraska Executive Director
- Chief Dental Officer
- Chief Compliance and Privacy Officer or Compliance Manager
- Associate Vice President of Administration and Operations
- Director of Call Center Operations
- Director of Quality Improvement and Risk Management
- Director of Claims Management
- Director of Utilization Management
- Manager of Provider Relations

Other departments may be represented by ad hoc members when necessary.

GAC Main Functions

- Reviewing complaints, grievances, and appeals reports and providing reports to the QIC.
- Performing analysis of reports to track and trend departmental effectiveness.
- Monitoring and developing corrective actions to improve outcomes.
- Incorporating any recommendations received back from QIC and revising interventions when necessary.

GAC Voting Rights/Procedures

- The GAC will operate by majority rule.
- A quorum will consist of at least six members with a minimum of four voting members.
- All GAC members will have voting rights on all non-clinical/dental issues.
- Only the provider members will have voting rights on clinical issues.
- No member may vote if he or she is involved personally in the case.

Each meeting will have an agenda. Attendance will be taken at each GAC meeting. Minutes will be recorded. Minutes of the previous meeting will be reviewed at each GAC meeting and may be publicly displayed. They will be maintained in a secured file in the Grievances and Appeals Department.

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

IX. Confidentiality

MCNA staff, committee members, and any other person who acts for or on behalf of MCNA are subject to MCNA's confidentiality policies and procedures. These comprehensive documents describe how MCNA complies with all HIPAA, HITECH, state, and federal laws and regulations, including 42 CFR 2.00.

Employees, committee members, consultants, and others must execute a confidentiality statement at the time of employment or committee appointment and annually thereafter. Access to personally identifiable health information or specific practitioner information and/or results of QI monitoring is provided on a need-to-know basis only, unless otherwise required by law. Member, practitioner, and facility information is confidential and subject to applicable state and federal law, utilizing the "minimum necessary" rule. Member dental records are kept in a locked environment, away from public access. Any data shared outside of MCNA is blinded and is not member identifiable. The Compliance Committee is responsible for the development, implementation, and monitoring of MCNA's confidentiality policies and procedures. MCNA's Compliance and Privacy Officer is a member of the Quality Improvement Committee.

Quality Improvement activities are confidential and are not considered discoverable or admissible in a court of law, under P.L. 2-603. The Health Care Quality Management Act (99-660, 19986) was enacted to improve the quality of medical/dental care and provides immunity from liability for damages with respect to actions taken in the course of such review. All Quality Improvement Committee (QIC) members and invited guests will sign a Confidentiality Agreement prior to participation in a meeting. All of the Confidentiality Agreements will be stored in the office of the Director of Quality Improvement and Risk Management.

X. Quality Improvement Activities with Other Departments and Functions

Quality Improvement is the responsibility of all staff, in all departments, all of the time. The following is a brief description of the monitoring activities conducted by the department to ensure quality improvement remains an active part of all areas within MCNA.

Member Services Responsibilities (Call Center Operations and Grievances and Appeals Departments)

- To handle member comments, inquiries, complaints, grievances, and appeals.
- To communicate Member's Rights and Responsibilities.
- To maintain a member's privacy and confidentiality; as well as to adhere to HIPAA privacy standards for identifying the member's identity with at least three pieces of information before releasing Protected Health Information (PHI).
- To monitor and report member satisfaction.
- To develop and implement member surveys, ensuring that opportunities for improvement are identified, actions are taken to improve service and care, and that follow up occurs.
- To monitor telephone activity to ensure quality member service.
- To track grievance and appeal timeliness.

Utilization Management Responsibilities

- To review inpatient and outpatient encounter data, noting trends and taking action as needed.
- To determine pre-authorizations, specialty referrals, second opinions, and/or cases of special circumstances.
- To evaluate the effects of prior authorization utilization.
- To reconsider appeals based upon new supporting evidence and supportive documentation.
- To report high-risk events such as large case management and adverse determinations.
- To ensure staff compliance with policies and procedures.
- To ensure provider adherence to Standards of Care.
- To conduct inter-rater reliability tests.
- To direct and analyze periodic reviews of enrollee service utilization patterns.

Case Management Responsibilities

- To manage the integration of resources from MCNA, providers, and the community in order to provide effective care for members who qualify for the Case Management Program.
- To coordinate with management activities regarding quality initiatives.
- To refer members for dental specialty care.
- To coordinate care for Children with Special Health Care Needs.
- To document emergency room care and use for the tracking of outcomes when applicable.

Provider Relations Responsibilities

- To provide education for providers, in conjunction with the QI Department, related to the program through updates to the Provider Manual, site visits, etc.
- To ensure that provider contracts are up to date.
- To ensure the appropriate availability of dental services.
- To monitor, investigate, and implement resolution for provider complaints and appeals.
- To conduct surveys that measure and monitor provider satisfaction and to implement interventions as warranted.
- To analyze and report on the Provider Satisfaction Survey results.
- To ensure network adequacy through the evaluation of GEO Access reports of member access-related complaints and of the provider network for deficient access points.
- To provide education for charting error reduction and encourage providers to adopt electronic health/dental records (EHRs).

Credentialing Responsibilities

- To oversee audits of provider files for completeness and accuracy.
- To coordinate, with the QI Department, review of providers with quality of care issues during the credentialing and recredentialing processes.
- To process and track initial and re-credentialed primary and specialty providers in addition to facilities.
- To process and track the termination and/or suspension of primary and specialty providers, as well as facilities.

Risk Management/Patient Safety

- To report risk management/patient safety issues to the QIC.

- To comply with all state and federal risk management requirements.
- To evaluate and, if necessary, refer risk management/quality of care/patient safety issues from the staff or other outside sources to the appropriate MCNA client representative, or state or federal regulatory official.

Improvement of Health Outcomes

- To report clinical and administrative performance measures to the QIC.
- To comply with all state and federal clinical and administrative reporting requirements.
- To evaluate compliance with performance standards.
- To identify performance trends for early and periodic screening, diagnostic, and treatment (EPSDT) services for member age categories.
- To report PMs and PIPs data by race, sex, and demographics.
- To identify improvement opportunities and development interventions at the QIC.

Information Systems Responsibilities

- To provide the system resources dedicated to the QI Program.
- To provide support for the QI Department in generating the regular and ad hoc reports needed to analyze the member population and trends in care.
- To monitor turnaround time for the receipt and posting of eligibility.

Enrollment Responsibilities

- To report monthly membership enrollment by prescribed due dates.
- To ensure member enrollment materials and annual benefit packets are mailed timely.

Claims Responsibilities

- To report on the timeliness of claims payments to the QIC on a monthly basis.
- To ensure follow-up on complaints from members and providers regarding claims payment, and to report the information to the QIC on a monthly basis.

Human Resources Responsibilities

- To conduct monthly New Employee Orientation.
- To provide staff education about dental managed care and QI activities.
- To conduct audits of employee files.

Compliance Responsibilities

- To develop and implement compliance-related standards, training, and monitoring for MCNA.
- To enforce protocols and ensure mechanisms are in place that provide corporate-wide compliance for exchanging Protected Health Information (PHI) and complying with the Health Insurance Portability and Accountability Act (HIPAA).
- To analyze regulatory environment and legal requirements and identify specific risk areas.
- To develop standards of operations to promote legal and ethical behavior.
- Monitor internal and external audits and reviews for the purpose of indentifying problems and implementing corrective and preventable action.
- To develop a Fraud, Waste, and Abuse Committee to review preliminary and full investigations and make recommendations.
- To develop a Special Investigations Unit (SIU) to collect and trend data (practice and utilization patterns) for provider profiling to identify irregularities and possible fraud, waste and abuse.

XI. Patient Safety

The following program is in place for collecting and providing information that addresses potential or identified patient safety issues. Regardless of delegated functions, whenever potential quality-of-care concerns are identified, the safety of the member is secured prior to communication with the responsible entity. Throughout the year, the QI Department collaborates with the health plans, providers, and members to improve the identification of, and response to, safety issues in treatment communities.

Identification of potential patient safety issues and quality of care concerns is accomplished through adverse incident reporting, member and provider complaints/grievances regarding quality of care issues, MCNA staff reports from utilization review, case management reviews and site visits, and member satisfaction data. All potential safety and quality of care concerns are reported to the Quality Improvement Committee and investigated by the QI Department in conjunction with the Utilization Management and Provider Relations departments. The timeframe of the initiation of an investigation will depend upon the seriousness of the situation. For the most serious cases, where members are clearly at risk of imminent harm, investigation begins immediately. For all other situations, investigation begins within one business day.

XII. Approach to Serving a Culturally and Linguistically Diverse Membership

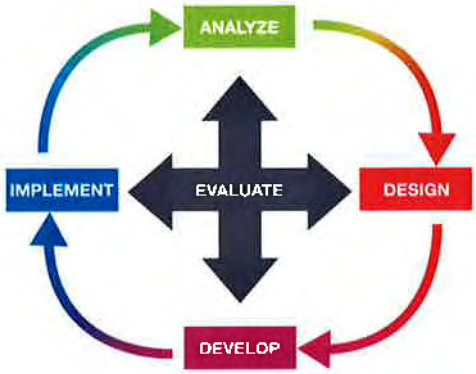
In accordance with 42 CFR 438.206, MCNA has a comprehensive written Cultural Competency Program (CCP) describing MCNA's system to ensure that services are provided in a culturally competent manner to all members, including those with limited English proficiency. The CCP describes how providers, MCNA employees, and information systems will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms, and

respects the worth of the individual enrollees and protects and preserves their dignity. The CCP is updated annually and submitted to the QIC form approval and reported to the Board of Directors.

MCNA may distribute a summary of the CCP to network providers if the summary includes information about how the provider may access the full CCP on the MCNA website. A complete description of the program can be found in the Cultural Competency Program description.

XIII. Evaluation of the QI Program and Annual Work Plan

The QIC reviews the progress of the QI Program monthly. A comprehensive evaluation of the QI Program is completed annually and is used to develop the following year's program. All documents are approved through the QIC and reported to the Board of Directors.



The QI Department, in collaboration with the Quality Improvement Committee, develops an Annual Work Plan. In conjunction with contracted entity input and department leaders, the Annual Work Plan is updated annually. Results are reported to the QIC. On an annual basis, the work plan is reviewed by the QIC and reported to the Board of Directors. As necessary, selected areas of performance from the work plan may be brought to the QIC and Board of Directors more frequently. The Annual Work Plan may be expanded whenever additional opportunities for quality improvement are identified. In the event MCNA does not meet contract specific performance targets for Performance Measures, the QI Department and appropriate personnel will adhere to the state agency's requirements for submission of a corrective action plan in accordance with the contract timeframe (e.g. 60 calendar days after being notified) that provides resolution to the identified deficiencies. MCNA may also be subject to sanctions for poor performance on quality and performance measures.

QI Program Evaluation

Under the direction of the CDO and Vice President of Dental Management and Quality Improvement, and with input from department heads, the Director of Quality Improvement and Risk Management produces a formal written assessment of the effectiveness of the QI Program. The assessment reviews the previous year's quality projects, initiatives, measurement techniques, prevention activities, and outcomes. It guides the development of the QI Program for the next year, and informs departmental QI plans. The evaluation assists staff in identifying the priority areas for study, annual quality improvement initiatives, resources needed to achieve objectives, and timeframes for the implementation of and the completion of initiatives.

The QIC reviews the evaluation report and assesses the adequacy of the program assessment. The QIC approves the evaluation. Information about this evaluation is published in the MCNA Provider newsletter, and providers are informed that the evaluation in its entirety is available on the MCNA website Provider Portal and in hard copy by request. The recommendations of the QIC are incorporated into the new annual work plan. The annual evaluation results are shared with all MCNA staff through summaries presented in departmental and staff meetings, and the entire evaluation report is posted on the MCNA Intranet site.

XIV. Monitoring and Identifying Opportunities for Improvement

MCNA utilizes Key Performance Indicators (KPIs) to measure, analyze, and improve performance. Indicators are selected and defined by developing standards for performance, which take into account contractual requirements that are to be met. The selection and definition of indicators also includes the review of contract and state-specific and national standard publications (i.e., Healthy People 2020, NCQA Quality Compass, National Health Interview Survey, US Centers for Disease Control and Prevention (CDC), Agency for Healthcare Research and Quality (AHRQ), and state-contracted external quality review organizations (EQROs)). The KPIs are approved by the QIC and reported to the Board of Directors. Below are examples of KPIs.

Key Performance Indicators	
Telephone Access Measure	**Performance Standard**
Percent % of Call Center calls answered by a live person or IVR within 3 rings or 15 seconds	95%
Average daily hold time after initial IVR response <2 minutes	95%
Call Center call abandonment rate %	< 3%
Utilization Management Measure	**Performance Standard**
Percent % of standard service authorizations processed with 14 calendar days or as extended within allowable timeframes	100%
Grievances Measure	**Performance Standard**
Percent % of grievances acknowledged within 5 business days of receipt	100%
Percent % of grievances resolved within 21 business days	100%
Claims Measure	**Performance Standard**
% of clean paper claims paid within 30 calendar days of receipt	100%
% of clean electronic claims paid within 14 calendar days of receipt	100%

The indicators are monitored through standard reporting requirements that each department head uses to assess progress. This reporting allows for structured communication with the QI Department. The KPIs are a standing agenda item for the QIC and subsequently reported to the Board of Directors.

XV. Dedicated Resources

In support of QI, MCNA provides information systems resources and other support staff that have the responsibility for working with personnel in each clinical and administrative department to identify problems related to quality of care for all covered dental care and professional services. Resources are available to aid in prioritizing problem areas for resolution, designing strategies for change, implementing improvement activities, measuring success, and determining if dental care is acceptable under current state and federal standards.

Title	FTE
Chief Executive Officer	0.2
Plan President	0.5
Nebraska Dental Director	1.0
Nebraska Executive Director	0.8
Chief Operating Officer	0.2
Chief Dental Officer	0.5
Chief Information and Security Officer	0.3
Chief Compliance and Privacy Officer	0.5
Senior Vice President and General Counsel	0.1
Vice President of External Affairs and Deputy General Counsel	0.2
Vice President of Operations	0.5
Vice President of Dental Management and Quality Improvement	0.3
Associate Vice President of Administration and Operations	0.5
Director of Quality Improvement and Risk Management	1.0
Director of Utilization Management and Case Management	0.4
Director of Grievances and Appeals	0.3
Director of Call Center Operations	0.5
Director of Network Development	0.3
Director of Credentialing	0.2
Director of Claims Management	0.2
Director of Human Resources	0.2
Manager of Quality Improvement	1.0
Manager of Credentialing	0.2
Manager of Member Advocate Outreach Specialists	0.5
Clinical Reviewer(s)	0.3
Provider Relations Representative (x3)	0.3
Credentialing Specialist (x2)	0.2

Attachment 43-1
Summer Sealant Slam Materials

July 25, 2016

Smith Family Dentistry
123 Main Street
Baton Rouge, LA 70801

RE: 2016 Summer Sealant Campaign

Dear MCNA Provider:

We are pleased to announce the launch of our 2016 Summer Sealant Campaign. At MCNA, we take pride in delivering high quality access to dental care and service excellence to our participating providers. As you may know, in 2010 the Centers for Medicare and Medicaid Services (CMS) challenged all states to increase the rate of sealant use for 6-9 year olds by 10 percentage points over a five-year period. Increasing sealant use for our members is a top priority for MCNA but we cannot accomplish this without your help.

To better understand the barriers providers face in the delivery of sealants, we sought counsel from our Louisiana Dental Advisory Group (DAC), which is comprised of MCNA participating providers, and representatives from the LSU School of Dentistry and the Louisiana Dental Association (LDA). The DAC is the voice of our provider network and they have given us the following recommendations for increasing sealant use:

1. **Increase the fee associated with each sealant.** As part of MCNA's Summer Sealant Campaign, we will be adding $10.00 to our standard fee for each sealant placed on all eligible 6-9 year olds on dates of service from July 25, 2016 to September 30, 2016.

   [Terms: $10.00 will be added to Code D1351 rate ($25.51 + $10.00) for sealants applied to first permanent molars TID Nos. 3, 14, 19, and 30.]

2. **Place a notification banner on the eligibility screen for 6-9 year olds.** MCNA has added a Benefit Alert that will appear on the eligibility screen for all 6-9 year olds in the portal and on the print eligibility confirmation page.

3. **Distribute a roster of eligible members to providers so they can contact members and schedule an appointment.** MCNA has attached an additional listing of eligible members that were seen by your practice at least once during the last nine months. This listing includes only 6-9 year olds who are currently eligible to receive sealants in

accordance with the Louisiana benefits. We are requesting your assistance in outreaching to these members to schedule an appointment for AAPD recommended preventive care, including sealants. For your convenience, we have included the member's last date of service in your practice and the most recent member contact information.

In addition to the foregoing initiatives, MCNA will assist you in making the most of our 2016 Summer Sealant Campaign as follows:

- Our Care Connections Team of skilled multi-lingual member advocates is making outbound calls to members to provide education about the benefits of preventive care and to assist them with scheduling an appointment.
- We are sending text message reminders promoting preventive dental care and our member services hotline to assist members in scheduling an appointment.
- We are collaborating with the LSU School of Dentistry to hold a Sealant Saturday event inviting only those members who do not yet have a dental home.
- Our Member Services team reviews every incoming member call for internal care gap alerts, including those for sealants. The representatives will make every effort to assist the member with scheduling an appointment prior to completing the call.

MCNA recognizes the time and effort you and your staff commit to providing services to our members. We strive to reduce your administrative burden as much as possible so that you can focus on the delivery of high quality dental care. We sincerely appreciate your partnership and look forward to improving the clinical outcomes for Louisiana's EPSDT members

Sincerely yours,

DeDe Davis
Vice President of Dental Management
And Quality Improvement

Dr. David McKeon
Executive Director, Louisiana Plan

mcnadental

MCNA's 2016 SUMMER SEALANT SLAM is in Full Swing!

Don't forget - our sealant campaign is happening now and we need your office to help us reach our goals for increasing sealant placement for Louisiana EPSDT members.

We will add $10.00 to our standard fee

for each sealant placed on first permanent molars (TIDs 3, 14, 19, and 30) of eligible Louisiana EPSDT members aged 6 – 9 years.

The Summer Sealant Slam benefits your office and children in the Louisiana EPSDT Dental Program by:

- Automatically increasing your reimbursement by **$10.00** for CDT code **D1351** each time you submit a claim for any eligible MCNA member on **dates of service from July 25, 2016, to September 30, 2016.**
- Increasing awareness and utilization of dental sealants as a powerful preventive service.
- Providing MCNA members without a dental home access to these services at special **Sealant Saturday** events, which are hosted by MCNA in partnership with the Louisiana State University School of Dentistry.

For more information, please call MCNA's Provider Hotline at **1-855-701-6262.** We look forward to connecting with you about this initiative and how we can assist your office in providing this important preventive service to the greatest number of members possible.

mcnadental

Do you need help finding a dentist? Please call MCNA's Member Hotline at **1-855-702-6262** and we will help you schedule an appointment.

You can also visit our website at **www.mcnala.net** to search for a dentist with our Provider Directory.

Toll Free: (855) 702-6262 • TTY: (800) 846-5277 • Web: http://www.mcnala.net • Follow us on

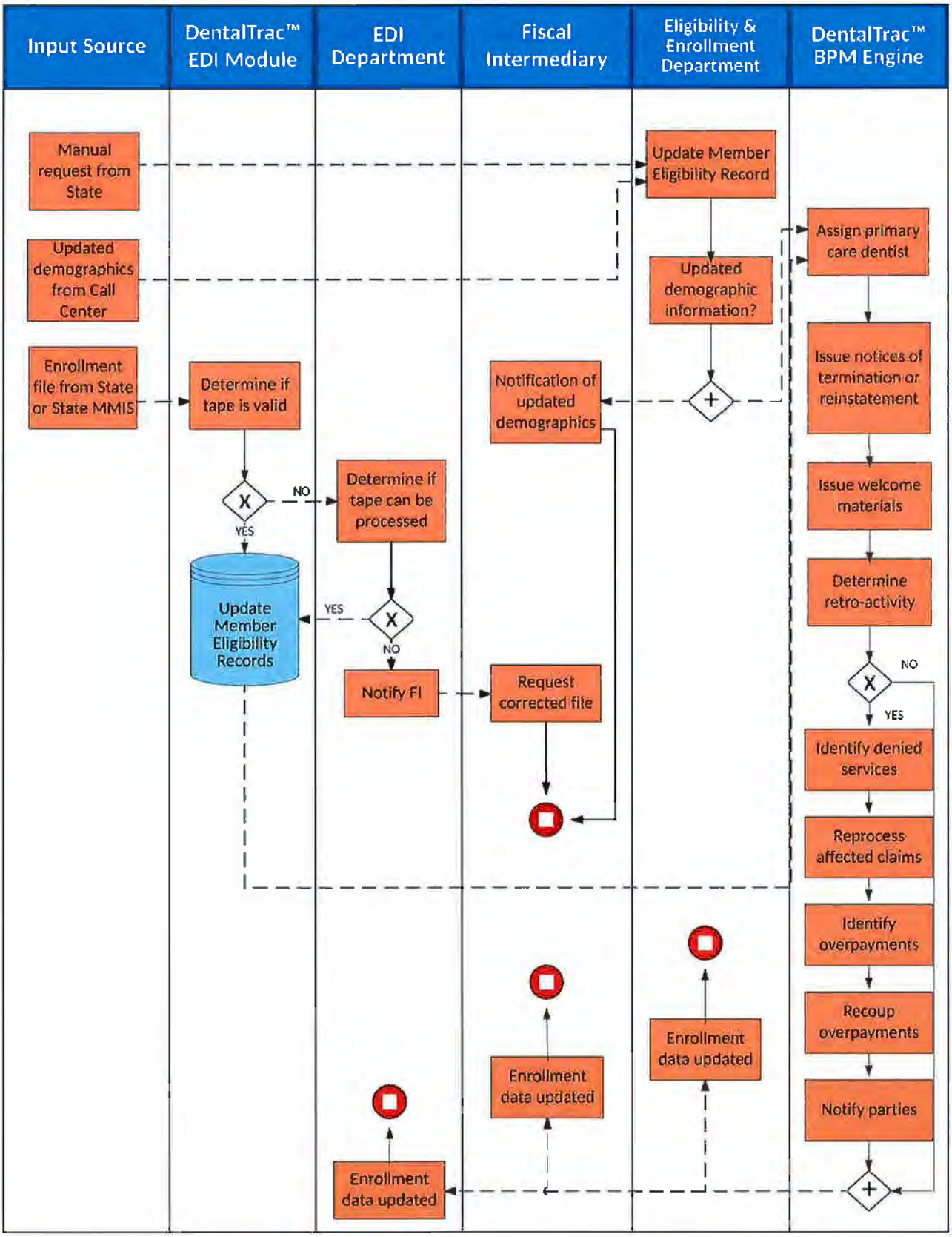
MCNA_LA-M_SUMMER-SEALANT-POSTCARD-2016[1.0]

Attachment 50-1
Prior Authorization Flowchart

This content has been redacted.

Attachment 63-1

Enrollment and Eligibility Flowchart



Attachment 64-1
Information Data Security Policy

This content has been redacted.

Attachment 64-2
Information Management Plan

This content has been redacted.

Attachment 65-1
Disaster Recovery Plan

This content has been redacted.

This content has been redacted.

NEBRASKA Administrative Services

Byron L. Diamond
Director

Pete Ricketts, Governor

ADDENDUM SIX
REVISED SCHEDULE OF EVENTS

Date: November 4, 2016

To: All Bidders

From: Michelle Thompson/Teresa Fleming, Buyers
AS Materiel State Purchasing Bureau

RE: Addendum for Request for Proposal Number 5427Z1

	ACTIVITY	DATE/TIME
8.	Evaluation period	~~November 4 – 18, 2016~~ October 31, 2016 – November 30, 2016
9.	"Oral Interviews/Presentations and/or Demonstrations" (if required)	TBD
10.	Post "Letter of Intent to Contract" to Internet at: http://das.nebraska.gov/materiel/purchasing.html	~~November 23, 2016~~ December 7, 2016
11.	Contract finalization period	~~November 28, 2016 – January 3, 2017~~ December 7, 2016 – January 16, 2017
12.	Contract award	~~January 3, 2017~~ January 16, 2017
13.	Contractor start date	July 1, 2017

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal.

NEBRASKA Administrative Services

Byron L. Diamond
Director

Pete Ricketts, Governor

ADDENDUM FIVE
#34 QUESTION and ANSWER

Date: October 25, 2016

To: All Bidders

From: Michelle Thompson/Teresa Fleming, Buyers
AS Materiel State Purchasing Bureau

RE: Addendum for Request for Proposal Number 5427 Z1
to be opened October 31, 2016 at 2:00 p.m. Central Time

Questions and Answers

Following are the questions submitted and answers provided for the above mentioned Request for Proposal. The questions and answers are to be considered as part of the Request for Proposal. It is the Bidder's responsibility to check the State Purchasing Bureau website for all addenda or amendments.

Question Number	RFP Section Reference	RFP Page Number	Question	State Response
34.	Section II.P	Page 6	According to the Nebraska Secretary of State's Office, and Chapter 21 Section 20,168 (4) The Requirements of the Business Corporation Act shall not be applicable to foreign or alien insurers, which are subject to the requirements of Chapter 44. Please confirm that a foreign insurer authorized to transact the business of accident and health insurance by the Nebraska Department of Insurance will not be required to submit a Secretary of State certification with their bid, pursuant to Section II.P of the RFP.	Confirmed, though effective January 1, 2017, Neb. Rev. Stat. 21-20,168(4) is replaced by a materially identical provision found at section 202 (MBCA 14.40) of LB749 (2014). However, the contractor may be required to provide a Certificate of Authority or a Certificate of Good Standing from the Department of Insurance.

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal.

RFP 5427 Z1
Addendum Four – Additional Revisions to RFP

#	Document	Section	Change From:	Change to:
1	RFP	IV.A.e.iii.a	Two (2) DBPM networks in Cass, Dodge, Douglas, Gage, Lancaster, Otoe, Sarpy, Saunders, Seward, and Washington counties.	Two (2) MCO networks in Cass, Dodge, Douglas, Gage, Lancaster, Otoe, Sarpy, Saunders, Seward, and Washington counties.
2	RFP	IV.A.e.iii.b	Two (2) DBPM networks in Adams, Antelope, Arthur, Banner, Blaine, Boone, Box Butte, Boyd, Brown, Buffalo, Burt, Butler, Cedar, Chase, Cherry, Cheyenne, Clay, Colfax, Cuming, Custer, Dakota, Dawes, Dawson, Deuel, Dixon, Dundy, Fillmore, Franklin, Frontier, Furnas, Garden, Garfield, Gosper, Grant, Greeley, Hall, Hamilton, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Jefferson, Johnson, Kearney, Keith, Keya Paha, Kimball, Knox, Lincoln, Logan, Loup, Madison, McPherson, Merrick, Morrill, Nance, Nemaha, Nuckolls, Pawnee, Perkins, Phelps, Pierce, Platte, Polk, Red Willow, Richardson, Rock, Saline, Scotts Bluff, Sheridan, Sherman, Sioux, Stanton, Thayer, Thomas, Thurston, Valley, Wayne, Webster, Wheeler, and York counties.	Two (2) MCO networks in Adams, Antelope, Arthur, Banner, Blaine, Boone, Box Butte, Boyd, Brown, Buffalo, Burt, Butler, Cedar, Chase, Cherry, Cheyenne, Clay, Colfax, Cuming, Custer, Dakota, Dawes, Dawson, Deuel, Dixon, Dundy, Fillmore, Franklin, Frontier, Furnas, Garden, Garfield, Gosper, Grant, Greeley, Hall, Hamilton, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Jefferson, Johnson, Kearney, Keith, Keya Paha, Kimball, Knox, Lincoln, Logan, Loup, Madison, McPherson, Merrick, Morrill, Nance, Nemaha, Nuckolls, Pawnee, Perkins, Phelps, Pierce, Platte, Polk, Red Willow, Richardson, Rock, Saline, Scotts Bluff, Sheridan, Sherman, Sioux, Stanton, Thayer, Thomas, Thurston, Valley, Wayne, Webster, Wheeler, and York counties.
3	RFP	IV.D.2; Table 1	Add new section	The Dental Director must be licensed to practice in the State of Nebraska.
4	RFP	IV.G.12.c	Add new section	The provider may discontinue seeing their members as long as they provide their members thirty (30) days of emergency care while in transition of finding a new dental home.

5	RFP	IV.G	Add new section	14. Member Handbook a. The DBPM must develop, maintain, and post to the member portal of its website a member handbook in both English and Spanish. In addition to the requirements described in this RFP, the handbook must comply with the requirements in 42 CFR 438.10. b. The draft member handbook must be submitted to MLTC for review and approval a minimum of thirty (30) calendar days after date of award. c. The DBPM must publish the member handbook on its website in the member portal. It must also have hard copies available and inform members how to obtain a hard copy member handbook if they want it. d. At a minimum, the DBPM must review and update the member handbook annually. The DBPM must submit the updated handbook to MLTC for review and approval a minimum of 45 calendar days before it is to be implemented. If the DBPM wishes to make changes to the handbook more frequently than annually, the revised language must still be submitted to MLTC a minimum of 45 calendar days prior to proposed implementation. e. The DBPM's updated member handbook must be made available to all members on an annual basis, through its website. When there is a significant change in the Member Handbook, the DBPM must provide members written notice of the change a minimum of 30 calendar days before the effective date of the change, that they may receive a new hard copy if they want it, and the process for requesting it. f. At a minimum, the member handbook must include: i. A table of contents. ii. A general description of basic features of how the DBPM

				operates and information about the DBPM in particular. iii. A description of the Member Services department, what services it can provide, and how member services representatives (MSRs) may be reached for assistance. The member handbook shall provide the toll-free telephone number, fax number, email address, and mailing address of the Member Services department as well as its hours of operation. iv. A section that stresses the importance of a member notifying Medicaid Eligibility of any change to its family size, mailing address, living arrangement, income, other health insurance, assets, or other situation that might affect ongoing eligibility. v. Member rights/protections and responsibilities, as specified in 42 CFR 438.100 and this RFP. vi. Appropriate and inappropriate behavior when seeing a DBPM provider. This section must include a statement that the member is responsible for protecting his/her ID cards and that misuse of the card, including loaning, selling, or giving it to another person, could result in loss of the member's Medicaid eligibility and/or legal action. vii. Instructions on how to request no-cost multi-lingual interpretation and translation services. This information must be included in all versions of the member handbook. viii. A description of the dental home selection process and the dental home's role as coordinator of services. ix. The member's right to select a different dental home within the DBPM network. x. Any restrictions on the member's freedom of choice of DBPM providers. xi. A description of the purpose of the Medicaid and DBPM ID cards, why both are necessary, and how to use them.

				xii. The amount, duration and scope of benefits available to the member under the contract between the DBPM and MLTC in sufficient detail to ensure that members understand the benefits for which they are eligible. xiii. Procedures for obtaining benefits, including authorization requirements. xiv. The extent to which, and how, members may obtain benefits, including from out-of-network providers. xv. Information about health education and promotion programs, including chronic care management. xvi. Appropriate utilization of services including not using the ED for non-emergent conditions. xvii. How to make, change, and cancel dental appointments and the importance of cancelling or rescheduling an appointment, rather than being a “no show”. xviii. Information about a member’s right to a free second opinion per 42 CFR 438.206(b)(3) and how to obtain it. xix. The extent to which, and how, after-hours and emergency coverage are provided, including: a) What constitutes an emergency medical condition, emergency services, and post-stabilization services, as defined in 42 CFR 438.114(a) and 42 CFR 422.113(c). b) That prior authorization is not required for emergency services. c) The process and procedures for obtaining emergency services, including use of the 911-telephone system. d) That, subject to provisions of 42 CFR Part 438, the member has a right to use any hospital or other setting for emergency care. xx. The policy about referrals for specialty care and for other benefits not furnished by the member’s dental home.

				xxi. How to obtain emergency and non-emergency medical transportation. xxii. Information about the EPSDT program and the importance of children obtaining these services. xxiii. Information about member copayments. The charging of a copayment is at the discretion of the DBPM. If the DBPM chooses to ask its providers to charge copayments, this cost-sharing must be in compliance with 42 CFR 447.50 through 447.57, and cannot exceed the amounts specified at 471 NAC 3-008. xxiv. The importance of notifying the DBPM immediately if the member files a workers' compensation claim, has a pending personal injury or medical malpractice lawsuit, or has been involved in an accident of any kind. xxv. How and where to access any benefits that are available under the Medicaid State Plan that are not covered under the DBPM's contract with MLTC, either because the service is carved out or the DBPM will not provide the service because of a moral or religious objection. xxvi. That the member has the right to refuse to undergo any medical service, diagnosis, or treatment or to accept any health service provided by the DBPM if the member objects (or in the case of a child, if the parent or guardian objects) on religious grounds. xxvii. Member grievance, appeal, and state fair hearing procedures and timeframes, as described in 42 CFR 438.400-424 and this RFP, as follows: a) For grievances and appeals: 1). Definitions of a grievance and an appeal. 2). The right to file a grievance or appeal.

				3). The requirements and timeframes for filing a grievance or appeal. 4). The availability of assistance in the filing process. 5). The toll-free number(s) the member can use to file a grievance or an appeal by telephone. 6). The fact that, when requested by a member, benefits can continue if the member files an appeal within the timeframes specified for filing at 477 NAC 10-001. Pursuant to the same regulation, the member should also be notified that the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member. b) For state fair hearing: 1). Definition of a state fair hearing. 2). The right to request a hearing. 3). The requirements and timeframes for requesting a hearing. 4). The availability of assistance to request a fair hearing. 5). The rules on representation at a hearing. 6). The fact that, when requested by a member, benefits can continue if the member files a request for a state fair hearing within the timeframes specified for filing at 477 NAC 10-001. Pursuant to the same regulation, the member should also be notified that the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member. xxviii. How a member may report suspected provider fraud and abuse, including but not limited to, the DBPM's and MLTC's toll-free telephone

				number and website links created for this purpose. xxix. Any additional information that is available upon request, including but not limited to: a) The structure and operation of the DBPM. b) The DBPM physician incentive plan (42 CFR 438.6). c) The DBPM service utilization policies. d) How to report alleged marketing violations to MLTC. e) Reports of transactions between the DBPM and parties in interest (as defined in section 1318(b) of the Public Health Service Act) provided to the State. xxx. A minimum of once a year, the DBPM must notify members of the option to receive the Member Handbook and the provider directory in either electronic or paper format.

6	RFP	IV.G	Add new section	15. Member Website a. The DBPM must maintain a website that includes a member portal. The member portal must be interactive and accessible using mobile devices, and have the capability for bi-directional communications (i.e., members can submit questions and comments to the DBPM and receive responses). b. The DBPM website must include general and up-to-date information about the Nebraska Medicaid program and the DBPM. All material to be included on the website must be submitted and approved by MLTC in advance of its intended posting. MLTC will review and approve or request changes as quickly as practical but within 30 calendar days of receipt. c. The DBPM must remain compliant with applicable privacy and security requirements (including but not limited to HIPAA) when providing member eligibility or member identification information on its website. d. The DBPM website should, at a minimum, be in compliance with Section 508 of the Americans with Disabilities Act, and meet all standards the Act sets for people with visual impairments and disabilities that make usability a concern. e. The DBPM website must follow all written marketing guidelines included in Section IV G - Member Services and Education. f. Use of proprietary items that would require use of a specific browser or other interface is not allowed. g. The DBPM must provide the following information on its website, and such information must be easy to find, navigate among, and be reasonably understandable to all members:

				i. The most recent version of the member handbook in both English and Spanish. ii. Telephone contact information for the DBPM, including the toll free customer service number prominently displayed and a telecommunications device for the deaf (TDD) number. iii. A searchable list of network providers, with a designation of open or closed panels. This directory must be updated in real time, for changes to the DBPM network. iv. A link to the enrollment broker's website and the enrollment broker's toll free number for questions about enrollment. v. A link to the Medicaid Eligibility website (http://accessnebraska.ne.gov) for questions about Medicaid eligibility. vi. Information about how to file grievances and appeals.

7	RFP	IV.G	Add new section	16. Requirements for Member Materials a. The DBPM must comply with the following requirements for all written member materials, regardless of the means of distribution (for example, printed, web, advertising, and direct mail). b. The DBPM must write all member materials in a style and reading level that will accommodate the reading skill of DBPM members. In general, the writing should be at no higher than a 6.9 grade level, as determined by the Flesch–Kincaid Readability Test. c. MLTC reserves the right to require the DBPM to submit evidence that written member materials were tested against the 6.9 grade reading-level standard. d. The DBPM must distribute member materials to each new member within 30 calendar days of enrollment. One of these documents must describe the DBPM's website, the materials that the members can find on the website and how to obtain written materials if the member does not have access to the website. e. Written material must be available in alternative formats, communication modes, and in an appropriate manner that considers the special needs of those who, for example, have a visual, speech, or hearing impairment; physical or developmental disability; or, limited reading proficiency. f. All members and Medicaid enrollees must be informed that information is available in alternative formats and communication modes, and how to access them. These alternatives must be provided at no expense to each member. g. The DBPM must make its written information available in the prevalent non-English languages in the State. Currently, the prevalent non-English language in

				the State is Spanish. The DBPM must make its written information available in any additional non-English languages identified by MLTC during the duration of the contract. h. All written materials must be clearly legible with a minimum font size of twelve-point, with the exception of member identification (ID) cards, or as otherwise approved by MLTC. i. The quality of materials used for printed materials must be, at a minimum, equal to the materials used for printed materials for the DBPM's commercial plans, if applicable. j. The DBPM's name, mailing address, (physical location, if different), and toll-free telephone number must be prominently displayed on all marketing materials, including the cover of all multi-page materials. k. All multi-page written member materials must notify the member that real-time oral interpretation is available for any language at no expense to them, and how to access those services. l. All written materials related to DBPM enrollment and dental home selection must advise members to verify with their usual providers that they are participating providers in the selected DBPM and are available to see the member. m. Marketing materials must be made available by the DBPM across the State. Materials may be customized for particular locations or populations within the State. n. All marketing activities must provide for equitable distribution of materials without bias toward or against any group. o. Marketing materials must accurately reflect information that is applicable to an average member of the DBPM. p. In all member materials, the DBPM must include the date of issue or revision.

				q. Copies of all member mailings/materials (print and multimedia) must be provided.
8	RFP	IV.I.9	Add new section	g. The DBPM must completely process credentialing applications from the provider within thirty (30) calendar days of receipt of a completed credentialing application. A completed application includes all necessary documentation and attachments. h. "Completely process" means that the DBPM must: i. Review, approve, and load approved providers to its provider files in its system and submit the information in the weekly electronic provider file to MLTC or MLTC's designee, or ii. Deny the application and ensure that the provider is not used by the DBPM. A provider whose application is denied must receive written notification of the decision, with a description of his/her/its appeal rights.
9	RFP	IV.D.2, Table 1	1. Planning and working with Provider Services staff to expand and enhance physical and behavioral health services for American Indian members.	1. Planning and working with Provider Services staff to expand and enhance dental services for American Indian members.
10	RFP	IV.P.5.b	b. Pursuant to Neb. Rev. Stat. §71-831, the DBPM must hold back 2% of the aggregate of all income and revenue earned by the DBPM and related parties under the contract in a separate account. The hold-back constitutes the maximum amount available to the DBPM to earn via the quality performance program.	b. Pursuant to Neb. Rev. Stat. §71-831, the DBPM must hold back 1.5% of the aggregate of all income and revenue earned by the DBPM and related parties under the contract in a separate account. The hold-back constitutes the maximum amount available to the DBPM to earn via the quality performance program.

11	RFP	IV.V.4	The DBPM must have a contracted provider network in place, sufficient in size and composition, to meet MLTC's access standards and the requirements of the covered population ninety (90) calendar days prior to the contract's start date. The DBPM should submit to MLTC a network development plan with its proposal. This plan must be updated upon contract award and bi-weekly until the contract start date. The plan must detail the DBPM's network, including GeoAccess reports, and describe any provider network gaps and the DBPM's remediation plans. Additional requirements regarding network adequacy are included in Section IV.I – Provider Network Requirements of this RFP.	The DBPM must have a contracted provider network in place, sufficient in size and composition, to meet MLTC's access standards and the requirements of the covered population thirty (30) calendar days prior to the contract's start date. The DBPM should submit to MLTC a network development plan with its proposal. This plan must be updated upon contract award and bi-weekly until the contract start date. The plan must detail the DBPM's network, including GeoAccess reports, and describe any provider network gaps and the DBPM's remediation plans. Additional requirements regarding network adequacy are included in Section IV.I – Provider Network Requirements of this RFP.

12	RFP	IV.U.4.iv	iv. Network Performance Requirement Between the date of award and the contract start date, the DBPM must have a contracted provider network in place, sufficient in size and composition to meet the service requirements of its members on the contract start date. The required attestation of network sufficiency must be submitted to MLTC a minimum of ninety (90) calendar days prior to the contract start date. MLTC may assess a penalty of $1,000.00, per calendar day, for each day that the provider network is not adequate to meet the service needs of its members.	iv. Network Performance Requirement Between the date of award and the contract start date, the DBPM must have a contracted provider network in place, sufficient in size and composition to meet the service requirements of its members on the contract start date. The required attestation of network sufficiency must be submitted to MLTC a minimum of thirty (30) calendar days prior to the contract start date. MLTC may assess a penalty of $1,000.00, per calendar day, for each day that the provider network is not adequate to meet the service needs of its members.
13	Attachment 12	Provider Network List	**Description:** Submit list of all network providers via the provider enrollment file as described in Section IV.I - Provider Network. **Due Date:** 90 days prior to contract start date.	**Description:** Submit list of all network providers via the provider enrollment file as described in Section IV.I - Provider Network. **Due Date:** 30 days prior to contract start date.
14	Attachment 11	#58	Section IV.O – Program Integrity	Section IV.R – Claims Management

Byron L. Diamond
Director

Pete Ricketts, Governor

ADDENDUM THREE
QUESTIONS and ANSWERS

Date: October 21, 2016

To: All Bidders

From: Michelle Thompson/Teresa Fleming, Buyers
AS Materiel State Purchasing Bureau

RE: Addendum for Request for Proposal Number 5427 Z1
to be opened October 31, 2016 at 2:00 p.m. Central Time

Questions and Answers

Following are the questions submitted and answers provided for the above mentioned Request for Proposal. The questions and answers are to be considered as part of the Request for Proposal. It is the Bidder's responsibility to check the State Purchasing Bureau website for all addenda or amendments.

Question Number	RFP Section Reference	RFP Page Number	Question	State Response
1.	Glossary of Terms	xiii	Appears to be a very broad definition of subcontractors, covering any entity that does any work related to the contract, example, a company that simply assembles creditialing information for DentaQuest to review to make creditialing decisions. Is that the intent?	A subcontractor is any organization or person who provides a function or service outside the scope of a provider agreement.
2.	Project Desctition and Scope of Work	Page 140 j-Subcontractors	There are several detailed requirements, such as page 140 tracking hours, in which we do not do for most of our subcontractorsIn the cases it does not apply, is it okay to put "not applicable" in these circumstances?	The intent is for the bidder to provide i -iv for any and all subcontractors. If "not applicable" is the appropriate response, provide as such.
3.	Attachment 7, 8 and 14	Attachment 7, 8 and 14	Will you be providing a narrative that identifies the specific data assumptions and methodologies behind the specific payment rates for each age band?	Please review the PowerPoint presented during the Pre-Proposal Conference for the specific assumptions within the rate development. MLTC will provide a data book when the rates are updated in the Spring of 2017. The PowerPoint can be found at the following website: http://das.nebraska.gov/materiel/purchasing/5427/5427.html. And the direct link to the PowerPoint is: http://das.nebraska.gov/materiel/purchasing/5427/Optumas%20Dental%20Rate%20Presentation.pptx
4.	Attachment 7	Attachment 7	What Fee Schedules were used during the experience period as well as any fee schedule changes during the experience period and expected during contract year?	The underlying reimbursement for the rate development is Medicaid FFS. The only fee schedule change was for the repricing of the UNMC provider services at the average of the top 5 Commercial Dental Providers in Nebraska.

5.	Attachment 7 and 14	Attachment 7 and 14	Will you be providing membership growth or decline as well as providing monthly membership in relation to FY 2014, FY 2015 and future expectations?	Due to the fluctuation in the monthly membership, the annual membership provided in Attachment 7 is a more accurate data point to use in your own calculation of risk as it relates to the capitation rates offered in the RFP. The projected membership has not been fully defined as it related to the upcoming biennium budget.
6.	Attachment 7, 8 and 14	Attachment 7, 8 and 14	Will you be providing the member access rates (Current) and Expected?	The access rate assumed within the rate development is consistent with the access rate that was present within FFS during the base data time period of FY14-FY15. The State's actuaries will not be providing any additional information surrounding expected access.
7.	Attachment 7, 8 and 14	Attachment 7, 8 and 14	What assumptions were used for Trending?	Please see Slide 9 and 10 of the FY18 Rates PowerPoint that was presented during the Pre-Proposal Conference for the trend assumptions. The PowerPoint can be found at the following website: http://das.nebraska.gov/materiel/purchasing/5427/5427.html. And the direct link to the PowerPoint is: http://das.nebraska.gov/materiel/purchasing/5427/Optumas%20Dental%20Rate%20Presentation.pptx
8.	Attachment 7 and 14	Attachment 7 and 14	Will you be providing Claim Lag data for the FY 2014 and FY 2015?	Since the IBNR adjustment shown on Slide 7 of the Optumas Dental Rate Presentation (please find link in the response to Question 7) is "de minimis" no further information will be provided.
9.	Attachment 7, 8 and 14	Attachment 7, 8 and 14	Will you be providing the assumptions for Coordinated care savings or Managed care savings?	There are no assumptions for coordinated care savings or managed care savings. Those savings are dependent upon how the DBPM manages the program. The State

				does not anticipate savings, but requires the DBPM to manage a more efficient and sustainable program.
10.	Attachment 7	Attachment 7	Will you be providing DCode level experience/utilization?	Yes, please see Attachment 16.
11.	Attachment 7, 8 and 14	Attachment 7, 8 and 14	Will you be providing any program changes assumed in the rating?	All adjustments, including policy adjustments was shared during the Pre-proposal Conference (please find link in the response to Question 7).
12.	Attachment 7, 8 and 14	Attachment 7, 8 and 14	Confirmation that "Net Medical Rate" only includes claim cost.	Confirmed.
13.	Attachment 7, 8 and 14	Attachment 7, 8 and 14	Confirmation that "Loaded Rate" excludes ACA/HIPF Taxes.	Since the program is new during FY18, the ACA/HIPF tax does not apply during the first contract year.
14.		Page viii	**"Auto assignment"** states that an enrollee, who does not select a dental home within a predetermined length of time during enrollment activities is automatically assigned to a dental home." How does automatic assignment work?	The DBPM will develop an algorithm that MLTC must approve. The algorithm may account for previous member-provider relations, familial relations, provider location, etc.
15.			Can dentists through the DBM get assistance with reasonably priced language interpretation so they are in compliance with OCR 1557 Rule? Language line is approximately $4.95/minute. Can this be added to the contract?	This will not be required of the DBPM. The DBPM could propose this as a value-add service.
16.			What is the total cost of the contract? We couldn't find it listed. If you do the math, it appears to be in the range of $55 million. Why is not just stated?	The total cost of the contract is dependent on the final capitation rates and the membership mix for each month of the contract.
17.			Can you require that the dentist portal include the ability to access the amount of	The bidder should provide a response that meets the requirements of the RFP.

			the $1,000 cap that has been spent for an adult patient? Otherwise, the dentist has no way of knowing what was spent in another clinic and could go over the cap.	
18.		Page 38	"*Providers may not bill members any amount greater than would be owed if the DBPM provided the services directly (i.e., no balance billing by providers is permitted)*." With a $1,000 cap on adult benefit, how will non-covered services be handled? How will covered services once the member reaches the annual maximum be handled? Are these determinations being left to the DBPM?	The DBPM may provide value-added services above what Medicaid currently covers. There are no planned changes to the policy related to Non-covered services.
19.		Page 40	"*The Dental Director must be currently licensed as a Doctor of Dentistry ("dentist") with no restrictions or other licensure limitations*." – The Dental Director should be licensed in the state of Nebraska.	Please see Addendum Four, #3.
20.		Page 48	*Value added services: Minimizing the occurrences of missed appointments through member incentives, technology-based appointment reminders, member education, or other mechanisms identified by the DBPM*. Consider that case management services also be included specifically in this sentence.	Case management is not precluded as a proposed value-added service.
21.	**8(e)(ii)**	Page 8	discusses minimizing the occurrences of missed appointments through member incentives, technology-based appointment reminders, member education, or other mechanisms identified by the DBPM. Is there a mechanism that requires the DBM to track missed/late cancelled appointments to help the Provider?	No. MLTC identified that as a priority for potential value-added services, but the DBPM will have the discretion to decide which value-added services it would like to propose. Please see Section IV.E.8.d.

22.		Page 57	Notice to Members of Provider Termination mentions "When timely notice from the provider is received, the notice to the member must be provided within fifteen (15) calendar days of the receipt of the termination notice from the provider." Timely notice is not defined. Include standard protocol that a dentist may to discontinue seeing a patient as long as patient is provided 30 days of emergency care while in transition of finding a new dental home.	Please see Addendum Four, #4.
23.			Can MLTC require the dentist portal to include what dental services the patient has received in the last 12 months to avoid duplicating services and billing? For example, dentist #1 could place a sealant, but in 6 months it falls off. Dentist #2, not knowing that the sealant was placed, billed, and lost, places another sealant and bills for it. Now dentist #2 is in violation of the rule that sealants can only be billed out every 2 years.	Please see response to Question 17.
24.		Page 64/65	*For the first year of the contract period, the DBPM must accept into its network any dental provider participating in the Medicaid program provided the dental provider is licensed and in enrolled with DHHS and accepts the terms and conditions of the contract offered to them by the DBPM. This provision also does not interfere with measures established by the DBPM to control costs and quality consistent with its responsibilities under this contract nor does it preclude the DBPM from using different reimbursement amounts for different*	The DBPM and provider will negotiate reimbursement through the contracting process but are required to reimburse no less than the published Medicaid fee-for-service rate in effect on July 1, 2016 for the first year of the contract.

			specialties or for different practitioners in the same specialty [42 CFR §438.12(b)(1)]. Note this opens the door to the DBPM negotiating rates with individual providers just like the commercial sector. Some dentists may experience lowering reimbursement rates especially after the first year. It sounds like the DBPM can pay a differentiated rates for dentists in network for good reason (under provider incentives). Good reason might be one dentist in the whole community/county being in network or a lack of specialists and one specialist is seeing a disproportionate amount of patients/members. Are we understanding this correctly?	
25.		Page 68	*Credentialing and Re-credentialing of Providers and Clinical Staff* – The contract does not appear to stipulate how quickly credentialing should be accomplished. This is a problem in some states that takes up to 6 months to credential a new provider and this becomes an issue. 30 days is preferred.	Please see Addendum Four, #8.
26.		Page 74	The DBPM must develop, establish, and maintain a provider advisory committee to create network development and management strategies and procedures. Include the requirement that the DBPM should share the *Reporting Dashboard* (page 125) with the advisory committee.	The Reporting Dashboard is an internal tool to ensure accountability. While MLTC or the DBPM may share the dashboard with external stakeholders, MLTC will not include that requirement in the RFP.
27.		Page 77	*QAPI Committee*: The RFP asks the DBPM to describe how they will get provider input into any QAPI plan. Include a representative from the NDA on the QAPI Committee.	Per Section IV.M.2.a.i-iii of the RFP establishes the minimum QAPI Committee membership. The bidder should provide a response that meets the requirements of the RFP.

28.		Page 82	*The DBPM must submit an electronic copy of the UM policies and procedures to MLTC for written approval within thirty (30) calendar days from the date of award, annually thereafter, and prior to any revisions*. The NDA requests that state to share this for input or request the state include a requirement in the contract that the DBPM needs to seek input on these from the NDA.	The bidder must meet all of the requirements of this RFP. The bidder should provide a response that meets the requirements of the RFP.
29.		Page 99	*For the first year of the contract, the DBPM rate of reimbursement must be no less than the published Medicaid fee-for-service rate in effect on July 1, 2016, unless MLTC has granted an exception for a provider-initiated alternative payment arrangement*." Can MLTC stipulate that the FFS fee schedule is the floor always rather than just the first year?	No, the DBPM and the providers should negotiate and contract alternative payment methods rather than only rely upon the fee schedule.
30.			Will the provider manual be available to dentists before they are asked to sign the provider contract?	MLTC will require the DBPM to submit for approval to MLTC its provider manual within thirty (30) days after contract award. Providers are free to contract with the DBPM before or after receiving the Provider Manual.

31.		Page 111	*MLTC reserves the right to review any claim paid by the DBPM or its designee. The DBPM has the right to collect or recoup any overpayments identified by the DBPM from providers of service in accordance with existing laws or regulations. However, if an overpayment is identified by the State or its designee one year or later from the date of payment, the DBPM will collect and remit the overpayment to MLTC. In the event the DBPM does not collect mispayments from the provider within 30 calendar days of notification of the overpayment, the DBPM must refund the overpayment to MLTC. Failure by the DBPM to collect an overpayment from a provider does not relieve the DBPM from remitting the identified overpayment to MLTC*." Nowhere in the contract does it say how far back the DBPM can go to claim overpayments. Neb.Rev.Stat. § 68-974 states that all recovery audit contractors retained by the department when conducting a recovery audit shall review claims within two years from the date of the payment. Does this two year lookback period apply to the DBPM? If not, include a two year lookback limitation.	The bidder must meet all of the requirements of this RFP. MLTC cannot limit the timeframe associated with any audit the Medicaid program is subject to.
32.			Would you mind clarifying Form A Bidder Contact Sheet? Do you have a specific order or location you would like this included in the response?	Bidders should complete Form A, Bidder Contact Sheet and include with their proposal response. The State does not have a specific order or

				location. The sections of the proposal response should be separated by an identified tab.
33.	Section IV.C.2	Page 35	Will a certificate of authority to conduct the business of accident and health insurance issued by the Nebraska Department of Insurance to a foreign (Texas) insurer satisfy the licensure requirements of this RFP?	No, the contractor will be required to obtain a certificate of authority from the State of Nebraska before go live.
34.	Section II.P	Page 6	According to the Nebraska Secretary of State's Office, and Chapter 21 Section 20,168 (4) The Requirements of the Business Corporation Act shall not be applicable to foreign or alien insurers, which are subject to the requirements of Chapter 44. Please confirm that a foreign insurer authorized to transact the business of accident and health insurance by the Nebraska Department of Insurance will not be required to submit a Secretary of State certification with their bid, pursuant to Section II.P of the RFP.	The State is looking into this and will provide a response at a later date.
35.	Section D Staffing Requirements 2.c	Page 38	Is the replacement of key staff approved by state prior to job offer? Is this also required for initial hires?	MLTC must approve initial and replacement hires of key staff prior to the key staff starting.
36.	Section D Staffing Requirements	Page 42	What will Dental QA and Government Quality be doing, separation of responsibilities?	MLTC requires the DBPM to employ a staff member dedicated to the daily business of quality management and improvement. MLTC's role in quality assurance is to review and audit the DBPM's quality measures and initiatives.

37.	Section E Core Medicaid Dental Benefits	Page 45	How often are the state benefit grid (from website) updated with CDT codes?	The program reviews the yearly release of any new code updates from the ADA around November or December for the following year. MLTC implements or makes needed additions or revisions to the codes and fee schedule for a January 1 release. MLTC also reviews and adds or revises the fee schedule during our fiscal year with a release date of each July 1.
38.	Section E Core Medicaid Dental Benefits	Page 45	Will we have access to the incumbent's current clinical guidelines?	This is a new program and there is no incumbent. Nebraska Medicaid's clinical guidelines can be found in the Medicaid & Long-Term Care Rules and Regulations.
39	Section H Grievance and Appeals	Page 59	Is there a time period when a member cannot file a grievance, i.e. 180 days after date of service or occurrence?	The DBPM must establish their grievance system that meets all relevant Federal and State regulatory requirements.
40.	Section H Grievance and Appeals 4.d.ii	Page 61	Requirement of only 1 level of appeal-does it then required to go to a Fair Hearing?	Per 42 CFR 438.402, the DBPM may have only one level of appeal for enrollees.
41.	Section H Grievance and Appeals 7.a	Page 63	Are all Fair Hearings telephonic? Are there any requirements to present in person?	Fair hearings are held in the DHHS Hearing Office in the State Office Building in Lincoln. The parties are permitted to appear in person or by telephone.
42.	Section H Grievance and Appeals 7.a	Page 65	Will we be provided the number of grievances, appeals, Fair Hearings historically?	The Fair Hearing Office opens appeals as directed by the Divisions. They opened 2 Medical Assistance Dental appeals in 2016 and 10 in 2015. In addition, they opened 99 Recovery Audit Contractor appeals in 2015, all of which appear to

				involve dental providers. It is estimated that a number of appeals opened as Medical Assistance Payment appeals involved dental providers, but they do not track those appeals by provider type.
43.	Section I Provider Network Requirements	Page 64	Will the State consider Letters of Intent or Letters of Agreements as acceptable for the necessary network coverage requirements?	Letters of Intent and Letters of Agreement are not required as part of the proposal. MLTC will determine network adequacy by the provider enrollment file, as well as data and analysis attesting to the sufficiency of the DBPM's network.
44.	Section I Provider Network Requirements 1.f	Page 65	Can the Plan terminate providers "without cause"	No, except when the provider does not act on re-validation. In this case, the plan may terminate.
45.	Section I Provider Network Requirements 1.h.v	Page 65	Is the methodology of the access surveys determined by the dental plan?	Yes, but the DBPM must submit the survey for MLTC's approval.
46.	Section I Provider Network Requirements 5.c	Page 66	We do not currently contract and list prosthodontists, will this be required for NB?	No. Contracts are not required but the services must be available.

47.	Section I Provider Network Requirements 5.e	Page 67	Is the dental plan able to interpret this requirement, and have a mechanism to require some requirements for specialty referrals, or are all specialty referrals to be "self-directed"?	The DBPM will submit their proposed process for MLTC approval during contract finalization.
48.	Section V Proposal Instructions A	Page 138	Where would the State prefer the Scope of Work response to be included within the Technical Proposal?	The State does not have a specific order. The sections of the proposal response should be separated by an identified tab.
49.	Attachment 4 Dental Access Standards		Will the State be providing a census?	Yes, please see Attachment 17. This is a census based on CFS service areas, which can be found here: http://dhhs.ne.gov/children_family_services/Documents/SvcAreaMap-NEW.pdf
50.	Attachment 14 - COA-level Rate Development	Page 3	There is an UNMC % adjustment applied to the base data. Can you please provide additional detail on what this adjustment accounts for and how it was calculated?	The State provided their actuary with the UNMC provider IDs. The State's actuary used that information to identify the UNMC claims inherent in the FFS data, and repriced the claims to an enhanced fee schedule provided by the State. This enhanced fee schedule reflects the average reimbursement of the top 5 Commercial Dental Providers in Nebraska.
51.	Attachment 1		Are there any limitations on the levels of Incentive Bonuses or Activities that improve health care quality that can be included as Net Qualified Medical Expense?	The definition for activities that improve quality is consistent with the Medicaid Managed Care Final Rule released by CMS. As such, there is no predefined maximum associated with these types of services.

52.	Attachment 1		Please define what is considered to be "related-party medical margin"	Related-party medical margin is any margin built into sub-capitation arrangements between a parent and subsidiary company, to the extent they exist.
53.	Attachment 1		Is the 2% Hold Back included in the calculation of "revenue earned" described in Section 3 of the MLR Calculation description? If so, is an adjustment allowed in the event a porion of the holdback is not ultimately "earned" by the DBPM?	The MLR calculation will include the portion of the hold back that is ultimately earned by the DBPM.
54.	Attachment 7		Please describe what, if any, adjustments have been made to the base experience data presented in the data book. Were any claims excluded and, if yes, why? Was there any repricing of historical claims to reflect payment at 100% of the dental fee schedule?	No dental claims were excluded. All claims are reimbursed at a 100% dental fee schedule so claims were not repriced.
55.	Attachment 7		Can the state provide the mapping used to align dental service codes with the CoS descriptions contained in the data book?	Please see Attachment 18.
56.	Attachment 7		Please describe the methodology used to categorize members in specific age cells. Is cell determined based on age at a point in time or does a member change cells within a SFY on their birthdate?	The rating cohorts are based on the member's age at the time the claim was incurred within the rate development. Operationally, a member's age cohort will be determined on a monthly basis when capitation payments are made.
57.	Attachment 7		Does the state anticipate any significant shifts in the projected population distribution relative to what was seen in the base experience period(s)? If yes, please describe.	MLTC does not anticipate shifts in the population distribution relative to the base data.

58.	Attachment 7		Please confirm that the Units column reflects the sum of actual service units submitted for each claims and does not represent visits or encounters.	Confirmed.
59.	Attachment 8		Please confirm that there are no planned adjustments to the capitation rates shown in this exhibit. It is assumed rates will be paid as shown with no adjustments for risk, region, gender differences in a particular DCO's membership distribution.	The rates will be updated in the Spring of 2017 to incorporate more recent base data and any new policy changes that may be in effect during the FY18 contract period.
60.	Attachment 13		Please provide a file containing projected membership by each county within the state	Due to counties having populations small enough to potentially identify individuals enrolled in Medicaid, MLTC cannot provide that information. However, please see the response to Question 49.
61.	Attachment 14		Please provided further detail around the UNMC Repricing factors applied in the rate development. What is the purpose of this adjustment? How were the SFY14 and SFY15 Adjustments estimated?	Please see response to Question 50. There was no estimated adjustments because MLTC had actual data.
62.	Attachment 14		What is the rationale for the 50/50 blending of SFY14 and 15 claims experience? I would expect greater weight would be assigned to the more recent data.	During the rate development process the FY14 data is trended forward one year to FY15 in order to place both years of data on the same basis prior to blending. There were no significant reasons that led MLTC to believe the FY15 base data more accurately represents the expected experience for the FY18 contract period, thus an equal blend of FY14 and FY15 was used when developing the final rates.

63.	Attachment 14		Please describe the process for determining the 2.0% Utilization Trend assumed in the rate development. Any detailed analysis supporting this estimate would be appreciated.	MLTC reviewed historical FFS data to help inform the aggregate PMPM trend across all services. This aggregate PMPM trend was uniformly distributed between the utilization and unit cost components of the trend assumption. These trend assumptions will be refined at the more detailed category of service level when the FY18 rates are updated in the Spring of 2017.
64.	Attachment 14		Please describe the process for determining the Unit Cost Trend assumed in the rate development. Are there any known changes to the state fee schedule included in this estimate? Any detailed analysis supporting this estimate would be appreciated.	See the response to Question 63.
65.	Attachment 14		Please confirm that the rate development assumes the annual trends shown in this exhibit will be compounded annually across a 36 month period. Additionally, please confirm that the annualized trends are EXACTLY as they appear in the exhibit (i.e. rounded to the nearest tenth of a percent) and that the 36 month compounding is NOT rounded in the calculation.	Confirmed. The FY14 base data was trended for 12 months in order to place both years of data on the same basis prior to blending. The two years were then blended together and trended from the midpoint of the FY15 time period (12/30/2014) to the midpoint of the FY18 time period (12/30/2017). The trends shown during the Pre-proposal Conference are the exact trends used in the rate development. However, please note that trends are applied at the COA and COS level of detail. As such, the trends shown on the “COA Rate Development” exhibit will be the effective COA trends across all services.

66.	RFP Document P.2.k	97	Can the state provide the certification document referenced in P.2.k on page 97? The rate development has been provided in Attachment 14 but the accompanying narrative would be helpful in better understanding the specific components of the development.	MLTC will provide a databook when the rates are updated in the Spring of 2017.
67.	RFP Document P.7.	101	Please provide further detail around the supplemental payments DBPM's are required to "pass through" to UNMC providers. Is it the intention of this program to be revenue neutral to the DBPM or does over/under utlization risk exist? Additionally, what is meant by the statement "these payments are calculated into the captiation rate on a quarterly basis"? This would imply the capitation rates shown in Attachment 8 will be modified multiple times per year???	The UNMC supplemental payment is a per member per month amount that is calculated based on utilization of service provided by the UNMC providers. The intention is to be revenue neutral. The UNMC supplemental payment is calculated quarterly and does not impact capitation rates.
68.	RFP Document R.12.a	112	Has the states actuary assumed a certain level of expected Third Party Liability payments in their rate development and, if so, what is the projected amount? This question is meant to include COB dollars as well.	The dollars underlying the rate development are the Medicaid paid amounts inherent in the FFS data. As such, MLTC is assuming that the TPL recovered in the contract period will resemble the level of TPL inherent in the base data.
69.	Section IV.C.3 Accreditation	35	Section IV.C.3, page 35, requires that the DBPM obtain Health Plan Accreditation through NCQA. Per our understanding of NCQA accreditation requirements, the DBPM would not qualify to apply for Health Plan Accreditation through NCQA. The DBPM could apply for NCQA Certification for the functions of Utilization Management	MLTC will accept URAC for accreditation.

			and/or Credentialing. Additionally URAC offers a comprehensive Dental Benefit Plan Accreditation. Can the State please clarify the requirement around NCQA? Is the requirement meant to reference NCQA Certification in Utilization Management and/or Credentialing? Additionally, would the State consider URAC accreditation in lieu of NCQA certification as the URAC accreditation is more comprehensive than NCQA certification.	
70.	IV.G Member Services and Education	51	Describe proposed member education content and materials and "attach examples" used with Medicaid or CHIP populations in other states. Describe innovative methods the DBPM has used for member education. Describe how the DBPM will provide equitable member education throughout the State. "Provide examples" and descriptions of how member education will be used to improve service coordination including: - The use of technological tools, including social media and mobile technology. - Partnership with community-based organizations for education and outreach. **Please confirm requested examples are not included in the page limit.**	MLTC confirms that requested examples are not included in the page limit.
71.	RFP Dental Management Document	4	Would the state please confirm that all attachments can be placed behind a tab for attachments behind the technical narrative?	This formatting is acceptable to the State.

72.	RFP Dental Management Document	4	Will the State please confirm that Calibri 11pt. Font with 1 inch margins on all sides is acceptable for all required responses?	This formatting is acceptable to the State.
73.	RFP Dental Management Document	4	Please confirm that a 10pt. font is acceptable for all tables and figures.	This formatting is acceptable to the State.
74.	Attachment 11 - Proposal Statements and IV.L Care Coordination Question 40	9	"Describe how the DBPM will assist members to identify and gain access to community resources that provide services the Medicaid program does not cover." Is the State solely referring to the identification and access to dental resources the Medicaid program does not cover?	MLTC requires the DBPM to direct members to community resources that broadly help improve health outcomes.
75.	SPB RFP Revised: 01/29/2016 page 41	41	Can the State please clarify that question #1. should be "dental health services" and not "physical and behavioral health services"? Tribal Network Liaison* The Tribal Network Liaison is responsible for: 1. Planning and working with Provider Services staff to expand and enhance physical and behavioral health services for American Indian members. 2. Serving as the single point of contact with tribal entities and all DBPM staff on American Indian issues and concerns. 3. Advocating for American Indian members with case management and member services staff.	Please see Addendum Four, #9.
76.	R. Claims Management, 6. Paid Claims Sampling, a.	107	Does the State require the provision of EOBs for all Medicaid recipients?	MLTC does not require this but the DBPM must have a method to verify services.

77.	R. Claims Management, 6. Paid Claims Sampling, c.	107	Regarding the language,"The service verification surveys may be conducted at any point after a claim has been paid, but no more than 45 calendar days after the date of payment. This sampling may be performed by mail, telephonically, or in person (e.g., during case management on-site visits)." Please provide additional detail regarding expectations for conducting service verification surveys, i.e., what should these surveys contain? and is the expectation that this process is conducted as part of credentialing and/or UM?	The DBPM will submit for MLTC's approval their proposed surveys. While this process may be used for credentialing or utilization management, the primary purpose is to ensure the DBPM and MLTC comply with Federal law regarding claims payment, processing, and verification that beneficiaries received billed for services. The bidder should provide a response that meets the requirements of the RFP.
78.	R. Claims Management, 6. Paid Claims Sampling, c.	107	Regarding the language, " Concurrent review will be allowed when tied back to a successfully adjudicated claim." Is the State's expecation that the plan conducts concurrent reviews for dental services?	Yes.
79.	Attachment 11	p.2, Q18	Question 18 requests "an overview of the proposed member website, including how it will satisfy requirements in this RFP." The Scope does not mention a member website; will the state please provide additional detail regarding the requirements for a "member website" and "member portal."	Please see Addendum Four.
80.	Attachment 11	p.2, Q17	Question 17 requests written material and references the "appropriate reading level" for all member materials. Please provide the appropriate grade reading level for the state of Nebraska.	The DBPM must write all member materials in a style and reading level that will accommodate the reading skill of the members. In general, the writing should be at no higher than a 6.9 grade level, as determined by the Flesch–Kincaid Readability Test.

81.	Attachment 12	p.1	Will the state provide additional detail regarding requirements for the draft copy of a Member Handbook? Section IV.G; is the Member Handbook also called Member Orientation as referenced in IV.G.4.a?	Yes. Please see Addendum Four, #5.
82.	Covered Benefits	43	Is transportation the responsibility of the member's health plan?	No
83.	Covered Benefits	43	Is the facility component of an emergency room visit the the responsibility of the member's health plan?	Yes, the DBPM will not be responsible for outpatient or inpatient hospital claims.
84.	Covered Benefits	43	Is the facility component of dental services performed in a hospital setting (in patient or outpatient) the responsibility of the member's health plan?	Yes, please see the response to Question 83.
85.	Provider Network Requirements	64	Can the state provide a file of their existing provider network, including name, address and phone numbers?	Please see Attachment 19. The spreadsheet provides the following: Provider Number, Business Name, Title Code, Provider Type Code, Practice Type Code, Address, City, Pay to Name, Pay to Name Address, Pay to Name City. MLTC looked at paid dental claims on MLTC's claims history database, and found there were two Provider Types who bill on dental claims: • Dentists (DDS) – Provider Type 40 • Tribal 638 Clinic – Provider Type 26 MLTC also found two different provider types usually listed as the rendering provider: • Dentists (DDS) – Provider Type 40 • Licensed Dental Hygienist – Provider

				Type 42 Furthermore, there were a small number of claims where the rendering provider was a personal care aid (Provide Type 33) or MD (Provider Type 01) or DO (Provider Type 02). MLTC did not consider them for this listing. The attached spreadsheet lists all active providers with a Provider Type of 40, 42, or 26 There can be multiple entries for the same provider/person if: • The provider has multiple Medicaid Provider IDs (normally to bill with multiple locations) • The provider has multiple NPIs attached to a single Medicaid Provider ID • The provider has multiple Taxonomy codes attached to a single Medicaid Provider ID
86.	III.F.3 "Insurance Coverage Amounts Required"	10	The RFP contains a requirement for Abuse & Molestation Insurance as part of the Commercial General Liability Insurance the bidder is to maintain. Would the State of Nebraska waive this requirement?	Provide all exceptions to Section III. Terms and Conditions under "NOTES/COMMENTS" in the applicable table.
87.	III.F.3 "Insurance Coverage Amounts Required"	10	The RFP contains a limit of $7,000,000 for Commercial Crime Coverage. Would the State of Nebraska accept $2,000,000?	See the response to Question 86.

88.	III.F.3 "Insurance Coverage Amounts Required"	10	The RFP contains a limit of $15,000,000 for Cyber Liability Coverage. Would the State of Nebraska accept $10,000,000?	See the response to Question 86.
89.	III.F.4 "Evidence of Coverage"	11	Several of the coverage limits contained in III.F.3 would require an adjustment to the bidder's current insurance limits which would come at a cost to the bidder. The RFP states in III.F.4: "The Contractor should furnish the State, <u>with their proposal response</u>, a certificate of insurance coverage complying with the above requirements …." Is this a mandatory requirement? May the bidder provide a certificate of insurance coverage evidencing required coverage after the intent to award decision?	The Certificate of Insurance is not a mandatory requirement of the RFP. Bidders may provide a Certificate of Insurance in their proposal response. The awarded bidder must provide a certificate of insurance coverage after the intent to award.
90.	IV.I.1 "Provider Network Requirements"	64 (78)	Is Bidder expected to build a network of Providers on a contracted Provider Agreement or Letter of Intent basis before we submit our bid? Or will we show in the RFP how we will build the Medicaid network if awarded?	No. MLTC requires the DBPM to provide a description of how the bidder will build their Medicaid network if awarded.
91.	Attachment 8 – Dental Rates	Attachment 8	Is the Total Loaded Rate ($19.94) the full-risk price for all 5-years until December 31, 2022? Or is it only for Fiscal-Year 2018?	These rates are only applicable for the SFY18 contract period.

<table>
<tr><td></td><td></td><td></td><td>
<table>
<tr><th colspan="5">FY2018 Rate Summary</th></tr>
<tr><th>Age Band</th><th>FY15 MMs</th><th>Net Medical Rate</th><th>NML</th><th>Loaded Rate</th></tr>
<tr><td>0-1</td><td>295,534</td><td>$ 1.63</td><td>9.0%</td><td>$ 1.80</td></tr>
<tr><td>2-5</td><td>467,090</td><td>$ 16.71</td><td>9.0%</td><td>$ 18.36</td></tr>
<tr><td>6-18</td><td>1,191,822</td><td>$ 25.61</td><td>9.0%</td><td>$ 28.13</td></tr>
<tr><td>19-24</td><td>123,094</td><td>$ 13.20</td><td>9.0%</td><td>$ 14.51</td></tr>
<tr><td>25-54</td><td>494,494</td><td>$ 16.75</td><td>9.0%</td><td>$ 18.40</td></tr>
<tr><td>55-64</td><td>123,876</td><td>$ 15.45</td><td>9.0%</td><td>$ 16.97</td></tr>
<tr><td>65+</td><td>218,284</td><td>$ 10.40</td><td>9.0%</td><td>$ 11.43</td></tr>
<tr><td>Total</td><td>2,914,194</td><td>$ 18.15</td><td>9.0%</td><td>$ 19.94</td></tr>
</table>
</td><td></td></tr>
<tr><td>92.</td><td>IV.4.2 “Key Staff Positions”</td><td>39-40 (53-54)</td><td>May we contact the current Nebraska Dental Director, Dr. Charles Craft?</td><td>No, that would be a violation of the RFP; Section II. D. Communication with State Staff and Evaluators.</td></tr>
<tr><td>93.</td><td>IV.4.2 “Key Staff Positions”</td><td>39-40 (53-54)</td><td>Is Bidder expected to hire a Dental Director <u>before</u> the RFP is awarded? Or can we identify a candidate, and upon award of the contract, hire that person before go-live?</td><td>MLTC does not expect the DBPM to hire a Dental Director before MLTC awards the contract. Please see Section IV.D.2 of the RFP to find MLTC’s requirements regarding the hiring key staff.</td></tr>
<tr><td>94.</td><td>IV.4.2 “Key Staff Positions”</td><td>39-40 (53-54)</td><td>What specifically is/was Dr. Craft’s job description?

Do his responsibilities require him to be present in the office M-F, 9a-5p?</td><td>Dr. Craft is employed by the DHHS, Division of Public Health. He is not a member of MLTC’s staff.

MLTC does not have that information.</td></tr>
<tr><td>95.</td><td>II.P “Secretary of State/ Tax Commissioner”</td><td>6 (20)</td><td>Bidder is registered with the Secretary of State. We cannot find anything about registering with the Tax Commissioner.

What are the requirements here?</td><td>The Secretary of State and the Tax Commissioner do not have separate requirements.</td></tr>
</table>

96.	Att. 11 #58 Section IV.O	13, of Attachment 11	Question 58 refers to RFP Section IV.O, however the body of the question "Describe the DBPM's method and process for capturing TPL and payment information from its claims system. Explain how the DBPM will use this information". Seems to be referring to Section IV.R of the main document. Can you confirm?	Yes, MLTC confirms. Please see Addendum Four, #14.
97.	Att. 15	BAA	Does the Business Associate Agreement which is contained in Attachment 15 need to be signed by the offerer and included in the proposal or whether the State and the successful bidder sign the BAA during the contract finalization period.	The State will require the awarded contractor to sign a Business Associate Agreement (BAA). The bidder is not required to submit the signed BAA as part of the proposal response.
98.	Att. 11 "Proposal Statements and Questions" #3	Att. 11, p.1	Question No. 3 states: "Describe the approach the DBPM will take to ensure compliance with all relevant provisions of Part 438 of Chapter 42 of the CFR, Title 471, 477, and 482 NAC." There is no page limit to the bidder's response. There are several hundred pages of regulations contained within the above cited sections. Bidder respectfully requests that the State explain if bidders are to address in general terms their compliance "approach" and how, in general, they will ensure compliance with Part 438 of Chapter 42 of the CFR, Title 471, 477, and 482 NAC or whether the State requests a detailed explanation of how the bidder will "ensure compliance with all relevant provisions" of these sections.	Bidders should describe their general approach to compliance regarding the cited regulations; however, the State did not put a limitation on the depth of detail the bidder may provide. The bidder should provide a response that meets the requirements of the RFP.

99.	I. Scope of the Request for Proposal, A. Schedule of Events	Page 1	a. Will any extensions be considered or granted to the bid deadline of October 25, 2016? b. Will any alternative effective dates (other than July 1, 2017) be considered? c. What activities will be completed in the contract finalization period? i. What process will be used for this activity?	a. See Addendum Two – Revised Schedule of Events. b. The State anticipates to go-live with this program on July 1st. c. The contract finalization period is the time allowed to negotiate terms and conditions, process a compliant Certificate of Insurance, Performance Bond, and Certificate of Good Standing. . i. this process will be facilitated by the State Purchasing Bureau.
100.	II Procurement Procedures, B. General Information.	Page 2	a. Will any other forms of contract be considered besides a fixed price contract?	No.
101.	II Procurement Procedures, C. Customer Service.	Page 2	a. With respect to development of enhancements, please define what the State envisions as the needed enhancements? i. How will success be defined? ii. How will success be measured? b. What are the customer service industry's best practices and processes? i. How are these determined? ii. What measurable criteria is the State considering?	Section II, C. Customer Service on page 2 refers to Customer as the State of Nebraska. This requirement is an overarching requirement of the Contractor in relation to the State.
102.	III. Terms and Conditions.	Page 7	a. Does the following sentence mean that if the Bidder requires a contract deviation that the bidder will not be considered? *"The State of Nebraska will not*	The State will not substitute the contractor's contract for the State's contract. The State will negotiate terms, but not to the point that our contract does not exist.

			consider proposals that…or terms for those of the State of Nebraska's." b. It appears that the Terms and Conditions section indicates the Bidder must accept the Terms and Conditions as written with no modifications. The State may then consider additional elements from the Bidder but only if the Bidder agrees to the Terms and Conditions as stated first. Is this a correct interpretation?	a. "The State of Nebraska will not consider proposals that **propose the substitution of the bidder's contract, agreements, or terms** for those of the State of Nebraska's." The State will not replace its terms and conditions for the bidder's contract, agreements or terms. b. "Bidders are expected to closely read the Terms and Conditions and provide a binding signature of intent to comply with the Terms and Conditions; provided, however, a bidder may indicate any exceptions to the Terms and Conditions by (1) clearly identifying the term or condition by subsection, and (2) including an explanation for the bidder's inability to comply with such term or condition which includes a statement recommending terms and conditions the bidder would find acceptable." The bidder may either "Accept", "Reject" or "Reject & Provide Alternative within RFP Response". The State will negotiate Terms and Conditions with the awarded bidder during the contract finalization period.

103.	III. Terms and Conditions. A. General.	Page 7	a.	Please define and/or direct us to the rules of contract interpretation as established in the State of Nebraska?	Case law statutes
104.	F. Insurance Requirements.	Page 9	a.	What is the State turnaround time for approval?	Once a compliant Certificate of Insurance is received by the awarded bidder; the approval will be determined in a couple of business days.
105.	L. State of Nebraska Personnel Recruitment Prohibition.	Page 13	a.	Are there any circumstances under which this prohibition could be altered? For example, the expertise of State employees currently engaged in delivering the Medicaid Dental services could be of value to the plan members and in the best interests of the members to continue to engage rather than lose due to the transition.	See the response to Question 86.
106.	Z. Early Termination.	Page 17	a.	Is the correct interpretation that the Contractor may not terminate the plan before 12/31/22? For any reason?	See the response to Question 86.
107.	8. Merger, Reorganization , and Change of Ownership	Page 36	a.	Does this requirement apply to just the Contractor, or does it also apply to any Subcontractors?	This requirement only applies to the Contractor, although MLTC expects the Contractor to notify MLTC of any material change that would affect members or providers.
108.	2. Key Staff positions	Page 39	a. b.	Does the State have existing job descriptions for each position? Will the State furnish those descriptions to the Bidders?	MLTC only provides the minimum duties and requires that hired staff are qualified. MLTC requires the DBPM to produce the job descriptions.

109.	E1a. General Provisions	Page 43	a. What are considered the prevailing dental community standards? i. How are these determined? ii. What measurable criteria is the State considering?	Prevailing dental community standards are determined by Medicaid's Rules and Regulations and the measurable criteria MLTC is considering can be found in Attachment 6 of the RFP.
110.	F. Fee-For-Service (FFS). 1. DBPM FFS Claim Services.	Page 48	i. Is this an additional service the Contractor is to provide without regard to incremental additional costs to the Contractor? ii. Is there any amount included in the administration fee for the Contractor's general or other administrative expenses? iii. Is there any amount included in the administration fee for Contractor profit margin?	MLTC will not make any additional considerations regarding the additional service of paying fee-for-service claims. Section IV.F.1 DBPM FFS Claim Services of the RFP prescribes payment.
111.	I. Provider Network Requirements.	Page 64	a. Will the state provide a list of all providers (including TIN, location, claim volume, etc.) currently contracted with the State for this Medicaid Dental program. i. If so, when will this list be provided? b. Are there any exception or non-standard payments, or fee schedules, to providers for access or other reasons? i. If so, how are these amounts determined? ii. If so, under what circumstances are these exceptions allowed? iii. If so, how do these amounts	a. Please see Question 85. b. There are only two exceptions to the fee schedule. The UNMC supplemental payment, which calculated in accordance with the following link: http://dhhs.ne.gov/medicaid/Documents/4.19bitem10.pdf The other exception is the encounter rate paid to IHS facilities as determined by Medicare.

			differ from the standard fee schedule set by the MLTC?	
112.	I. Provider Network Requirements. 4. Geographic Standards.	Page 64	a. Will the State make any allowances in the Geographic Standards for current gaps between the existing State provider network and the Geographic Standards? b. How does the State envision the Contractor resolving gaps between access and Geographic Standards when no provider exists in an area that meets the Geographic Standards? c. What is the timeframe in which a Contractor must meet the Geographic Standards when a new member residence is identified that is not within the Geographic Standards?	a. MLTC will not make any allowances for network adequacy gaps. b. MLTC requires the DBPM to develop a provider network availability plan to identify such gaps and describe the remedial action(s) that the DBPM will take to address those gaps. c. MLTC requires the DBPM to have an adequate network, as stated in the RFP, at the contractor start date.
113.	I. Provider Network Requirements. 10. Provider Enrollment in Medicaid.	Page 68	a. Does this requirement only apply to the provider network the Contractor develops for this Medicaid Dental program? b. When a Contractor maintains multiple commercial provider networks, does this requirement mean the Contractor must require providers in those commercial networks to become providers to NE Medicaid Dental?	a. Yes, this requirement only applies to providers who wish to provide Nebraska Medicaid dental benefits. b. No provider is required to become a Nebraska Medicaid provider. However, the DBPM must contract with all providers the DBPM intends to reimburse for providing Medicaid dental services.

114.	P. DBPM Reimbursement.	Page 96	a. If there are any exception or non-standard payments, or fee schedules to providers for access or other reasons, are these amounts included in the determination of the capitation rate? b. Is the intent for the Contractor to agree to any method of determination and/or any assumptions used in the determination of the capitation rate? c. How often during the life of the contract will capitation rates be updated? Annually? Semi-Annually? i. On what date? ii. How far in advance of their effective date/application? d. If the method and/or assumptions for determining the capitation rate changes from time to time, does the Contractor have the ability to approve of these changes? Or is this element "take it or leave it"? e. If the fee schedule for providers is changed by the State (for any reason), will the capitation rate be changed prior to the implementation of the fee schedule changes? f. Have the implications of the requirements of the RFP been factored into the determination of the future capitation rates? i. In other words, if the RFP includes changes, enhancements,	a. There were no adjustments related to reimbursement other than the UNMC adjustment described in the response to Question 50. b. The Contractor should evaluate the proposed capitation rate and the associated actuarial assumptions and determine if the proposed rates are feasible for the Contractor's business model. c. Capitation rates will be updated on an annual basis and will be submitted to CMS no later than April 1st of the preceding contract period (i.e. the SFY19 rates will be submitted to CMS by April 1st, 2018). d. MLTC will provide substantiation and documentation of all aspects of the rate development methodology, however, the State will look to CMS/OACT for approval. The Contractor should evaluate the proposed capitation rate and the associated actuarial assumptions and determine if the proposed rates are feasible for the Contractor's business model. e. Significant changes in fee schedules will prompt a review of existing rates. To the extent that the impact is greater than +/- 1.5%, MLTC will update the rates prior to implementation. f. MLTC has developed the rates consistent with State policy. As such,

			improvements, system changes and other requirements that increase utilization and/or cost compared to current practices and outcomes, have these components been factored into the determination of the future capitation rate? ii. Will such prospective implications be included in the determination? Or will the capitation rate always be "after the fact"? g. Is there any allowance for the Contractor's costs of initial implementation included in the capitation rate? h. Is there any allowance for the Contractor's costs of on-going changes, enhancements, system changes, future implementations, etc. included in the capitation rate?	utilization is assumed to only increase by the secular utilization trend. To the extent MLTC knows ahead of time of the rate implications, MLTC does include them. g. The capitation rates do not include any additional funds for implementation costs. h. MLTC intends to use the DBPM's encounter data for prospective contract periods. As such, any enhancements or system changes that are reflected in the encounter data will be considered in future rate development cycles.
115.	U. Contract Monitoring.	Page 126	a. Is there a maximum limit to the amount of monetary actions, damages, sanctions, penalties, etc. that may be applied under the Contract for any one item? b. Is there an aggregate annual maximum on the amount of monetary actions, damages, sanctions, penalties, etc. that may be applied under the Contract? i. If so, is it limited to the 2%	a. No. b. No. i. No, the 1.5% (please see Addendum Four) holdback constitutes the maximum amount available to the DBPM to earn via the quality performance program. ii. There is no maximum to liquated damages, sanctions, penalties, etc.

			holdback? ii. If not limited to the 2% holdback, what is the maximum? iii. If no maximum, please confirm that the correct interpretation is that there is no limit to the amount of these items that may be levied on the Contractor.	iii. That is the correct interpretation.
116.			I wanted to email you and ask about the NCQA Certification that is required in the dental RFP. Dental plans aren't eligible for HPA through NCQA and wanted to point that out. We have noticed this is a requirement in the RFP? I am not sure if this was just carried over by mistake from the Heritage plan requirements with the health plans?	See response to Question 69.
117	Quality Performance Program Measures – CY1	Attachment 9	Does the performance guarantee **Average Speed to Answer:** Calls to Member/Provider lines must be answered on average within 30 seconds imply the call center will answer 100% of the calls within 30 seconds? Can this be negotiated to fall in-line with standards of 80% of calls answered in 30 seconds?	MLTC does not expect the DBPM call center to answer 100% of the calls within 30 seconds. MLTC does require the average time for the call center to answer a call to be within 30 seconds. MLTC predicates this metric on average call wait-times and it is not negotiable.
118	Section III, OO – Proprietary Information	23	We would like clarification on how the State wishes for Proprietary Information to be marked on Original Proposal? Would it be acceptable to redact the proprietary information on the original RFP,	Yes, it would be acceptable for the bidder to redact the proprietary information on the original RFP and provide a document with the applicable information. Package proprietary information according to

			then, on a separate document named PROPRIETARY, include the information redacted from the original RFP, along with the page number and paragraph where the information would be included?	Section III. OO Proprietary.
119	Section IV, F, -Fee-For-Service (FFS) Dental Claims Management and Processing	48	How many FFS members will there be under the FFS arrangement? How will the State identify FFS members?	Remaining fee-for-service members are yet to be determined. MLTC will identify the FFS members by their eligibility category.
120.	Section IV.F FFS-Claims Management and Processing	Attachment 11, page 16	Please elaborate on what is meant by claim brokering. What is the state looking for specifically with Question 76 and 77? Is the state referring to claim negotiating and financial settlement with providers?	See Section IV.F.1: The State is currently in the process of replacing its aged Medicaid Management Information System (MMIS). As part of this transition, the State is moving toward a model of contracting with risk-bearing entities for the provision of services for nearly all Medicaid members and services. As this transition continues, the State will be responsible for processing fewer FFS claims for fewer members. Rather than procure a standalone claims processing system for these remaining needs, the State intends to enter into a services agreement with the DBPM for the management and processing of remaining FFS dental claims. In addition to the DBPM responsibilities outlined in this RFP, MLTC will pay the DBPM an administrative

				processing fee for each unique adjudicated FFS claim or adjustment on a monthly basis. MLTC will provide the per unique claim initial rate. Payment for FFS dental claims management services will be paid separately from managed care capitation payments.
121.	Terms and Conditions, F 4 Evidence of Coverage		Under the Terms and Conditions, F 4 Evidence of Coverage, it asks we provide a certificate of insurance, but not sure if we are to fax it or include in our response or both. If we do need to fax the form, can you confirm we need fax by the opening date of 10/25? **F. 4. EVIDENCE OF COVERAGE** The Contractor should furnish the State, with their proposal response, a certificate of insurance coverage complying with the above requirements to the attention of the Buyer at 402-471-2089 (fax) Administrative Services State Purchasing Bureau 1526 K Street, Suite 130 Lincoln, NE 68508 These certificates or the cover sheet must reference the RFP number, and the certificates must include the name of the company, policy numbers, effective dates, dates of expiration, and amounts and	See the response to Question 89. The Certificate of Insurance does not need to be faxed before the opening date.

			types of coverage afforded. If the State is damaged by the failure of the Contractor to maintain such insurance, then the Contractor shall be responsible for all reasonable costs properly attributable thereto. Notice of cancellation of any required insurance policy must be submitted to Administrative Services State Purchasing Bureau when issued and a new coverage binder must be submitted immediately to ensure no break in coverage.	
122.	III.FF "Performance Bond"	19-20	The RFP states: "The Contractor will be required to supply a bond executed by a corporation authorized to contract surety in the State of Nebraska, payable to the State of Nebraska, ***which shall be valid for the life of the contract*** to include any renewal and/or extension periods." The contract term is 5 years and there are two potential 1 year extensions after the initial term for a potential 7 year contract. Bidder is unable to obtain a 5 to 7 year bond term but is able to obtain the bond for the first year which will be extended via a continuation certificate/annual bond form every year thereafter, including extensions. Can the State of the Nebraska please advise if it will accept a one year, continuous renewal bond?	Yes, the State of Nebraska will accept a one year, continuous renewable bond.

123.			I refer to RFP 5427 Z1 (Medicaid Dental Benefit Program). The RFP provides for page limitations for responses. As a courtesy to the reader, our format includes a copy of the question before each of our responses. While some questions may be one or two sentences long, other questions are more extensive in length. We would like to confirm that a recitation of the question would not contribute towards our page limitations.	The recitation of the question will not contribute towards the page limitations.

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal.

NEBRASKA Administrative Services

Byron L. Diamond
Director

Pete Ricketts, Governor

ADDENDUM TWO
REVISED SCHEDULE OF EVENTS

Date: October 19, 2016

To: All Bidders

From: Michelle Thompson/Teresa Fleming, Buyers
AS Materiel State Purchasing Bureau

RE: Addendum for Request for Proposal Number 5427Z1
to be opened ~~October 25, 2016~~ October 31, 2016 at 2:00 p.m. Central Time

	ACTIVITY	DATE/TIME
5.	State responds to written questions through Request for Proposal "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html	~~October 17, 2016~~ TBD
6.	Proposal opening Location: State Purchasing Bureau 1526 K Street, Suite 130 Lincoln, NE 68508	~~October 25, 2016~~ October 31, 2016 2:00 PM Central Time
7.	Review for conformance of mandatory requirements	~~October 26 - 28, 2016~~ November 1 – 3, 2016
8.	Evaluation period	~~October 31 – November 15, 2016~~ November 4 – 18, 2016
9.	"Oral Interviews/Presentations and/or Demonstrations" (if required)	TBD
10.	Post "Letter of Intent to Contract" to Internet at: http://das.nebraska.gov/materiel/purchasing.html	~~November 21, 2016~~ November 23, 2016

ACTIVITY		DATE/TIME
11.	Contract finalization period	~~November 22, 2016 – January 3, 2017~~ November 28, 2016 – January 3, 2017
12.	Contract award	January 3, 2017
13.	Contractor start date	July 1, 2017

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal.

NEBRASKA Administrative Services

Byron L. Diamond
Director

Pete Ricketts, Governor

ADDENDUM ONE
REVISED SCHEDULE OF EVENTS

Date: October 17, 2016

To: All Bidders

From: Michelle Thompson/Teresa Fleming, Buyers
AS Materiel State Purchasing Bureau

RE: Addendum for Request for Proposal Number 5427Z1
to be opened October 25, 2016 at 2:00 p.m. Central Time

	ACTIVITY	DATE/TIME
5.	State responds to written questions through Request for Proposal "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html	~~October 17, 2016~~ TBD
6.	Proposal opening Location: State Purchasing Bureau 1526 K Street, Suite 130 Lincoln, NE 68508	October 25, 2016 2:00 PM Central Time
7.	Review for conformance of mandatory requirements	October 26 - 28, 2016
8.	Evaluation period	October 31 – November 15, 2016
9.	"Oral Interviews/Presentations and/or Demonstrations" (if required)	TBD
10.	Post "Letter of Intent to Contract" to Internet at: http://das.nebraska.gov/materiel/purchasing.html	November 21, 2016
11.	Contract finalization period	November 22, 2016 – January 3, 2017
12.	Contract award	January 3, 2017
13.	Contractor start date	July 1, 2017

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal.

State of Nebraska (State Purchasing Bureau)
REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES FORM

RETURN TO:
State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, Nebraska 68508
Phone: 402-471-6500
Fax: 402-471-2089

SOLICITATION NUMBER	RELEASE DATE
RFP 5427 Z1	**September 1, 2016**
OPENING DATE AND TIME	PROCUREMENT CONTACT
October 25, 2016 2:00 p.m. Central Time	**Michelle Thompson / Teresa Fleming**

This form is part of the specification package and must be signed in ink and returned, along with proposal documents, by the opening date and time specified.

PLEASE READ CAREFULLY!

SCOPE OF SERVICE

The State of Nebraska, Administrative Services (AS), Materiel Division, State Purchasing Bureau, is issuing this Request for Proposal, RFP Number 5427 Z1 for the purpose of selecting a qualified contractor to manage the Medicaid Dental Benefit Program.

The State of Nebraska intends to award one (1) contract for the scope of work as described in Section IV.A – Program Description through IV.W – Termination of DBPM Contract.

Written questions are due no later than October 3, 2016, and should be submitted via e-mail to as.materielpurchasing@nebraska.gov Written questions may also be sent by facsimile to (402) 471-2089.

A Pre-Proposal Conference with mandatory attendance will be held on Tuesday, September 27, 2016 from 1:00 – 3:00 PM Central Time at Nebraska State Office Building, 301 Centennial Mall South, Lower Level, Conference Room A, Lincoln, NE 68509.

Bidder should submit one (1) original of the entire proposal. Proposals must be submitted by the proposal due date and time.

PROPOSALS MUST MEET THE REQUIREMENTS OUTLINED IN THIS REQUEST FOR PROPOSAL TO BE CONSIDERED VALID. PROPOSALS WILL BE REJECTED IF NOT IN COMPLIANCE WITH THESE REQUIREMENTS.

1. Sealed proposals must be received in State Purchasing Bureau by the date and time of proposal opening per the schedule of events. No late proposals will be accepted. No electronic, e-mail, fax, voice, or telephone proposals will be accepted.
2. This form "REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES" MUST be manually signed, in ink, and returned by the proposal opening date and time along with bidder's proposal and any other requirements as specified in the Request for Proposal in order for a bidder's proposal to be evaluated.
3. It is the responsibility of the bidder to check the website for all information relevant to this solicitation to include addenda and/or amendments issued prior to the opening date. Website address is as follows: http://das.nebraska.gov/materiel/purchasing.html

IMPORTANT NOTICE: Pursuant to Neb. Rev. Stat. § 84-602.02, all State contracts in effect as of January 1, 2014, and all contracts entered into thereafter, will be posted to a public website. Beginning July 1, 2014, all contracts will be posted to a public website managed by the Department of Administrative Services.

In addition, all responses to Requests for Proposals will be posted to the Department of Administrative Services public website. The public posting will include figures, illustrations, photographs, charts, or other supplementary material. Proprietary information identified and marked according to state law is exempt from posting. To exempt proprietary information you must submit a written showing that the release of the information would give an advantage to named business competitor(s) and show that the named business competitor(s) will gain a demonstrated advantage by disclosure of information. The mere assertion that information is proprietary is not sufficient. (Attorney General Opinion No. 92068, April 27, 1992) The agency will then determine if the interests served by nondisclosure outweigh any public purpose served by disclosure. Cost proposals will not be considered propriety.

To facilitate such public postings, the State of Nebraska reserves a royalty-free, nonexclusive, and irrevocable right to copy, reproduce, publish, post to a website, or otherwise use any contract or response to this RFP for any purpose, and to authorize others to use the documents. Any individual or entity awarded a contract, or who submits a response to this RFP, specifically waives any copyright or other protection the contract or response to the RFP may have; and, acknowledge that they have the ability and authority to enter into such waiver. This reservation and waiver is a prerequisite for submitting a response to this RFP and award of the contract. Failure to agree to the reservation and waiver of protection will result in the response to the RFP being non-conforming and rejected.

Any entity awarded a contract or submitting a RFP agrees not to sue, file a claim, or make a demand of any kind, and will indemnify, hold, and save harmless the State and its employees, volunteers, agents, and its elected and appointed officials from and against any and all claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses ("the claims"), sustained or asserted against the State, arising out of, resulting from, or attributable to the posting of contracts, RFPs and related documents.

BIDDER MUST COMPLETE THE FOLLOWING

By signing this Request for Proposal for Contractual Services form, the bidder guarantees compliance with the provisions stated in this Request for Proposal, agrees to the terms and conditions unless otherwise agreed to (see Section III) and certifies that bidder maintains a drug free work place environment.

Per Nebraska's Transparency in Government Procurement Act, Neb. Rev Stat § 73-603 DAS is required to collect statistical information regarding the number of contracts awarded to Nebraska Contractors. This information is for statistical purposes only and will not be considered for contract award purposes.

_____ **NEBRASKA CONTRACTOR AFFIDAVIT**: Bidder hereby attests that bidder is a Nebraska Contractor. "Nebraska Contractor" shall mean any bidder who has maintained a bona fide place of business and at least one employee within this state for at least the six (6) months immediately preceding the posting date of this RFP.

_____ I hereby certify that I am a **Resident disabled veteran or business located in a designated enterprise zone** in accordance with Neb. Rev. Stat. § 73-107 and wish to have preference, if applicable, considered in the award of this contract.

FIRM: _____

COMPLETE ADDRESS: _____

TELEPHONE NUMBER: _____ FAX NUMBER: _____

SIGNATURE: _____ DATE: _____

TYPED NAME & TITLE OF SIGNER: _____

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GLOSSARY OF ACRONYMS

ACD: Automatic Call Distribution System

ADA: Americans with Disabilities Act

AHRQ: Agency for Healthcare Research and Quality

ASC: Ambulatory Surgical Center

BCP: Business Continuity Plan

CAHPS: Consumer Assessment of Healthcare Providers and Subsystems

CAP: Corrective Action Plan

CAQH: Council for Affordable Quality Healthcare

CFR: Code of Federal Regulations

CHIP: Nebraska Children's Health Insurance Program

CME: Confirmation of DBPM Enrollment

CMS: Centers for Medicare and Medicaid Services

COA: Certificate of Authority

COB: Coordination of Benefits

CPA: Certified Public Accountant

CPT: Current Procedural Terminology

CQI: Continuous Quality Improvement

DBP: Dental Benefits Program

DBPM: Dental Benefits Program Manager

DHHS: Nebraska Department of Health and Human Services

DME: Durable Medical Equipment

DOI: Department of Insurance

DQA: Dental Quality Alliance

DRP: Disaster Recovery Plan

ECM: Electronic Claims Management

EFT: Electronic Funds Transfer

EOB: Explanation of Benefits

EPSDT: Early and Periodic Screening, Diagnostic, and Treatment

EQR: External Quality Review

EQRO: External Quality Review Organization

FDA: Food and Drug Administration

FFP: Federal Financial Participation

FFS: Fee For Service

FQHC: Federally Qualified Health Center

FWA: Fraud, Waste and Abuse

HCBS: Home and Community Based Services Waiver

HCPCS: Healthcare Common Procedure Coding System

HEDIS: Healthcare Effectiveness Data and Information Set

HIPAA: Health Insurance Portability and Accountability Act

HIPF: Health Insurance Providers Fee

IHS: Indian Health Service

IS: Information Systems

I/T/U: Indian Health Services/Tribal 638/Urban Indian Health

IVR: Interactive voice response

MCO: Managed Care Organization

MFPAU: Medicaid Fraud and Patient Abuse unit

MITA: Medicaid Information Technical Architecture

MLR: Medical Loss Ratio

MLTC: Nebraska DHHS, Division of Medicaid and Long-Term Care

MM: Member Months

MMIS: Medicaid Management Information System

NAC: Nebraska Administrative Code

NCCI: National Correct Coding Initiative

NCQA: National Committee for Quality Assurance

NEMT: Non-Emergency Medical Transportation

NMMCP: Nebraska Medicaid Managed Care Program

NMPI: Nebraska Medicaid Program Integrity

NPI: National Provider Identifier

OEM: Original Equipment Manufacturer

OIG: Office of the Inspector General

PACE: Program of All-inclusive Care for the Elderly

PAHP: Prepaid Ambulatory Health Plan

PCP: Primary Care Provider

PCS: Provider Complaint System

PHI: Personal Health Information

PIHP: Prepaid Inpatient Health Plan

PIP: Performance Improvement Project

PMPM: Per Member, Per Month

QAPI: Quality Assurance and Performance Improvement

QI: Quality Improvement

QM: Quality Management

QPP: Quality Performance Program

RA: Remittance Advice

RFP: Request for Proposal

RHC: Rural Health Clinic

SDF: Software development firm

SHD: Systems Help Desk

SSAE: Standards for Attestation Engagements

TPL: Third Party Liability

TTY/TDD: Telephone Typewrite and Telecommunications Device for the Deaf

UM: Utilization Management

UNMC: University of Nebraska Medical Center

UR: Utilization Review

VPN: Virtual Private Network

GLOSSARY OF TERMS

ACCESSNebraska: The State service delivery system for public benefits, accessible through a toll-free telephone number and website.

Action: Defined in this RFP as the:

1. Denial or limited authorization of a requested service, including the type or level of service.
2. Reduction, suspension, or termination of a previously authorized service.
3. Denial, in whole or in part, of payment for a service.
4. Failure of a DBPM to act within timeframes provided in this RFP or as directed by the State.
5. Failure of a DBPM to process grievances, appeals, or expedited appeals within required timeframes.

Addendum: Something to be added or deleted to an existing document; a supplement.

Adjudicate: To pay or deny a claim.

Adjustment: Modification to an adjudicated claim.

Agency: Any state agency, board, or commission other than the University of Nebraska, the Nebraska State colleges, the courts, the Legislature, or any other office or agency established by the Constitution of Nebraska.

Agent/Representative: A person authorized to act on behalf of another.

Allowable quality improvement expense: A DBPM's expenditure on qualified quality improvement activities described in Attachment 1 – Medical Loss Ratio Requirements of this RFP.

Amend: To alter or change by adding, subtracting, or substituting.

Amendment: A written correction or alteration to a document.

Appeal: A request for review of an action.

Appropriation: Legislative authorization to expend public funds for a specific purpose. Money set apart for a specific use.

Auto assignment: The process by which an enrollee, who does not select a dental home within a predetermined length of time during enrollment activities is automatically assigned to a dental home.

Award: All purchases, leases, or contracts which are based on competitive proposals will be awarded according to the provisions in the Request for Proposal. The State reserves the right to reject any or all proposals, wholly or in part, or to award to multiple bidders in whole or in part. The State reserves the right to waive any deviations or errors that are not material, do not invalidate the legitimacy of the proposal, and do not improve the bidder's competitive position. All awards will be made in a manner deemed in the best interest of the State.

Best and Final Offer (BAFO): In a competitive bid, the final offer submitted which contains the bidder's (vendor's) most favorable terms for price.

Bid/Proposal: The offer submitted by a vendor in a response to written solicitation.

Bid Bond: An insurance agreement, accompanied by a monetary commitment, by which a third party (the surety) accepts liability and guarantees that the vendor will not withdraw the bid.

Bidder: A vendor who submits an offer bid in response to a written solicitation.

Business: Any corporation, partnership, individual, sole proprietorship, joint-stock company, joint venture, or any other private legal entity.

Business Day: Any weekday, except State-recognized holidays.

Calendar Day: Every day shown on the calendar including Saturdays, Sundays, and State/Federal holidays.

Cancellation: To call off or revoke a purchase order without expectation of conducting or performing it at a later time.

Capitation payment: A monthly payment by the State to a DBPM on behalf of each member of a DBPM for the provision of covered services under the contract.

Children's Health Insurance Program (CHIP): Nebraska's CHIP program is a combination Medicaid CHIP state with a Medicaid CHIP expansion program under Title XXI called "Kid's Connection". Kid's Connection provides health care coverage to targeted low-income uninsured children, from birth through age 18, in families with incomes at or below 200 percent of the federal poverty level. The separate CHIP program provides Medicaid coverage for the unborn children of pregnant women who are otherwise not Medicaid eligible.

Clean claim: A claim, received by a DBPM for adjudication, that requires no further information, adjustment, or alteration by the provider of the services, or by a third party, in order to be processed and paid by the DBPM. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Claim: A bill for services, a line item of service, or all services for one member within a bill.

Collusion: An agreement or cooperation between two or more persons or entities to accomplish a fraudulent, deceitful, or unlawful purpose.

Commodities: Any equipment, material, supply or goods; anything movable or tangible that is provided or sold.

Commodities Description: Detailed descriptions of the items to be purchased; may include information necessary to obtain the desired quality, type, color, size, shape, or special characteristics necessary to perform the work intended to produce the desired results.

Competition: The effort or action of two or more commercial interests to obtain the same business from third parties.

Complaint: See grievance.

Confidential Information: Unless otherwise defined below, "Confidential Information" shall also mean proprietary trade secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. § 84-712.05(3)). In accordance with Nebraska Attorney General Opinions 92068 and 97033, proof that information is proprietary requires identification of specific, named competitor(s) who would be advantaged by release of the information and the specific advantage the competitor(s) would receive.

Contract: An agreement between two or more parties creating obligations that are enforceable or otherwise recognizable at law; the writing that sets forth such an agreement.

Contract Administration: The management of the contract which includes and is not limited to; contract signing, contract amendments and any necessary legal actions.

Contract Management: The management of day to day activities at the agency which includes and is not limited to ensuring deliverables are received, specifications are met, handling meetings and making payments to the Contractor.

Contract Period: The duration of the contract.

Contractor: Any individual or entity having a contract to furnish commodities or services.

Cooperative Purchasing: The combining of requirements of two or more political entities to obtain advantages of volume purchases, reduction in administrative expenses or other public benefits.

Copyright: A property right in an original work of authorship fixed in any tangible medium of expression, giving the holder the exclusive right to reproduce, adapt and distribute the work.

Core benefits and services: The minimum package of services to which a member is entitled under the Nebraska Medicaid State Plan and that must be provided by a DBPM to members enrolled in the DBP.

Customer Service: The process of ensuring customer satisfaction by providing assistance and advice on those products or services provided by the Contractor.

Default: The omission or failure to perform a contractual duty.

Dental home: 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.

Deviation: Any proposed change(s) or alteration(s) to either the terms and conditions or deliverables within the scope of the written solicitation or contract.

Disenroll: See Disenrollment, below.

Disenrollment: A change in the status of a member from being enrolled in the DBPM.

Documentation: The user manuals and any other materials in any form or medium customarily provided by the contractor to the users of the licensed software that will provide the State with sufficient information to operate, diagnose, and maintain the licensed software properly, safely, and efficiently.

Earned hold-back: The portion of the hold-back a DBPM may keep based upon MLTC's determination of the DBPM's results compared with identified performance measures.

Emergency medical condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or, (3) serious dysfunction of any bodily organ or part.

Emergency services: Covered inpatient and outpatient services that are either furnished by a provider that is qualified to furnish these services under Title 42 CFR, or the services needed to evaluate or stabilize an emergency medical condition.

Encounter data: Line-level utilization and expenditure data for services furnished to members through a DBPM.

Enrollee: An individual entitled to benefits under Title XIX or Title XXI of the Social Security Act and under the rules for participation in the Nebraska Medical Assistance Program.

Enrollment file: A proprietary data file provided by the State to a DBPM. It is the basis for monthly payments to the DBPM.

Evaluation: The process of examining an offer after opening to determine the vendor's responsibility, responsiveness to requirements, and to ascertain other characteristics of the offer that relate to determination of the successful award.

Evaluation Committee: Committee(s) appointed by the requesting agency that advises and assists the procuring office in the evaluation of bids/proposals (offers made in response to written solicitations).

Extension: Continuance of a contract for a specified duration upon the agreement of the parties beyond the original Contract Period. Not to be confused with "Renewal Period".

Federally qualified health centers: A designation that includes all organizations receiving grants under Section 330 of the Public Health Service Act.

Fee-for-service: A method of provider reimbursement based on payments for each service rendered.

Forfeited hold-back: The portion of the hold-back a DBPM must forfeit, based upon MLTC's determination of the DBPM's results compared with identified performance measures. Forfeited hold-back may also be referred to as unearned hold-back.

Foreign Corporation: A foreign corporation that was organized and chartered under the laws of another state, government, or country.

Generally accepted actuarial principles: The common set of actuarial standards, as determined by the American Academy of Actuaries.

Grievance: A written or verbal expression of dissatisfaction about any matter other than an action.

Health Insurance Providers Fee (HIPF): As required by Section 9010 of the Patient Protection and Affordable Care Act (ACA), the fee imposed on each covered entity engaged in the business of providing health insurance for United States health risks.

Hold-back: The portion of the DBPM's revenue that the DBPM must reserve in the hold-back account and may potentially earn based upon MLTC's determination of the DBPM's results on identified performance measures.

Hold-back account: The account a DBPM must establish for the purpose of reserving the hold-back.

Information system(s) (IS): A combination of computing and telecommunications hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e., structured data that may include digitized audio and video and documents, as well as non-digitized audio

and video; and/or (b) the processing of information and non-digitized audio and video for purposes of enabling or facilitating a business process or related transaction.

Insolvency: A financial condition that exists when an entity is unable to pay its debts as they become due in the usual course of business, or when the liabilities of the entity exceed its assets.

Late Bid/Proposal: An offer received after the Opening Date and Time.

Mandatory/Must: Required, compulsory, or obligatory.

Material change: Changes affecting the delivery of care or services provided under this RFP. Material changes include, but are not limited to, changes in composition of the provider network, subcontractor network, the DBPM's complaint and grievance procedures; healthcare delivery systems, services, changes to expanded services; benefits; geographic service area; enrollment of a new population; procedures for obtaining access to or approval for healthcare services; any and all policies and procedures that required MLTC approval prior to implementation; and the DBPM's capacity to meet minimum enrollment levels. MLTC must make the final determination as to whether a change is material.

May: Discretionary, permitted; used to express possibility.

Medicaid fraud: Fraud is defined by Federal law (42 CFR 455.2) as "an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law."

Medical loss ratio (MLR): The percentage of qualifying revenue spent on covered services for members and allowable QI expenses under this contract.

Medical necessity: Health care services and supplies that are medically appropriate and:

1. Necessary to meet the basic health needs of the member.
2. Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service.
3. Consistent in type, frequency, and duration of treatment with scientifically-based guidelines of national medical, research, or health care coverage organizations or governmental agencies.
4. Consistent with the diagnosis of the condition.
5. Required for means other than convenience of the client or his/her provider.
6. No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency.
7. Of demonstrated value.
8. No more intensive level of service than can be safely provided.

Member: A Medicaid enrollee who is currently enrolled with a DBPM.

Must: See Shall/Will/Must.

Nebraska Medicaid Program (NE Medicaid or Medicaid): NE Medicaid provides health care services to eligible elderly and disabled individuals and eligible low-income pregnant women, children and parents. NE Medicaid also includes the Children's Health Insurance Program and home and community-based services for individuals qualified for Medicaid waivers NE Medicaid is administered by the Division of Medicaid and Long Term Care (MLTC) of the Nebraska Department of Health and Human Services (DHHS).

Net qualified medical expense (for the medical loss ratio): The sum of:

1. Claims incurred
2. Claims incurred but not paid, plus provisions for adverse deviation and loss adjustment expense
3. Medical incentive bonuses
4. Activities that improve health care quality, per 45 CFR 158.150
5. Less related-party medical margin

Non-quality improvement (QI) administrative expenses: All non-benefit expenses of operating pursuant to the requirements of this contract, other than medical, prescription drugs, DME, and other benefits for the contract year. Non-benefit, administrative expenses include:

1. Direct administration: customer service, enrollment, medical management, claims administration, etc.
2. Indirect administration: accounting, actuarial, legal, human resources, etc.

Non-QI administrative expense rate: Non-QI Administrative Expenses divided by Qualifying Revenue.

Open Market Purchase: Authorization may be given to an agency to purchase items above direct purchase authority due to the unique nature, price, quantity, location of the using agency, or time limitations by the AS Materiel Division, State

Purchasing Bureau.

Opening Date and Time: Specified date and time for the public opening of received, labeled, and sealed formal proposals.

Outsourcing: The contracting out of a business process which an organization may have previously performed internally or has a new need for, to an independent organization from which the process is purchased back.

Payroll & Financial Center (PFC): Electronic procurement system of record.

Peer review: A process of evaluating work completed by practitioners in the same professional field.

Performance Bond: An insurance agreement, accompanied by a monetary commitment, by which a third party (the surety) accepts liability and guarantees that the Contractor fulfills any and all obligations under the contract.

Practitioner: A Medicaid enrolled provider who is licensed, registered, or certified by MLTC to practice in the State.

Pre-Bid/Pre-Proposal Conference: A meeting scheduled for the purpose of clarifying a written solicitation and related expectations.

Prepaid ambulatory health plan (PAHP): As defined in 42 CFR §438.2, a PAHP is an entity that:

1. Provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates.
2. Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees.
3. Does not have a comprehensive risk contract.

Product: Something that is distributed commercially for use or consumption and that is usually (1) tangible personal property, (2) the result of fabrication or processing, and (3) an item that has passed through a chain of commercial distribution before ultimate use or consumption.

Project: The total scheme, program, or method worked out for the accomplishment of an objective, including all documentation, commodities, and services to be provided under the contract.

Proposal: See Bid/Proposal.

Proprietary Information: Proprietary information is defined as trade secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and service no public purpose (see Neb. Rev. Stat. § 84-712.05(3)). In accordance with Attorney General Opinions 92068 and 97033, proof that information is proprietary requires identification of specific named competitor(s) advantaged by release of the information and the demonstrated advantage the named competitor(s) would gain by the release of information.

Protest: A complaint about a governmental action or decision related to a Request for Proposal or resultant contract, brought by a vendor who has timely submitted a bid response in connection with the award in question, to AS Materiel Division or another designated agency with the intention of achieving a remedial result.

Provider: Any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency under the FFS model, or for the managed care program, any individual or entity who/that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers the services.

Public Proposal Opening: The process of opening correctly submitted offers at the time and place specified in the written solicitation and in the presence of anyone who wished to attend.

Quality management: The continuous process of assuring appropriate, timely, accessible, available, and medically necessary delivery of services and maintaining established guidelines and standards reflective of the current state of dental health knowledge.

Readiness review: MLTC's assessment of the DBPM's ability to fulfill the contract. Such review may include but not be limited to review of proper licensure, operational protocols, DBPM standards, and DBPM systems. This review may be done as a desk review, on-site review, or combination and may include interviews with pertinent DBPM personnel.

Related party medical margin: The difference between medical costs incurred, including a related-party relationship and those incurred in the absence of a related-party arrangement. An arrangement whereby a DBPM pays a related party a sub-capitation.

Release Date: The date of public release of the written solicitation to seek offers

Renewal Period: Optional contract periods subsequent to the original Contract Period for a specified duration with previously agreed to terms and conditions. Not to be confused with Extension.

Request for Proposal (RFP): A written solicitation utilized for obtaining competitive offers.

Responsible Bidder: A bidder who has the capability in all respects to perform fully and lawfully all requirements with integrity and reliability to assure good faith performance.

Responsive Bidder: A bidder who has submitted a bid which conforms to all requirements of the solicitation document.

Risk contract: A contract under which the contractor: (1) assumes risk for the cost of the services covered under the contract; and (2) incurs loss if the cost of furnishing the services exceeds the payments under the contract.

Significant Business Transaction: Any business transaction or series of transactions during any State fiscal year that exceed(s) $25,000 or five percent (5%) of the DBPM's total operating expenses, whichever is greater.

Shall/Will/Must: An order/command; mandatory.

Should: Expected; suggested, but not necessarily mandatory.

Solvency: The minimum standard of financial health for a DBPM, where assets exceed liabilities and timely payment requirements can be met.

Software License: Legal instrument with or without printed material that governs the use or redistribution of licensed software.

Sole Source – Commodity: When an item is available from only one source due to the unique nature of the requirement, its supplier, or market conditions.

Sole Source – Services: A service of such a unique nature that the vendor selected is clearly and justifiably the only practical source to provide the service. Determination that the vendor selected is justifiably the sole source is based on either the uniqueness of the service or sole availability at the location required.

Specifications: The detailed statement, especially of the measurements, quality, materials, and functional characteristics, or other items to be provided under a contract.

State: The State of Nebraska or Nebraska.

State fair hearing: A request by a member or provider to appeal a decision made by a DBPM, addressed to the State.

State share: A portion of funds originally contributed by the State, rather than the Federal government, to the operation of the Medicaid program.

Subcontractor: Any subcontractor including any organization or person who provides a function or service for a DBPM specifically related to securing or fulfilling the DBPM's obligations under the terms of a contract. A subcontractor does not include a provider unless the provider is responsible for services other than those that could be covered by a provider agreement.

System (see Module): Any collection or aggregation of two (2) or more Modules that is designed to function, or is represented by the Contractor as functioning or being capable of functioning, as an entity.

Termination: Occurs when either party, pursuant to a power created by agreement or law, puts an end to the contract prior to the stated expiration date. All obligations which are still executory on both sides are discharged but any right based on prior breach or performance survives.

Third-party liability (TPL): Refers to the legal obligation of third parties to pay part or all of the expenditures for medical assistance furnished under a Medicaid state plan.

Third-party resource: Any individual, entity, or program that is or may be liable to pay all or part of the cost of any medical services furnished to a member.

Trade Secret: Information, including, but not limited to, a drawing, formula, pattern, compilation, program, device, method, technique, code, or process that (a) derives independent economic value, actual or potential, from not being known to, and not being ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use; and (b) is the subject of efforts that are reasonable under the circumstances to maintain its secrecy (see Neb. Rev. Stat. §87-502(4)).

Trademark: A word, phrase, logo, or other graphic symbol used by a manufacturer or vendor to distinguish its product from those of others, registered with the U.S. Patent and Trademark Office.

Turnover: Those activities that the DBPM is required to perform upon termination or expiration of the contract in situations in which the DBPM must transition contract operations to MLTC or a third party.

Upgrade: Any change that improves or alters the basic function of a product of service.

Value-added services: Those services a DBPM provides in addition to services covered under this contract for which the DBPM receives no additional payment from the State.

Vendor: An individual or entity lawfully conducting business in the State of Nebraska, or licensed to do so, who seeks to provide goods or services under the terms of a written solicitation.

Vendor Performance Report: A report issued to the Contractor by State Purchasing Bureau when products or services delivered or performed fail to meet the terms of the purchase order, contract, and/or specifications, as reported to State Purchasing Bureau by the agency. The State Purchasing Bureau shall contact the Contractor regarding any such report. The vendor performance report will become a part of the permanent record for the Contractor. The State may require vendor to cure. Two such reports may be cause for immediate termination.

Will: See Shall/Will/Must.

Work Day: See Business Day.

I. SCOPE OF THE REQUEST FOR PROPOSAL

The State of Nebraska, Administrative Services (AS), Materiel Division, State Purchasing Bureau (hereafter known as State Purchasing Bureau), is issuing this Request for Proposal, RFP Number 5427 Z1 for the purpose of selecting a qualified Contractor to manage the Medicaid Dental Benefit Program. Any resulting contract is not an exclusive contract to furnish the services provided for in this Request for Proposal, and does not preclude the purchase of similar services from other sources.

A contract resulting from this Request for Proposal will be issued from date of award through December 31, 2022. The contract has the option to be renewed for two (2) additional one (1) year periods as mutually agreed upon by all parties. The State reserves the right to extend the period of this contract beyond the termination date when mutually agreeable to the Contractor and the State of Nebraska.

ALL INFORMATION PERTINENT TO THIS REQUEST FOR PROPOSAL CAN BE FOUND ON THE INTERNET AT: http://das.nebraska.gov/materiel/purchasing.html

A. SCHEDULE OF EVENTS

The State expects to adhere to the tentative procurement schedule shown below. It should be noted, however, that some dates are approximate and subject to change.

	ACTIVITY	DATE/TIME
1.	Release Request for Proposal	September 1, 2016
2.	Last day to submit "Notification of Intent to Attend Pre-Proposal Conference"	September 22, 2016
3.	Mandatory Pre-Proposal Conference Location: Nebraska State Office Building 301 Centennial Mall South Lower Level, Conference Room A Lincoln, NE 68509 ** Registration Advisement:* *Bids will only be accepted from those Companies/Firms which properly register their attendance at this meeting by completing all of the required information on the State Registration Sheet.*	September 27, 2016 1:00 – 3:00 PM Central Time
4.	Last day to submit written questions after Pre-Proposal Conference	October 3, 2016
5.	State responds to written questions through Request for Proposal "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html	October 17, 2016
6.	Proposal opening Location: State Purchasing Bureau 1526 K Street, Suite 130 Lincoln, NE 68508	October 25, 2016 2:00 PM Central Time
7.	Review for conformance of mandatory requirements	October 26 - 28, 2016
8.	Evaluation period	October 31 – November 15, 2016
9.	"Oral Interviews/Presentations and/or Demonstrations" (if required)	TBD
10.	Post "Letter of Intent to Contract" to Internet at: http://das.nebraska.gov/materiel/purchasing.html	November 21, 2016
11.	Contract finalization period	November 22, 2016 – January 3, 2017
12.	Contract award	January 3, 2017
13.	Contractor start date	July 1, 2017

II. PROCUREMENT PROCEDURES

A. PROCURING OFFICE AND CONTACT PERSON

Procurement responsibilities related to this Request for Proposal reside with the State Purchasing Bureau. The point of contact for the procurement is as follows:

Name:	Michelle Thompson / Teresa Fleming
Agency:	State Purchasing Bureau
Address:	1526 K Street, Suite 130 Lincoln, NE 68508
Telephone:	402-471-6500
Facsimile:	402-471-2089
E-Mail:	as.materielpurchasing@nebraska.gov

B. GENERAL INFORMATION

The Request for Proposal is designed to solicit proposals from qualified vendors who will be responsible for managing the Medicaid Dental Benefit Program. Proposals that do not conform to the mandatory items as indicated in the Request for Proposal will not be considered.

Proposals shall conform to all instructions, conditions, and requirements included in the Request for Proposal. Prospective bidders are expected to carefully examine all documentation, schedules, and requirements stipulated in this Request for Proposal, and respond to each requirement in the format prescribed.

A fixed-price contract will be awarded as a result of this proposal. In addition to the provisions of this Request for Proposal and the awarded proposal, which shall be incorporated by reference in the contract, any additional clauses or provisions required by the terms and conditions will be included as an amendment to the contract.

C. CUSTOMER SERVICE

In addition to any specified service requirements contained in this agreement, the Contractor agrees and understands that satisfactory customer service is required. Contractor will develop or provide technology and business procedures designed to enhance the level of customer satisfaction and to provide the customer appropriate information given their situation. Contractor, its employees, Subcontractors, and agents must be accountable, responsive, reliable, patient, and have well-developed communication skills as set forth by the customer service industry's best practices and processes.

D. COMMUNICATION WITH STATE STAFF AND EVALUATORS

From the date the Request for Proposal is issued until a determination is announced regarding the selection of the Contractor, contact regarding this project between potential Contractors and individuals employed by the State is restricted to only written communication with the staff designated above as the point of contact for this Request for Proposal. Bidders shall not have any communication with, or attempt to communicate with or influence in any way, any evaluator involved in this RFP.

Once a Contractor is preliminarily selected, as documented in the intent to contract, that Contractor is restricted from communicating with State staff until a contract is signed. Violation of this condition may be considered sufficient cause to reject a Contractor's proposal and/or selection irrespective of any other condition.

The following exceptions to these restrictions are permitted:

1. written communication with the person(s) designated as the point(s) of contact for this Request for Proposal or procurement;
2. contacts made pursuant to any pre-existing contracts or obligations;
3. state staff and/or Contractor staff present at the Pre-Proposal Conference when recognized by the State Purchasing Bureau staff facilitating the meeting for the purpose of addressing questions; and
4. State-requested presentations, key personnel interviews, clarification sessions or discussions to finalize a contract.

Violations of these conditions may be considered sufficient cause to reject a bidder's proposal and/or selection irrespective of any other condition. No individual member of the State, employee of the State, or member of the Evaluation Committee is empowered to make binding statements regarding this Request for Proposal. The buyer will issue any clarifications or opinions regarding this Request for Proposal in writing.

E. WRITTEN QUESTIONS AND ANSWERS

Any explanation desired by a bidder regarding the meaning or interpretation of any Request for Proposal provision must be submitted in writing to the State Purchasing Bureau and clearly marked "RFP Number 5427 Z1; Medicaid Dental Benefit Program Questions". It is preferred that questions be sent via e-mail to as.materielpurchasing@nebraska.gov. Questions may also be sent by facsimile to 402-471-2089, but must include a cover sheet clearly indicating that the transmission is to the attention of Michelle Thompson / Teresa Fleming, showing the total number of pages transmitted, and clearly marked "RFP Number 5427 Z1; Medicaid Dental Benefit Program Questions".

It is recommended that Bidders submit questions sequentially numbered, include the RFP reference and page number using the following format.

Question Number	RFP Section Reference	RFP Page Number	Question

Written answers will be provided through an addendum to be posted on the Internet at http://das.nebraska.gov/materiel/purchasing.html on or before the date shown in the Schedule of Events.

F. PRE-PROPOSAL CONFERENCE

A pre-proposal conference will be held on the date, time, and location shown in the Schedule of Events. Attendance at the pre-proposal conference is mandatory in order to submit a proposal. Bidders will have an opportunity to ask questions at the conference to assist in the clarification and understanding of the Request for Proposal requirements. The State will make every reasonable attempt to answer those questions before the end of the conference. Bidders attending the pre-proposal meeting may submit further questions in writing for questions which the bidder requires an official written response as shown in the Schedule of Events.

Written answers to written questions along with a list of conference attendees will be provided through an addendum to be posted on the Internet at http://das.nebraska.gov/materiel/purchasing.html on or before the date shown in the Schedule of Events. Verbal responses provided during the pre-proposal meeting shall not be binding on the State of Nebraska.

1. NOTIFICATION OF INTENT TO ATTEND MANDATORY PRE-PROPOSAL CONFERENCE

Notification of attendance should be submitted to the State Purchasing Bureau via e-mail (as.materielpurchasing@nebraska.gov), facsimile (402-471-2089), hand delivery or US mail by the date shown in the Schedule of Events. Potential bidders should utilize the "Notification of Intent to Attend Pre-Proposal Conference" (see Form B) that accompanies this document to the contact person shown on the cover page of the Request for Proposal Form. This form should be filled out in its entirety and returned no later than the date shown in the Schedule of Events.

G. ORAL INTERVIEWS/PRESENTATIONS AND/OR DEMONSTRATIONS

The Evaluation Committee(s) may conclude after the completion of the Technical Proposal evaluation that oral interviews/presentations and/or demonstrations are required in order to determine the successful bidder. All bidders may not have an opportunity to interview/present and/or give demonstrations; the State reserves the right to select only the top scoring bidders to present/give oral interviews in its sole discretion. The scores from the oral interviews/presentations and/or demonstrations will be added to the scores from the Technical Proposal. The presentation process will allow the bidders to demonstrate their proposal offering, explaining and/or clarifying any unusual or significant elements related to their proposals. Bidders' key personnel may be requested to participate in a structured interview to determine their understanding of the requirements of this proposal, their authority and reporting relationships within their firm, and their management style and philosophy. Bidders shall not be allowed to alter or amend their proposals. Only representatives of the State and the presenting bidders will be permitted to attend the oral interviews/presentations and/or demonstrations.

Once the oral interviews/presentations and/or demonstrations have been completed the State reserves the right to make a contract award without any further discussion with the bidders regarding the proposals received.

Detailed notes of oral interviews/presentations and/or demonstrations may be recorded and supplemental information (such as briefing charts, et cetera) may be accepted; however, such supplemental information shall not be considered an amendment to a bidders' proposal. Additional written information gathered in this manner shall not constitute replacement of proposal contents.

Any cost incidental to the oral interviews/presentations and/or demonstrations shall be borne entirely by the bidder and will not be compensated by the State.

H. SUBMISSION OF PROPOSALS

The following describes the requirements related to proposal submission, proposal handling, and review by the State.

To facilitate the proposal evaluation process, one (1) original of the entire proposal must be submitted. Proposals must be submitted by the proposal due date and time. A separate sheet must be provided that clearly states which sections have been submitted as proprietary or have copyrighted materials. All proprietary information the bidder wishes the State to withhold must be submitted in accordance with the instructions outlined in Section III, Proprietary Information. Proposal responses should include the completed Form A, Bidder Contact Sheet. Proposals must reference the Request for Proposal number and be sent to the specified address. Please note that the address label should appear as specified in Section II part A on the face of each container or bidder's bid response packet. Rejected late proposals will be returned to the bidder unopened, if requested, at bidder's expense. If a recipient phone number is required for delivery purposes, 402-471-6500 should be used. The Request for Proposal number must be included in all correspondence.

Emphasis should be concentrated on conformance to the Request for Proposal instructions, responsiveness to requirements, completeness, and clarity of content. Proposal responses should be concise. If the bidder's proposal is presented in such a fashion that makes evaluation difficult or overly time consuming, it is likely that the proposal will be rejected.

The Technical Proposal should be presented in separate sections (loose-leaf binders are preferred) on standard 8 ½" x 11" paper, except that charts, diagrams and the like may be on fold-outs which, when folded, fit into the 8 ½" by 11" format. Pages may be consecutively numbered for the entire proposal, or may be numbered consecutively within sections. Figures and tables should be numbered consecutively within sections. Figures and tables should be numbered and referenced in the text by that number. They should be placed as close as possible to the referencing text.

I. PROPOSAL OPENING

The sealed proposals will be publicly opened and the bidding entities announced on the date, time, and location shown in the Schedule of Events. Proposals will be available for viewing by those present at the proposal opening. Vendors may also contact the State to schedule an appointment for viewing proposals after the Intent to Award has been posted to the website.

J. LATE PROPOSALS

Proposals received after the time and date of the proposal opening will be considered late proposals. Rejected late proposals will be returned to the bidder unopened, if requested, at bidder's expense. The State is not responsible for proposals that are late or lost due to mail service inadequacies, traffic, or any other reason(s).

K. REJECTION OF PROPOSALS

The State reserves the right to reject any or all proposals, wholly or in part, or to award to multiple bidders in whole or in part. The State reserves the right to waive any deviations or errors that are not material, do not invalidate the legitimacy of the proposal and do not improve the bidder's competitive position. All awards will be made in a manner deemed in the best interest of the State.

L. EVALUATION OF PROPOSALS

All proposals that are responsive to the Request for Proposal will be evaluated. Each category will have a maximum possible point potential. The State will conduct a fair, impartial, and comprehensive evaluation of all responsive proposals in accordance with the criteria set forth below. The State may elect to use a third-party to conduct credit checks as part of the corporate overview evaluation. Areas that will be addressed and scored during the evaluation include:

1. Corporate Overview should include but is not limited to:
- **a.** the ability, capacity, and skill of the bidder to deliver and implement the system or project that meets the requirements of the Request for Proposal;
- **b.** the character, integrity, reputation, judgment, experience, and efficiency of the bidder;
- **c.** whether the bidder can perform the contract within the specified time frame;
- **d.** the quality of bidder performance on prior contracts;
- **e.** such other information that may be secured and that has a bearing on the decision to award the contract; and

2. Technical Approach.

Neb. Rev. Stat. § 73-107 allows for a preference for a resident disabled veteran or business located in a designated enterprise zone. When a state contract is to be awarded to the lowest responsible bidder, a resident disabled veteran or a business located in a designated enterprise zone under the Enterprise Zone Act shall be allowed a preference over any other resident or nonresident bidder, if all other factors are equal.

Resident disabled veterans means any person (a) who resides in the State of Nebraska, who served in the United States Armed Forces, including any reserve component or the National Guard, who was discharged or otherwise separated with a characterization of honorable or general (under honorable conditions), and who possesses a disability rating letter issued by the United States Department of Veterans Affairs establishing a service-connected disability or a disability determination from the United States Department of Defense and (b)(i) who owns and controls a business or, in the case of a publicly owned business, more than fifty percent of the stock is owned by one or more persons described in subdivision (a) of this subsection and (ii) the management and daily business operations of the business are controlled by one or more persons described in subdivision(a) of this subsection. Any contract entered into without compliance with this section shall be null and void.

Therefore, if a resident disabled veteran or business located in a designated enterprise zone submits a bid in accordance with Neb. Rev. Stat. § 73-107 and has so indicated on the RFP cover page under "Bidder must complete the following" requesting priority/preference to be considered in the award of this contract, the following will need to be submitted by the vendor within ten (10) business days of request:

1. Documentation from the United States Armed Forces confirming service;
2. Documentation of discharge or otherwise separated characterization of honorable or general (under honorable conditions);
3. Disability rating letter issued by the United States Department of Veterans Affairs establishing a service-connected disability or a disability determination from the United States Department of Defense; and
4. Documentation which shows ownership and control of a business or, in the case of a publicly owned business, more than fifty percent of the stock is owned by one or more persons described in subdivision (a) of this subsection; and the management and daily business operations of the business are controlled by one or more persons described in subdivision (a) of this subsection.

Failure to submit the requested documentation within ten (10) business days of notice will disqualify the bidder from consideration of the preference.

Evaluation criteria will be released with the Request for Proposal. Evaluation criteria and a list of respondents will be posted to the State Purchasing Bureau website at http://das.nebraska.gov/materiel/purchasing.html

M. EVALUATION COMMITTEE

Proposals will be independently evaluated by members of the Evaluation Committee(s). The Evaluation Committee(s) will consist of staff with the appropriate expertise to conduct such proposal evaluations. Names of the members of the Evaluation Committee(s) will not be published.

Prior to award, bidders are advised that only the point of contact indicated on the front cover of this Request for Proposal For Contractual Services Form can clarify issues or render any opinion regarding this Request for Proposal. No individual member of the State, employee of the State, or member of the Evaluation Committee(s) is empowered to make binding statements regarding this Request for Proposal.

Any contact, or attempted contact, with an evaluator that is involved with this RFP may result in the rejection of this proposal and further administrative actions may be taken.

N. MANDATORY REQUIREMENTS

The proposals will first be examined to determine if all mandatory requirements listed below have been addressed to warrant further evaluation. Proposals not meeting mandatory requirements will be excluded from further evaluation. The mandatory requirement items are as follows:

1. Request for Proposal For Contractual Services form, signed in ink;
2. Corporate Overview;
3. Completed Section III; and
4. Technical Approach.

O. REFERENCE CHECKS

The State reserves the right to check any reference(s), regardless of the source of the reference information, including but not limited to, those that are identified by the company in the proposal, those indicated through the explicitly specified contacts, those that are identified during the review of the proposal, or those that result from communication with other entities involved with similar projects. The State may use a third-party to conduct reference checks.
Information to be requested and evaluated from references may include, but is not limited to, some or all of the following: financial stability of the company, project description and background, job performed, functional and technical abilities, communication skills and timeliness, cost and schedule estimates and accuracy, problems (poor quality deliverables, contract disputes, work stoppages, et cetera), overall performance, and whether or not the

reference would rehire the firm or individual. Only top scoring bidders may receive reference checks, and negative references may eliminate bidders from consideration for award.

P. SECRETARY OF STATE/TAX COMMISSIONER REGISTRATION REQUIREMENTS

All bidders should be authorized to transact business in the State of Nebraska. All bidders are expected to comply with all Nebraska Secretary of State Registration requirements. It is the responsibility of the bidder to comply with any registration requirements pertaining to types of business entities (e.g. person, partnership, foreign or domestic limited liability company, association, or foreign or domestic corporation or other type of business entity). The bidder who is the recipient of an Intent to Award will be required to certify that it has so complied and produce a true and exact copy of its current (within ninety (90) calendar days), valid Certificate of Good Standing or Letter of Good Standing; or in the case of a sole proprietorship, provide written documentation of sole proprietorship. This must be accomplished prior to the award of the contract. Construction Contractors are expected to meet all applicable requirements of the Nebraska Contractor Registration Act and provide a current, valid certificate of registration. Further, all bidders shall comply with any and all other applicable Nebraska statutes regarding transacting business in the State of Nebraska. Bidders should submit the above certification(s) with their bid.

If a bank is registered with the Office of Comptroller of Currency, it is not required to register with the State. However, the Office of Comptroller of Currency does have a certificate of good standing/registration. The bank could provide that for verification. (Optional)

Q. VIOLATION OF TERMS AND CONDITIONS

Violation of the terms and conditions contained in this Request for Proposal or any resultant contract, at any time before or after the award, shall be grounds for action by the State which may include, but is not limited to, the following:

1. Rejection of a bidder's proposal;
2. Withdrawal of the Intent to Award;
3. Termination of the resulting contract;
4. Legal action; or
5. Suspension of the bidder from further bidding with the State for the period of time relative to the seriousness of the violation, such period to be within the sole discretion of the State.

III. TERMS AND CONDITIONS

By signing the "Request for Proposal for Contractual Services" form, the bidder guarantees compliance with the provisions stated in this Request for Proposal, agrees to the Terms and Conditions unless otherwise agreed to, and certifies bidder maintains a drug free work place environment.

Bidders are expected to closely read the Terms and Conditions and provide a binding signature of intent to comply with the Terms and Conditions; provided, however, a bidder may indicate any exceptions to the Terms and Conditions by (1) clearly identifying the term or condition by subsection, and (2) including an explanation for the bidder's inability to comply with such term or condition which includes a statement recommending terms and conditions the bidder would find acceptable. Rejection in whole or in part of the Terms and Conditions may be cause for rejection of a bidder's proposal. **Bidders must include completed Section III with their proposal response.**

The State of Nebraska is soliciting bids in response to the RFP. The State of Nebraska will not consider proposals that propose the substitution of the bidder's contract, agreements, or terms for those of the State of Nebraska's. Any License, Service Agreement, Customer Agreement, User Agreement, Bidder Terms and Conditions, Document, or Clause purported or offered to be included as a part of this RFP must be submitted as individual clauses, as either a counter-offer or additional language, and each clause must be acknowledged and accepted in writing by the State. If the Bidder's clause is later found to be in conflict with the RFP or resulting contract the Bidder's clause shall be subordinate to the RFP or resulting contract.

A. GENERAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The contract resulting from this Request for Proposal shall incorporate the following documents:

1. Amendment to Contract Award with the most recent dated amendment having the highest priority;
2. Contract Award and any attached Addenda;
3. The Request for Proposal form and the Contractor's Proposal, signed in ink;
4. Amendments to RFP and any Questions and Answers; and
5. The original RFP document and any Addenda.

These documents constitute the entirety of the contract.

Unless otherwise specifically stated in a contract amendment, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference with number one (1) receiving preference over all other documents and with each lower numbered document having preference over any higher numbered document: 1) Amendment to Contract Award with the most recent dated amendment having the highest priority, 2) Contract Award and any attached Addenda, 3) the signed Request for Proposal form and the Contractor's Proposal, 4) Amendments to RFP and any Questions and Answers, 5) the original RFP document and any Addenda.

Any ambiguity in any provision of this contract which shall be discovered after its execution shall be resolved in accordance with the rules of contract interpretation as established in the State of Nebraska.

Once proposals are opened they become the property of the State of Nebraska and will not be returned.

B. AWARD

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

All purchases, leases, or contracts which are based on competitive proposals will be awarded according to the provisions in the Request for Proposal. The State reserves the right to reject any or all proposals, in whole or in part, or to award to multiple bidders in whole or in part, and at its discretion, may withdraw or amend the Request for Proposal at any time. The State reserves the right to waive any deviations or errors that are not material, do not invalidate the legitimacy of the proposal, and do not improve the bidder's competitive position. All awards will be made in a manner deemed in the best interest of the State. The Request for Proposal does not commit the State to award a contract. If, in the opinion of the State, revisions or amendments will require substantive changes in proposals, the due date may be extended.

By submitting a proposal in response to this Request for Proposal, the bidder grants to the State the right to contact or arrange a visit in person with any or all of the bidder's clients.

Once intent to award decision has been determined, it will be posted to the Internet at:
http://das.nebraska.gov/materiel/purchasing.html

Protest procedure is available on the Internet at:
http://das.nebraska.gov/materiel/purchase_bureau/docs/vendors/protest/ProtestGrievanceProcedureForVendors.pdf

Any protests must be filed by a vendor within ten (10) business days after the intent to award decision is posted to the Internet.

C. COMPLIANCE WITH CIVIL RIGHTS LAWS AND EQUAL OPPORTUNITY EMPLOYMENT / NONDISCRIMINATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall comply with all applicable local, state, and federal statutes and regulations regarding civil rights laws and equal opportunity employment. The Nebraska Fair Employment Practice Act prohibits Contractors of the State of Nebraska, and their Subcontractors, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions, compensation, or privileges of employment because of race, color, religion, sex, disability, marital status, or national origin (Neb. Rev. Stat. §§ 48-1101 to 48-1125). The Contractor guarantees compliance with the Nebraska Fair Employment Practice Act, and breach of this provision shall be regarded as a material breach of contract. The Contractor shall insert a similar provision in all Subcontracts for services to be covered by any contract resulting from this Request for Proposal.

D. PERMITS, REGULATIONS, LAWS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall procure and pay for all permits, licenses, and approvals necessary for the execution of the contract. The Contractor shall comply with all applicable local, state, and federal laws, ordinances, rules, orders, and regulations.

E. OWNERSHIP OF INFORMATION AND DATA

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State of Nebraska shall have the unlimited right to publish, duplicate, use, and disclose all non-proprietary information and data developed or derived by the Contractor pursuant to this contract.

The Contractor must guarantee that it has the full legal right to the materials, supplies, equipment, and other rights or titles (e.g. rights to licenses transfer or assign deliverables) necessary to execute this contract. The contract price shall, without exception, include compensation for all royalties and costs arising from patents, trademarks, and copyrights that are in any way involved in the contract. It shall be the responsibility of the Contractor to pay for all royalties and costs, and the State must be held harmless from any such claims.

F. INSURANCE REQUIREMENTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall not commence work under this contract until all the insurance required hereunder has been obtained and such insurance has been approved by the State. The Contractor shall maintain all required insurance for the life of this contract and shall ensure that the State Purchasing Bureau has the most current certificate of insurance throughout the life of this contract. If Contractor will be utilizing any Subcontractors, the Contractor is responsible for obtaining the certificate(s) of insurance required herein under from any and all Subcontractor(s). The Contractor is also responsible for ensuring Subcontractor(s) maintain the insurance required until completion of the contract requirements. The Contractor shall not allow any Subcontractor to commence work on any Subcontract until all similar insurance required of the Subcontractor has been obtained and approved by the Contractor. Approval of the insurance by the State shall not limit, relieve, or decrease the liability of the Contractor hereunder.

If by the terms of any insurance a mandatory deductible is required, or if the Contractor elects to increase the mandatory deductible amount, the Contractor shall be responsible for payment of the amount of the deductible in the event of a paid claim.

Insurance coverages shall function independent of all other clauses in the contract, and in no instance shall the limits of recovery from the insurance be reduced below the limits required by this section.

1. WORKERS' COMPENSATION INSURANCE

The Contractor shall take out and maintain during the life of this contract the statutory Workers' Compensation and Employer's Liability Insurance for all of the contactors' employees to be engaged in work

on the project under this contract and, in case any such work is sublet, the Contractor shall require the Subcontractor similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the Subcontractor's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work is to be performed, including Occupational Disease. This policy shall include a waiver of subrogation in favor of the State. The amounts of such insurance shall not be less than the limits stated hereinafter.

2. COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE

The Contractor shall take out and maintain during the life of this contract such Commercial General Liability Insurance and Commercial Automobile Liability Insurance as shall protect Contractor and any Subcontractor performing work covered by this contract from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this contract, whether such operation be by the Contractor or by any Subcontractor or by anyone directly or indirectly employed by either of them, and the amounts of such insurance shall not be less than limits stated hereinafter.

The Commercial General Liability Insurance shall be written on an occurrence basis, and provide Premises/Operations, Products/Completed Operations, Independent Contractors, Personal Injury, and Contractual Liability coverage. The policy shall include the State, and others as required by the contract documents, as Additional Insured(s). This policy shall be primary, and any insurance or self-insurance carried by the State shall be considered excess and non-contributory. The Commercial Automobile Liability Insurance shall be written to cover all Owned, Non-owned, and Hired vehicles.

3. INSURANCE COVERAGE AMOUNTS REQUIRED

COMMERCIAL GENERAL LIABILITY	
General Aggregate	$4,000,000
Products/Completed Operations Aggregate	$4,000,000
Personal/Advertising Injury	$1,000,000 per occurrence
Bodily Injury/Property Damage	$1,000,000 per occurrence
Medical Payments	$10,000 any one person
Damage to Rented Premises	$300,000 each occurrence
Contractual	Included
Independent Contractors	Included
Abuse & Molestation	Included
If higher limits are required, the Umbrella/Excess Liability limits are allowed to satisfy the higher limit.	
WORKER'S COMPENSATION	
Employers Liability Limits	$500K/$500K/$500K
Statutory Limits- All States	Statutory - State of Nebraska
USL&H Endorsement	Statutory
Voluntary Compensation	Statutory
COMMERCIAL AUTOMOBILE LIABILITY	
Bodily Injury/Property Damage	$1,000,000 combined single limit
Include All Owned, Hired & Non-Owned Automobile liability	Included
UMBRELLA/EXCESS LIABILITY	
Over Primary Insurance	$5,000,000
PROFESSIONAL LIABILITY	
Errors and Omissions	$7,000,000
COMMERCIAL CRIME	
Crime/Employee Dishonesty Including 3rd Party Fidelity	$7,000,000
CYBER LIABILITY	
Breach of Privacy, Security Breach, Denial of Service, Remediation, Fines and Penalties	$15,000,000
SUBROGATION WAIVER	
"Workers' Compensation policy shall include a waiver of subrogation in favor of the State of Nebraska."	
LIABILITY WAIVER	
"Commercial General Liability & Commercial Automobile Liability policies shall be primary and any insurance or self-insurance carried by the State shall be considered excess and non-contributory."	

4. EVIDENCE OF COVERAGE

The Contractor should furnish the State, with their proposal response, a certificate of insurance coverage complying with the above requirements to the attention of the Buyer at 402-471-2089 (fax)

Administrative Services
State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, NE 68508

These certificates or the cover sheet must reference the RFP number, and the certificates must include the name of the company, policy numbers, effective dates, dates of expiration, and amounts and types of coverage afforded. If the State is damaged by the failure of the Contractor to maintain such insurance, then the Contractor shall be responsible for all reasonable costs properly attributable thereto.

Notice of cancellation of any required insurance policy must be submitted to Administrative Services State Purchasing Bureau when issued and a new coverage binder must be submitted immediately to ensure no break in coverage.

G. COOPERATION WITH OTHER CONTRACTORS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State may already have in place or choose to award supplemental contracts for work related to this Request for Proposal, or any portion thereof.

1. The State reserves the right to award the contract jointly between two or more potential Contractors, if such an arrangement is in the best interest of the State.

2. The Contractor must agree to cooperate with such other Contractors, and shall not commit or permit any act which may interfere with the performance of work by any other Contractor.

H. INDEPENDENT CONTRACTOR

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

It is agreed that nothing contained herein is intended or should be construed in any manner as creating or establishing the relationship of partners between the parties hereto. The Contractor represents that it has, or will secure at its own expense, all personnel required to perform the services under the contract. The Contractor's employees and other persons engaged in work or services required by the contractor under the contract shall have no contractual relationship with the State; they shall not be considered employees of the State.

All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination against the Contractor, its officers, or its agents) shall in no way be the responsibility of the State. The Contractor will hold the State harmless from any and all such claims. Such personnel or other persons shall not require nor be entitled to any compensation, rights, or benefits from the State including without limit, tenure rights, medical and hospital care, sick and vacation leave, severance pay, or retirement benefits.

I. CONTRACTOR RESPONSIBILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor is solely responsible for fulfilling the contract, with responsibility for all services offered and products to be delivered as stated in the Request for Proposal, the Contractor's proposal, and the resulting contract. The Contractor shall be the sole point of contact regarding all contractual matters.

If the Contractor intends to utilize any Subcontractor's services, the Subcontractor's level of effort, tasks, and time allocation must be clearly defined in the Contractor's proposal. The Contractor shall agree that it will not utilize any Subcontractors not specifically included in its proposal in the performance of the contract without the prior written authorization of the State. Following execution of the contract, the Contractor shall proceed diligently with all services and shall perform such services with qualified personnel in accordance with the contract.

J. CONTRACTOR PERSONNEL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor warrants that all persons assigned to the project shall be employees of the Contractor or specified Subcontractors, and shall be fully qualified to perform the work required herein. Personnel employed by the Contractor to fulfill the terms of the contract shall remain under the sole direction and control of the Contractor. The Contractor shall include a similar provision in any contract with any Subcontractor selected to perform work on the project.

Personnel commitments made in the Contractor's proposal shall not be changed without the prior written approval of the State. Replacement of key personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications.

The State reserves the right to require the Contractor to reassign or remove from the project any Contractor or Subcontractor employee.

In respect to its employees, the Contractor agrees to be responsible for the following:

1. any and all employment taxes and/or other payroll withholding;
2. any and all vehicles used by the Contractor's employees, including all insurance required by state law;
3. damages incurred by Contractor's employees within the scope of their duties under the contract;
4. maintaining workers' compensation and health insurance and submitting any reports on such insurance to the extent required by governing State law; and
5. determining the hours to be worked and the duties to be performed by the Contractor's employees.

K. CONTRACT CONFLICTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Contractor shall insure that contracts or agreements with sub-contractors and agents, and the performance of services in relation to this contract by sub-contractors and agents, does not conflict with this contract.

L. STATE OF NEBRASKA PERSONNEL RECRUITMENT PROHIBITION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall not recruit or employ any State employee or agent who has worked on the Request for Proposal or project, or who had any influence on decisions affecting the Request for Proposal or project, for a period of two years after the date of award.

M. CONFLICT OF INTEREST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

By submitting a proposal, bidder certifies that there does not now exist any relationship between the bidder and any person or entity which is or gives the appearance of a conflict of interest related to this Request for Proposal or project.

The bidder certifies that it shall not take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its services hereunder or which creates an actual or appearance of conflict of interest.

The bidder certifies that it will not employ any individual known by bidder to have a conflict of interest.

N. PROPOSAL PREPARATION COSTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State shall not incur any liability for any costs incurred by bidders in replying to this Request for Proposal, in the demonstrations and/or oral presentations, or in any other activity related to bidding on this Request for Proposal.

O. ERRORS AND OMISSIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The bidder shall not take advantage of any errors and/or omissions in this Request for Proposal or resulting contract. The bidder must promptly notify the State of any errors and/or omissions that are discovered.

P. BEGINNING OF WORK

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The bidder shall not commence any billable work until a valid contract has been fully executed by the State and the successful Contractor. The Contractor will be notified in writing when work may begin.

Q. ASSIGNMENT BY THE STATE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State shall have the right to assign or transfer the contract or any of its interests herein to any agency, board, commission, or political subdivision of the State of Nebraska. There shall be no charge to the State for any assignment hereunder.

R. ASSIGNMENT BY THE CONTRACTOR

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor may not assign, voluntarily or involuntarily, the contract or any of its rights or obligations hereunder (including without limitation rights and duties of performance) to any third party, without the prior written consent of the State, which will not be unreasonably withheld.

S. DEVIATIONS FROM THE REQUEST FOR PROPOSAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The requirements contained in the Request for Proposal become a part of the terms and conditions of the contract resulting from this Request for Proposal. Any deviations from the Request for Proposal must be clearly defined by the bidder in its proposal and, if accepted by the State, will become part of the contract. Any specifically defined deviations must not be in conflict with the basic nature of the Request for Proposal, mandatory requirements, or applicable state or federal laws or statutes. "Deviation", for the purposes of this RFP, means any proposed changes or alterations to either the contractual language or deliverables within the scope of this RFP. The State discourages deviations and reserves the right to reject proposed deviations.

T. GOVERNING LAW

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The contract shall be governed in all respects by the laws and statutes of the State of Nebraska. Any legal proceedings against the State of Nebraska regarding this Request for Proposal or any resultant contract shall be brought in the State of Nebraska administrative or judicial forums as defined by State law. The Contractor must be in compliance with all Nebraska statutory and regulatory law.

U. ATTORNEY'S FEES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

In the event of any litigation, appeal, or other legal action to enforce any provision of the contract, the Contractor agrees to pay all expenses of such action, as permitted by law, including attorney's fees and costs, if the State is the prevailing party.

V. ADVERTISING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor agrees not to refer to the contract award in advertising in such a manner as to state or imply that the company or its services are endorsed or preferred by the State. News releases pertaining to the project shall not be issued without prior written approval from the State.

W. STATE PROPERTY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall be responsible for the proper care and custody of any State-owned property which is furnished for the Contractor's use during the performance of the contract. The Contractor shall reimburse the State for any loss or damage of such property; normal wear and tear is expected.

X. SITE RULES AND REGULATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall use its best efforts to ensure that its employees, agents, and Subcontractors comply with site rules and regulations while on State premises. If the Contractor must perform on-site work outside of the daily operational hours set forth by the State, it must make arrangements with the State to ensure access to the facility and the equipment has been arranged. No additional payment will be made by the State on the basis of lack of access, unless the State fails to provide access as agreed to between the State and the Contractor.

Y. NOTIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

During the bid process, all communication between the State and a bidder shall be between the bidder's representative clearly noted in its proposal and the buyer noted in Section II.A. Procuring Office and Contact Person, of this RFP. After the award of the contract, all notices under the contract shall be deemed duly given upon delivery to the staff designated as the point of contact for this Request for Proposal, in person, or upon delivery by U.S. Mail, facsimile, or e-mail. Each bidder should provide in its proposal the name, title, and complete address of its designee to receive notices.

1. Except as otherwise expressly specified herein, all notices, requests, or other communications shall be in writing and shall be deemed to have been given if delivered personally or mailed, by U.S. Mail, postage prepaid, return receipt requested, to the parties at their respective addresses set forth above, or at such other addresses as may be specified in writing by either of the parties. All notices, requests, or communications shall be deemed effective upon personal delivery or three (3) calendar days following deposit in the mail.

2. Whenever the Contractor encounters any difficulty which is delaying or threatens to delay its timely performance under the contract, the Contractor shall immediately give notice thereof in writing to the State reciting all relevant information with respect thereto. Such notice shall not in any way constitute a basis for an extension of the delivery schedule or be construed as a waiver by the State of any of its rights or remedies to which it is entitled by law or equity or pursuant to the provisions of the contract. Failure to give such notice, however, may be grounds for denial of any request for an extension of the delivery schedule because of such delay.

Either party may change its address for notification purposes by giving notice of the change, and setting forth the new address and an effective date.

For the duration of the contract, all communication between Contractor and the State regarding the contract shall take place between the Contractor and individuals specified by the State in writing. Communication about the contract between Contractor and individuals not designated as points of contact by the State is strictly forbidden.

Z. EARLY TERMINATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The contract may be terminated as follows:

1. The State and the Contractor, by mutual written agreement, may terminate the contract at any time.

2. The State, in its sole discretion, may terminate the contract for any reason upon thirty (30) calendar day's written notice to the Contractor. Such termination shall not relieve the Contractor of warranty or other service obligations incurred under the terms of the contract including turnover requirements as described in Section IV.W – Termination of DBPM Contract. In the event of termination the Contractor shall be entitled to payment, determined on a pro rata basis, for services satisfactorily performed or provided.

3. The State will provide the Contractor with a timely written Notice of Intent to Terminate (Notice) that states the nature and basis of the penalty or sanction and pre-termination hearing rights.

4. The Contractor may, at the discretion of the State, be allowed to correct the deficiencies within the thirty (30) calendar day notice period, unless other provisions in this Section demand otherwise, prior to the issuance of a Notice of Termination.

5. In accordance with 42 CFR §438.710, the State will conduct a pre-termination hearing upon the request of the DBPM as outlined in the Notice to provide DBPM the opportunity to contest the nature and basis of the sanction.

a. The request must be submitted in writing to the State prior to the determined date of termination stated in the Notice.

b. The DBPM must receive a written notice of the outcome of the pre-termination hearing, if applicable, indicating decision reversal or affirmation.

6. The State will notify Medicaid members enrolled in the DBPM in writing, consistent with 42 CFR §438.710 and §438.722, of the affirming termination decision and of their options for receiving Medicaid services and to disenroll immediately.

7. The State may terminate the contract immediately for the following reasons:

a. if directed to do so by statute;
b. Contractor has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business;
c. a trustee or receiver of the Contractor or of any substantial part of the Contractor's assets has been appointed by a court;
d. fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by its Contractor, its employees, officers, directors, or shareholders;
e. an involuntary proceeding has been commenced by any party against the Contractor under any one of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for at least sixty (60) calendar days; or (ii) the Contractor has consented, either expressly or by operation of law, to the entry of an order for relief; or (iii) the Contractor has been decreed or adjudged a debtor;
f. a voluntary petition has been filed by the Contractor under any of the chapters of Title 11 of the United States Code;

g. Contractor intentionally discloses confidential information;
h. Contractor has or announces it will discontinue support of the deliverable;
i. second or subsequent documented "vendor performance report" form deemed acceptable by the State Purchasing Bureau; or
j. Contractor engaged in collusion or actions which could have provided Contractor an unfair advantage in obtaining this contract.

AA. FUNDING OUT CLAUSE OR LOSS OF APPROPRIATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State may terminate the contract, in whole or in part, in the event funding is no longer available. The State's obligation to pay amounts due for fiscal years following the current fiscal year is contingent upon legislative appropriation of funds for the contract. Should said funds not be appropriated, the State may terminate the contract with respect to those payments for the fiscal years for which such funds are not appropriated. The State will give the Contractor written notice thirty (30) calendar days prior to the effective date of any termination, and advise the Contractor of the location (address and room number) of any related equipment. All obligations of the State to make payments after the termination date will cease and all interest of the State in any related equipment will terminate. The Contractor shall be entitled to receive just and equitable compensation for any authorized work which has been satisfactorily completed as of the termination date. In no event shall the Contractor be paid for a loss of anticipated profit.

BB. BREACH BY CONTRACTOR

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State may terminate the contract, in whole or in part, if the Contractor fails to perform its obligations under the contract in a timely and proper manner. The State may, by providing a written notice of default to the Contractor, allow the Contractor to cure a failure or breach of contract within a period of thirty (30) calendar days (or longer at State's discretion considering the gravity and nature of the default). Said notice shall be delivered by Certified Mail, Return Receipt Requested, or in person with proof of delivery. Allowing the Contractor time to cure a failure or breach of contract does not waive the State's right to immediately terminate the contract for the same or different contract breach which may occur at a different time. In case of default of the Contractor, the State may contract the service from other sources and hold the Contractor responsible for any excess cost occasioned thereby.

Pursuant to 42 CFR §438.708 the State may provide benefits to members through other options included in the Medicaid State Plan if the State, at its sole discretion, determines that the Contractor has failed to carry out the substantive terms of the contract, or meet applicable requirements in Sections 1932, 1903(m) or 1905(t) of the Social Security Act.

CC. ASSURANCES BEFORE BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If any document or deliverable required pursuant to the contract does not fulfill the requirements of the Request for Proposal/resulting contract, upon written notice from the State, the Contractor shall deliver assurances in the form of additional Contractor resources at no additional cost to the project in order to complete the deliverable, and to ensure that other project schedules will not be adversely affected.

DD. ADMINISTRATION – CONTRACT TERMINATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

1. Contractor must provide confirmation that upon contract termination all deliverables prepared in accordance with this agreement shall become the property of the State of Nebraska; subject to the ownership provision (section E) contained herein, and is provided to the State of Nebraska at no additional cost to the State.

2. Contractor must provide confirmation that in the event of contract termination, all records that are the property of the State will be returned to the State within thirty (30) calendar days. Notwithstanding the above, Contractor may retain one copy of any information as required to comply with applicable work product documentation standards or as are automatically retained in the course of Contractor's routine back up procedures.

EE. PENALTY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State has the option to invoke penalties as described in Section IV – Project Description.

FF. PERFORMANCE BOND

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor will be required to supply a bond executed by a corporation authorized to contract surety in the State of Nebraska, payable to the State of Nebraska, which shall be valid for the life of the contract to include any renewal and/or extension periods. The amount of the bond must be $10,000,000.00. The bond will guarantee that the Contractor will faithfully perform all requirements, terms and conditions of the contract. Failure to comply shall be

grounds for forfeiture of the bond as liquidated damages. Amount of forfeiture will be determined by the agency based on loss to the State. The bond will be returned when the service has been satisfactorily completed as solely determined by the State, after termination or expiration of the contract.

The Contractor must obtain and maintain a performance bond, rated a minimum of A by A.M. Best Company, of a standard commercial scope from a surety company or companies holding a certificate of authority to transact surety business in the state. The Contractor must not leverage the bond as collateral for debt or create other creditors using the bond as security. The Contractor must be in breach of this contract if it fails to maintain or renew the performance bond as required by this contract.

1. The Contractor must obtain a performance bond in an amount equal to $10,000,000.00. The bond will guarantee that the selected contractor will faithfully perform all requirements, terms and conditions of the contract. Failure to comply must be grounds for forfeiture of the bond as liquidated damages. Amount of forfeiture will be determined by the agency based on loss to the State. The bond will be returned when the service has been satisfactorily completed as solely determined by the State, after termination or expiration of the contract.

2. The Contractor agrees that if it is declared to be in default of any term of this contract, MLTC may elect to, in addition to any other remedies it may have under this contract, obtain payment under the performance bond for the following:

- **a.** Making funds available through a consensus proceeding in the appropriate court for payment to subcontracted providers and non-contracted health care providers for reimbursement due to nonpayment of claims by Contractor, in the event of a breach of Contractor's obligation under this contract;
- **b.** Reimbursing MLTC for any payments made by MLTC on behalf of the Contractor;
- **c.** Reimbursing MLTC for any extraordinary administrative expenses incurred by a breach of Contractor's obligations under this contract, including, expenses incurred after termination of this contract by MLTC;
- **d.** Making any payments or expenditures deemed necessary to MLTC, in its sole discretion, incurred by MLTC in the direct operation of the contract pursuant to the terms of this contract and to reimburse MLTC for any extraordinary administrative expenses incurred in connection with the direct operation of the Contractor; and
- **e.** The Contractor must reimburse MLTC for expenses exceeding the performance bond amount.

GG. FORCE MAJEURE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Neither party shall be liable for any costs or damages resulting from its inability to perform any of its obligations under the contract due to a natural disaster, or other similar event outside the control and not the fault of the affected party ("Force Majeure Event"). A Force Majeure Event shall not constitute a breach of the contract. The party so affected shall immediately give notice to the other party of the Force Majeure Event. The State may grant relief from performance of the contract if the Contractor is prevented from performance by a Force Majeure Event. The burden of proof for the need for such relief shall rest upon the Contractor. To obtain release based on a Force Majeure Event, the Contractor shall file a written request for such relief with the State Purchasing Bureau. Labor disputes with the impacted party's own employees will not be considered a Force Majeure Event and will not suspend performance requirements under the contract.

HH. PAYMENT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

State will render payment to Contractor when the terms and conditions of the contract and specifications have been satisfactorily completed on the part of the Contractor as solely determined by the State. Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §§ 81-2401 through 81-2408). The State may require the Contractor to accept payment by electronic means such as ACH deposit. In no event shall the State be responsible or liable to pay for any services provided by the Contractor prior to the Effective Date, and the Contractor hereby waives any claim or cause of action for any such services.

II. RIGHT TO AUDIT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Contractor shall establish and maintain a reasonable accounting system that enables the State to readily audit contract. The State and its authorized representatives shall have the right to audit, to examine, and to make copies of or extracts from all financial and related records (in whatever form they may be kept, whether written, electronic, or other) relating to or pertaining to this contract kept by or under the control of the Contractor, including, but not limited to those kept by the Contractor, its employees, agents, assigns, successors, and Subcontractors. Such records shall include, but not be limited to, accounting records, written policies and procedures; all paid vouchers including those for out-of-pocket expenses; other reimbursement supported by invoices; ledgers; cancelled checks; deposit slips; bank statements; journals; original estimates; estimating work sheets; contract amendments and change order files; back charge logs and supporting documentation; insurance documents; payroll documents; timesheets; memoranda; and correspondence.

Contractor shall, at all times during the term of this contract and for a period of five (5) years after the completion of this contract, maintain such records, together with such supporting or underlying documents and materials. The Contractor shall at any time requested by the State, whether during or after completion of this contract and at Contractor's own expense make such records available for inspection and audit (including copies and extracts of records as required) by the State. Such records shall be made available to the State during normal business hours at the Contractor's office or place of business. In the event that no such location is available, then the financial records, together with the supporting or underlying documents and records, shall be made available for audit at a time and location that is convenient for the State. Contractor shall ensure the State has these rights with Contractor's assigns, successors, and Subcontractors, and the obligations of these rights shall be explicitly included in any subcontracts or agreements formed between the Contractor and any Subcontractors to the extent that those Subcontracts or agreements relate to fulfillment of the Contractor's obligations to the State.

Costs of any audits conducted under the authority of this right to audit and not addressed elsewhere will be borne by the State unless certain exemption criteria are met. If the audit identifies overpricing or overcharges (of any nature) by the Contractor to the State in excess of one-half of one percent (.5%) of the total contract billings, the Contractor shall reimburse the State for the total costs of the audit. If the audit discovers substantive findings related to fraud, misrepresentation, or non-performance, the Contractor shall reimburse the State for total costs of audit. Any adjustments and/or payments that must be made as a result of any such audit or inspection of the Contractor's invoices and/or records shall be made within a reasonable amount of time (not to exceed 90 days) from presentation of the State's findings to Contractor.

JJ. TAXES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State is not required to pay taxes of any kind and assumes no such liability as a result of this solicitation. Any property tax payable on the Contractor's equipment which may be installed in a state-owned facility is the responsibility of the Contractor.

KK. INSPECTION AND APPROVAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Final inspection and approval of all work required under the contract shall be performed by the designated State officials. The State and/or its authorized representatives shall have the right to enter any premises where the Contractor or Subcontractor duties under the contract are being performed, and to inspect, monitor or otherwise evaluate the work being performed. All inspections and evaluations shall be at reasonable times and in a manner that will not unreasonably delay work.

LL. CHANGES IN SCOPE/CHANGE ORDERS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The State may, upon the written agreement of Contractor, make changes to the contract within the general scope of the RFP. The State may, at any time work is in progress, by written agreement, make alterations in the terms of work as shown in the specifications, require the Contractor to make corrections, decrease the quantity of work, or make such other changes as the State may find necessary or desirable. The Contractor shall not claim forfeiture of contract by reasons of such changes by the State.

Corrections of any deliverable, service or performance of work required pursuant to the contract shall not be deemed a modification. Changes or additions to the contract beyond the scope of the RFP are not permitted; however, the contract must meet all applicable federal legal requirements and regulations, including Medicaid laws, rules and regulations, and any future amendments to the contract that are required to bring Nebraska in compliance with federal Medicaid law must be deemed part of the scope of the requested bid. Changes or additions to the contract beyond the scope of the RFP are not permitted except as noted herein.

MM. SEVERABILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If any term or condition of the contract is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and conditions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the contract did not contain the particular provision held to be invalid.

NN. CONFIDENTIALITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

All materials and information provided by the State or acquired by the Contractor on behalf of the State shall be regarded as confidential information. All materials and information provided by the State or acquired by the Contractor on behalf of the State shall be handled in accordance with federal and state law, and ethical standards. The Contractor must ensure the confidentiality of such materials or information. Should said confidentiality be breached by a Contractor; Contractor shall notify the State immediately of said breach and take immediate corrective action.

It is incumbent upon the Contractor to inform its officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a (i)(1), which is made applicable to Contractors by 5 U.S.C. 552a (m)(1), provides that any officer or employee of a Contractor, who by virtue of his/her employment or official position has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

OO. PROPRIETARY INFORMATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Data contained in the proposal and all documentation provided therein, become the property of the State of Nebraska and the data becomes public information upon opening the proposal. If the bidder wishes to have any information withheld from the public, such information must fall within the definition of proprietary information contained within Nebraska's public record statutes. **All proprietary information the bidder wishes the State to withhold must be submitted in a sealed package, which is separate from the remainder of the proposal, and provide supporting documents showing why such documents should be marked proprietary**. The separate package must be clearly marked PROPRIETARY on the outside of the package. **Bidders may not mark their entire Request for Proposal as proprietary**. Failure of the bidder to follow the instructions for submitting proprietary and copyrighted information may result in the information being viewed by other bidders and the public. Proprietary information is defined as trade secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. § 84-712.05(3)). In accordance with Attorney General Opinions 92068 and 97033, bidders submitting information as proprietary may be required to prove specific, named competitor(s) who would be advantaged by release of the information and the specific advantage the competitor(s) would receive. Although every effort will be made to withhold information that is properly submitted as proprietary and meets the State's definition of proprietary

information, the State is under no obligation to maintain the confidentiality of proprietary information and accepts no liability for the release of such information.

PP. CERTIFICATION OF INDEPENDENT PRICE DETERMINATION/COLLUSIVE BIDDING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

By submission of this proposal, the bidder certifies that it is the party making the foregoing proposal and that the proposal is not made in the interest of, or on behalf of, any undisclosed person, partnership, company, association, organization, or corporation; that the proposal is genuine and not collusive or sham; that the bidder has not directly or indirectly induced or solicited any other bidder to put in a false or sham proposal, and has not directly or indirectly colluded, conspired, connived, or agreed with any bidder or anyone else to put in a sham proposal, or that anyone shall refrain from bidding; that the bidder has not in any manner, directly or indirectly, sought by agreement, communication, or conference with anyone to fix the proposal price of the bidder or any other bidder, or to fix any overhead, profit, or cost element of the proposal price, or of that of any other bidder, or to secure any advantage against the public body awarding the contract of anyone interested in the proposed contract; that all statements contained in the proposal are true; and further that the bidder has not, directly or indirectly, submitted the proposal price or any breakdown thereof, or the contents thereof, or divulged information or data relative thereto, or paid, and will not pay, any fee to any corporation, partnership, company association, organization, proposal depository, or to any member or agent thereof to effectuate a collusive or sham proposal.

QQ. STATEMENT OF NON-COLLUSION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The proposal shall be arrived at by the bidder independently and be submitted without collusion with, and without any direct or indirect agreement, understanding or planned common course of action with, any person; firm; corporation; bidder; Contractor of materials, supplies, equipment or services described in this RFP. Bidder shall not collude with, or attempt to collude with, any state officials, employees or agents; or evaluators or any person involved in this RFP. The bidder shall not take any action in the restraint of free competition or designed to limit independent bidding or to create an unfair advantage.

Should it be determined that collusion occurred, the State reserves the right to reject a bid or terminate the contract and impose further administrative sanctions.

RR. PRICES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Price information is provided under Section IV.P – DBPM Reimbursement.

SS. ETHICS IN PUBLIC CONTRACTING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

No bidder shall pay or offer to pay, either directly or indirectly, any fee, commission compensation, gift, gratuity, or anything of value to any State officer, legislator, employee or evaluator based on the understanding that the receiving person's vote, actions, or judgment will be influenced thereby. No bidder shall give any item of value to any employee of the State Purchasing Bureau or any evaluator.

Bidders shall be prohibited from utilizing the services of lobbyists, attorneys, political activists, or consultants to secure the contract. It is the intent of this provision to assure that the prohibition of state contact during the procurement process is not subverted through the use of lobbyists, attorneys, political activists, or consultants. It is the intent of the State that the process of evaluation of proposals and award of the contract be completed without external influence. It is not the intent of this section to prohibit bidders from seeking professional advice, for example consulting legal counsel, regarding terms and conditions of this Request for Proposal or the format or content of their proposal.

If the bidder is found to be in non-compliance with this section of the Request for Proposal, they may forfeit the contract if awarded to them or be disqualified from the selection process.

In compliance with the Byrd Anti-Lobbying Amendment, contractors who apply or bid must file the required certification that each tier will not use federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any federal contract, grant or any other award covered by 31 U.S.C. §1352. Each tier must also disclose any lobbying with nonfederal funds that takes place in connection with obtaining any federal award. Such disclosures are forwarded from tier-to-tier up to the recipient (45 CFR §3).

TT. INDEMNIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

1. GENERAL

The Contractor agrees to defend, indemnify, hold, and save harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses ("the claims"), sustained or asserted against the State, arising out of, resulting from, or attributable to the willful misconduct, negligence, error, or omission of the Contractor, its employees, Subcontractors, consultants, representatives, and agents, except to the extent such Contractor liability is attenuated by any action of the State which directly and proximately contributed to the claims.

2. INTELLECTUAL PROPERTY

The Contractor agrees it will, at its sole cost and expense, defend, indemnify, and hold harmless the indemnified parties from and against any and all claims, to the extent such claims arise out of, result from, or are attributable to, the actual or alleged infringement or misappropriation of any patent, copyright, trade secret, trademark, or confidential information of any third party by the Contractor or its employees, Subcontractors, consultants, representatives, and agents; provided, however, the State gives the Contractor prompt notice in writing of the claim. The Contractor may not settle any infringement claim that will affect the State's use of the Licensed Software without the State's prior written consent, which consent may be withheld for any reason.

If a judgment or settlement is obtained or reasonably anticipated against the State's use of any intellectual property for which the Contractor has indemnified the State, the Contractor shall, at the Contractor's sole cost and expense, promptly modify the item or items which were determined to be infringing, acquire a license or licenses on the State's behalf to provide the necessary rights to the State to eliminate the infringement, or provide the State with a non-infringing substitute that provides the State the same functionality. At the State's election, the actual or anticipated judgment may be treated as a breach of warranty by the Contractor, and the State may receive the remedies provided under this RFP.

3. PERSONNEL

The Contractor shall, at its expense, indemnify and hold harmless the indemnified parties from and against any claim with respect to withholding taxes, worker's compensation, employee benefits, or any other claim, demand, liability, damage, or loss of any nature relating to any of the personnel provided by the Contractor.

4. SELF-INSURANCE

The State of Nebraska is self-insured for any loss and purchases excess insurance coverage pursuant to Neb. Rev. Stat. § 81-8,239.01 (Reissue 2008). If there is a presumed loss under the provisions of this agreement, Contractor may file a claim with the Office of Risk Management pursuant to Neb. Rev. Stat. §§ 81-8,829 – 81-8,306 for review by the State Claims Board. The State retains all rights and immunities under the State Miscellaneous (Section 81-8,294), Tort (Section 81-8,209), and Contract Claim Acts (Section 81-8,302), as outlined in Neb. Rev. Stat. § 81-8,209 *et seq.* and under any other provisions of law and accepts liability under this agreement to the extent provided by law.

UU. NEBRASKA TECHNOLOGY ACCESS STANDARDS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Contractor shall review the Nebraska Technology Access Standards, found at http://nitc.nebraska.gov/standards/2-201.html and ensure that products and/or services provided under the contract are in compliance or will comply with the applicable standards to the greatest degree possible. In the event such standards change during the Contractor's performance, the State may create an amendment to the contract to request the contract comply with the changed standard at a cost mutually acceptable to the parties.

VV. ANTITRUST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor hereby assigns to the State any and all claims for overcharges as to goods and/or services provided in connection with this contract resulting from antitrust violations which arise under antitrust laws of the United States and the antitrust laws of the State.

WW. DISASTER RECOVERY/BACK UP PLAN

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor shall have a disaster recovery and back-up plan, of which a copy should be provided to the State, which includes, but is not limited to equipment, personnel, facilities, and transportation, in order to continue services as specified under the specifications in the contract in the event of a disaster.

XX. TIME IS OF THE ESSENCE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Time is of the essence in this contract. The acceptance of late performance with or without objection or reservation by the State shall not waive any rights of the State nor constitute a waiver of the requirement of timely performance of any obligations on the part of the Contractor remaining to be performed.

YY. RECYCLING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Preference will be given to items which are manufactured or produced from recycled material or which can be readily reused or recycled after their normal use as per Neb. Rev. Stat. § 81-15,159.

ZZ. DRUG POLICY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

Contractor certifies it maintains a drug free work place environment to ensure worker safety and workplace integrity. Contractor agrees to provide a copy of its drug free workplace policy at any time upon request by the State.

AAA. EMPLOYEE WORK ELIGIBILITY STATUS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of employees physically performing services within the State of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of an employee.

If the Contractor is an individual or sole proprietorship, the following applies:

1. The Contractor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at http://das.nebraska.gov/materiel/purchasing.html

The completed United States Attestation Form should be submitted with the Request for Proposal response.

2. If the Contractor indicates on such attestation form that he or she is a qualified alien, the Contractor agrees to provide the US Citizenship and Immigration Services documentation required to verify the Contractor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.

3. The Contractor understands and agrees that lawful presence in the United States is required and the Contractor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. § 4-108.

BBB. CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND INELIGIBILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

The Contractor, by signature to this RFP, certifies that the Contractor is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency from participating in transactions (debarred). The Contractor also agrees to include the above requirements in any and all Subcontracts into which it enters. The Contractor shall immediately notify the Department if, during the term of this contract, Contractor becomes debarred. The Department may immediately terminate this contract by providing Contractor written notice if Contractor becomes debarred during the term of this contract.

Contractor, by signature to this RFP, certifies that Contractor has not had a contract with the State of Nebraska terminated early by the State of Nebraska. If Contractor has had a contract terminated early by the State of Nebraska, Contractor must provide the contract number, along with an explanation of why the contract was terminated early. Prior early termination may be cause for rejecting the proposal.

CCC. OFFICE OF PUBLIC COUNSEL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If it provides, under the terms of this contract and on behalf of the State of Nebraska, health and human services to individuals; service delivery; service coordination; or case management, Contractor shall submit to the jurisdiction of the Office of Public Counsel, pursuant to Neb. Rev. Stat. §§ 81-8,240 et seq. This section must survive the termination of this contract and shall not apply if Contractor is a long-term care facility subject to the Long-Term Care Ombudsman Act, Neb. Rev. Stat. §§ 81-2237 et seq.

DDD. LONG-TERM CARE OMBUDSMAN

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:

If it is a long-term care facility subject to the Long-Term Care Ombudsman Act, Neb. Rev. Stat. §§ 81-2237 et seq., Contractor shall comply with the Act. This section shall survive the termination of this contract.

IV. PROJECT DESCRIPTION AND SCOPE OF WORK

The bidder should provide the following information in response to this Request for Proposal.

A. PROGRAM DESCRIPTION

1. Description of the Current Medicaid Program

a. The State of Nebraska's Medicaid program is administered by the Department of Health and Human Services (DHHS), Division of Medicaid & Long-Term Care (MLTC). DHHS is comprised of six (6) divisions:

i. The Division of Behavioral Health provides funding, oversight, and technical assistance to the six (6) local behavioral health regions. The regions contract with local programs to provide public inpatient, outpatient, emergency community mental health, and substance use disorder services.

ii. The Division of Children and Family Services administers child welfare, adult protective services, economic support programs, and the youth rehabilitation and treatment centers.

iii. The Division of Developmental Disabilities administers publicly-funded community-based disability services. The Division also operates several sites that provide services for individuals with developmental disabilities.

iv. MLTC administers the Medicaid program, which provides health care services to eligible elderly and disabled individuals, and low income pregnant women, children, and parents. The Division also administers non-institutional home and community-based services for qualified individuals, the aged, adults and children with disabilities, and infants and toddlers with special needs.

v. The Division of Public Health is responsible for preventive and community health programs and services. It also regulates and licenses health-related professionals, health care facilities, and services.

vi. The Division of Veterans' Homes oversees the State Veterans' Homes located in Bellevue, Norfolk, Grand Island and Scottsbluff.

b. Nebraska Medicaid currently provides health care coverage for approximately 230,000 individuals each month at an annual cost of approximately $1.8 billion.

c. The Nebraska Medicaid Managed Care Program (NMMCP), implemented in July 1995, includes approximately 189,000 individuals enrolled in physical health managed care and approximately 229,000 individuals enrolled in behavioral health managed care. Those individuals who are enrolled in behavioral health managed care, but not physical health managed care, receive their physical health services from the Nebraska Medical Assistance Program under a fee-for-service (FFS) reimbursement model.

d. NMMCP is authorized under section 1932 of the Social Security Act, which permits a state to operate a managed care program through its Medicaid State Plan. Additionally, Nebraska operates a 1915(b) waiver in order to require special needs children and Native Americans to participate in the managed care program. The 1915(b) waiver permits Nebraska Medicaid to operate the behavioral health managed care program.

e. NMMCP currently includes:

i. Physical health managed care provided, through comprehensive at risk contracts that are fully-capitated and require the contracted entity to be a managed care organization (MCO) or health insuring organization.

ii. Behavioral health managed care provided through an at risk contract which is not comprehensive, but is fully-capitated, and requires that the managed care entity be a prepaid inpatient health plan (PIHP).

iii. Physical health managed care currently provided through:

a) Two (2) DBPM networks in Cass, Dodge, Douglas, Gage, Lancaster, Otoe, Sarpy, Saunders, Seward, and Washington counties.

b) Two (2) DBPM networks in Adams, Antelope, Arthur, Banner, Blaine, Boone, Box Butte, Boyd, Brown, Buffalo, Burt, Butler, Cedar, Chase, Cherry, Cheyenne, Clay, Colfax, Cuming, Custer, Dakota, Dawes, Dawson, Deuel, Dixon, Dundy, Fillmore, Franklin, Frontier, Furnas, Garden, Garfield, Gosper, Grant, Greeley, Hall, Hamilton, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Jefferson, Johnson, Kearney, Keith, Keya Paha, Kimball, Knox, Lincoln, Logan, Loup, Madison, McPherson, Merrick, Morrill, Nance, Nemaha, Nuckolls, Pawnee, Perkins, Phelps, Pierce, Platte, Polk, Red Willow, Richardson, Rock, Saline, Scotts Bluff, Sheridan, Sherman, Sioux, Stanton, Thayer, Thomas, Thurston, Valley, Wayne, Webster, Wheeler, and York counties.

iv. Behavioral health managed care provided through one statewide PIHP network.

v. MLTC currently contracts with vendors to perform the following services for the NMMCP:

a) Physical health managed care services.

b) Behavioral health managed care services.

c) Enrollment broker services.

d) External quality review (EQR) services.

e) Actuarial services.

f) Pharmacy benefit management services.

2. Implementation of Heritage Health

MLTC anticipates the launch of the Heritage Health managed care program on January 1, 2017. The implementation of Heritage Health brings several notable changes to the State's managed care program including:

a. Integration of physical and behavioral health managed care through three (3) contracted MCO's for all 93 counties in the State of Nebraska.

b. Inclusion of pharmacy services in the core benefit package and the MCO capitation rate.

c. Inclusion of the Aged, Blind and Disabled populations who are dually eligible for Medicaid and Medicare, in a home and community-based services (HCBS) waiver program, or living in an institution, for integrated physical health, behavioral health, and pharmacy services.

d. Expansion of enrollment broker services to complete the process of member enrollment.

3. Current Nebraska Medicaid Dental Program

a. Nebraska Medicaid currently provides Medicaid eligible individuals with covered dental services through a fee-for-service (FFS) program as described in 471 NAC 6. Nebraska Medicaid pays for covered services when those services meet the following basic criteria:

i. Provided to an individual who is Medicaid eligible on the day that they receive the service.

ii. Dentally necessary.

iii. Treatment provided is the least costly service meeting the treatment needs.

iv. Reasonable in amount and duration of care, treatment or service.

v. Within the scope of the coverage criteria contained in NAC 471 6.

vi. Within accepted dental or medical practice standards.

vii. Within the limitations contained in 471 NAC 6-005.

viii. Provided in accordance with prior authorization requirements contained in 471 NAC 6-004 and 6-005.

b. For Medicaid eligible individuals age 21 and older, dental coverage is limited to $1,000.00 per fiscal year. The $1,000.00 limit is calculated at the Medicaid dental fee schedule rate for the treatment provided or on the all-inclusive encounter rate paid to Indian Health Service (IHS) or Federally Qualified Health Centers (FQHC) facilities.

4. Purpose of this Solicitation

a. MLTC seeks to transition the delivery of dental services for Medicaid and CHIP eligible individuals to a capitated, Prepaid Ambulatory Health Plan (PAHP).

b. The purpose of this RFP is to solicit proposals from qualified bidders to manage the Medicaid Dental Benefit Program (DBP) for all eligible Medicaid recipients, utilizing the most cost-effective manner and in accordance with the terms and conditions detailed in this RFP.

c. MLTC believes oral health is a vital part of an individual's overall health status. The State anticipates the implementation of a Dental PAHP and the selection of a Dental Benefits Program Manager (DBPM) will advance MLTC's oral health goals, which include:

i. Improved access to routine and specialty dental care.

ii. Improved coordination of care.

iii. Better dental health outcomes.

iv. Increased quality of dental care.

v. Outreach and education to promote dental health.

vi. Increased personal responsibility and self-management.

vii. Overall savings to the Nebraska Medicaid program by preventing treatable dental conditions from becoming costly medical conditions.

d. MLTC anticipates it will select one qualified bidder to act as the DBPM.

e. The DBPM awarded this contract must be prepared to deliver services to a population of approximately 230,000 Medicaid enrollees.

f. This RFP solicits proposals, details proposal requirements, defines MLTC's minimum service requirements, and outlines the state's process for evaluating proposals and selecting the DBPM.

5. Excluded Populations

a. Aliens who are eligible for Medicaid for an emergency condition only.

b. Beneficiaries who have excess income or who are required to pay a premium, except those who are continuously eligible due to a share of cost obligation to a nursing facility or for HCBS Waiver services.

c. Participants in the Program for All-Inclusive Care for the Elderly (PACE).

d. Beneficiaries with Medicare coverage where Medicaid only pays co-insurance and deductibles.

e. Inmates of public institutions.

f. 599 CHIP Clients.

6. Changes to Population Groups and Services

MLTC may add, delete, or otherwise modify included and excluded population groups and services. If changed, the contract will be amended, and the DBPM given as much advance notice as reasonably possible.

B. ELIGIBILITY AND ENROLLMENT

1. Enrollment

a. MLTC or its designee will provide Nebraska Medicaid recipient information to the DBPM via a daily 834 electronic file transfer, hereafter referred to as the "Member File". The DBPM will utilize the Member File to identify all individuals eligible for enrollment, based on predetermined eligibility criteria as outlined in this RFP. The DBPM's responsibilities subsequent to eligibility determination will include, but will not necessarily be limited to, the following:

i. Being available by telephone to provide assistance to DBP potential members, and educating the Medicaid eligible about the DBP in general, including the manner in which services typically are accessed under the DBPM, the role of the dental home, the responsibilities of the DBPM member, his/her right to file grievances and appeals, and the rights of the member to choose any dental home within the DBPM, subject to the capacity of the provider.

ii. Educating the member, or in the case of a minor, the member's parent or guardian, about benefits and services available through the DBP.

iii. Identifying any barriers to access to care for the DBP members such as the necessity for multi-lingual interpreter services and special assistance needed for members with visual and hearing impairment and members with physical or mental disabilities.

b. Enrollment Procedures

i. Effective Date of Enrollment

DBPM enrollment for members in a given month will be effective at 12:01AM on the first (1st) calendar day of the month of Medicaid eligibility.

ii. Change in Status

The DBPM agrees to report in writing to MLTC 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, email address, telephone number and insurance coverage.

c. Disenrollment

i. Disenrollment is any action taken by MLTC or its designee to remove a DBP member from the DBP following the receipt and approval of a written request for disenrollment or a determination made by MLTC or its designee that the member is no longer eligible for Medicaid or the DBP.

ii. MLTC will notify the DBPM of the member's disenrollment due to the following reasons:

a) Loss of Medicaid eligibility or loss of DBP enrollment eligibility.

b) Death of a member.

c) Member's intentional submission of fraudulent information.

d) Member becomes an inmate in a public institution.

e) Member moves out-of-state.

f) To implement the decision of a hearing officer in an appeal proceeding by the member against the DBPM or as ordered by a court of law.

d. Disenrollment Effective Date

i. The effective date of disenrollment must be no later than the first day of the second month following the calendar month the request for disenrollment is submitted.

ii. If MLTC or its designee fails to make a disenrollment determination by the first day of the second month following the month in which the request for disenrollment is submitted, the disenrollment is considered approved. The DBPM must process all member file updates from the MLTC prior to the reconciliation process. Noncompliance with the reconciliation process may result in administrative sanctions.

iii. MLTC and the DBPM must reconcile enrollment/disenrollment issues at the end of each month utilizing an agreed upon procedure.

e. Enrollment and Disenrollment Updates

i. Daily Updates

MLTC or its designee will provide updates to the DBPM daily via electronic media (ASC X12N 834 Benefit Enrollment and Maintenance transaction) of members newly enrolled with the DBPM. The DBPM must have written policies and procedures for receiving these updates, incorporating them into its management information system, and ensuring this information is available to its providers. Policies and procedures must be provided to MLTC for review and approval a minimum of 60 calendar days prior to the contract start date.

ii. Weekly Reconciliation

a) The DBPM is responsible for weekly reconciliation of the enrollment/disenrollment file received from MLTC or its designee.

b) The DBPM must provide written notification to the enrollment broker of any data inconsistencies within ten (10) calendar days of receipt of the file.

c) The DBPM will receive a monthly electronic file (ASC X12N 820 transaction) from MLTC listing all members for whom the DBPM received a capitation payment and the amount received. The DBPM is responsible for reconciling this file against its internal records. It is the DBPM's responsibility to notify MLTC of any discrepancies within three (3) months of file receipt. Lack of compliance with reconciliation requirements may result in the withholding of a portion of future monthly payments or other liquidated damages as defined in this RFP.

C. BUSINESS REQUIREMENTS

1. Compliance with State and Federal Laws and Regulations

a. The DBPM must abide by all relevant provisions found in 42 CFR, Part §438, Managed Care; Title 471 Nebraska Administrative Code (NAC) Nebraska Medical Assistance Program Services; Title 477 NAC, Medicaid Eligibility; and Title 482 NAC, Nebraska Medicaid Managed Care.

b. The contract that result from this RFP must comply with all applicable Federal and State laws and regulations including but not limited to Title IX of the Education Amendments of 1972 (regarding educational programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act; and 45 CFR parts §160 and §164 (the Health Insurance Portability and Accountability Act [HIPAA] privacy rule).

c. The DBPM must comply with any applicable Federal and State laws that pertain to member rights and ensure that its staff and affiliated providers also do this when furnishing services to members.

2. Dental Benefit Program Manager Licensure

The DBPM must have a Certificate of Authority (COA) to transact the business of insurance in Nebraska as a Prepaid Limited Health Service Organization by the contractor start date.

3. Accreditation

a. The DBPM must attain health plan accreditation from the National Committee for Quality Assurance (NCQA). If the DBPM is not currently accredited by NCQA, the DBPM must attain NCQA accreditation within eighteen (18) months of the date of award.

b. The DBPM's application for accreditation must be submitted as soon after the date of award as allowed by NCQA. The DBPM must provide MLTC with a copy of all correspondence between the DBPM and NCQA regarding the application process, the accreditation requirements, and the DBPM's progress toward accreditation.

c. Achievement of provisional accreditation status will require a corrective action plan (CAP) within thirty (30) calendar days of receipt of the final report from NCQA. Any failure to obtain full NCQA accreditation and to maintain the accreditation thereafter will be considered a breach of the contract and may result in contract termination at the sole discretion of the State.

4. Business Location

The DBPM must establish and maintain a business office or work site within the State, staffed with the primary contract personnel and managers responsible for the services provided under the contract. The DBPM is responsible for all costs related to securing and maintaining the facility for start-up and ongoing operations, including, but not limited to, hardware and software acquisition and maintenance, leasehold improvements, utilities, telephone service, office equipment, supplies, janitorial services, security, storage, transportation, document shredders, and insurance. If any activities are approved by MLTC to be performed offsite, then the DBPM must provide toll-free communications with MLTC staff to conduct those business operations. The DBPM must provide meeting space to MLTC as requested when onsite at the DBPM's location.

5. Cooperation with Other Entities and Programs

a. The DBPM must develop processes and procedures and designate points of contact for collaboration with other entities and programs that serve members including but not limited to:

i. Nebraska Office of Oral Health and Dentistry programs including the Oral Health Access for Young Children program. More information on this program can be found at: http://dhhs.ne.gov/publichealth/Pages/dental_index.aspx

ii. Together For Kids and Families – Medical/Dental Home Work Group

iii. Division of Behavioral Health funded programs.

iv. Division of Children and Family Services funded programs that support the safety, permanency, and well-being of children in the care and custody of the State.

v. Division of Developmental Disabilities programs that involve rehabilitative and habilitative services for persons with developmental disabilities.

vi. The Nebraska Department of Education Early Development Network.

vii. Community agencies including but not limited to the Area Agencies on Aging and League of Human Dignity Waiver Offices.

viii. The Office of Probation.

ix. Other MLTC programs, initiatives, and contractors related to dental care and health care coordination, including Heritage Health MCOs.

b. The DBPM must collaborate with these entities and programs when serving members and identifying and responding to members' health needs. It must address and attempt to resolve any

coordination of care issues with Heritage Health MCOs and other State agencies and their contractors, tribes, and other community providers as expeditiously as possible.

c. The DBPM must also collaborate with these entities and programs and its network providers regarding planning initiatives and system transformation.

6. Service Orientation, Interoperability, and Data Exchange

The State's Medicaid program is undergoing significant modernization across many projects. In alignment with CMS-MITA guidance, key objectives shared by all MLTC projects include high levels of capability/maturity with respect to service orientation, interoperability, and data exchange. MLTC expects the DBPM to transmit and receive data in compliance with all applicable Federal (including but not limited to HIPAA), and State standards and mandates, both currently and in the future. The DBPM must work with MLTC to develop and support an effective data exchange between the DBPM and all stakeholders involved in the Medicaid program, including MLTC. The DBPM must also provide to MLTC at its request reports via electronic data exchanges to support enhanced analytics and report drill-down capabilities.

7. Financial Viability/Solvency Requirements

a. Insolvency

The DBPM must provide that its Medicaid members are not held liable for:

i. The DBPM's debts in the event of the DBPM's insolvency.

ii. The cost of covered services provided to the member, for which MLTC does not pay the DBPM.

iii. The cost of covered services provided to the member, for which MLTC or the DBPM does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangement.

iv. Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the DBPM provided the services directly.

b. Solvency

A non-federally-qualified DBPM must provide adequate assurances that Medicaid enrollees will not be liable for the entity's debt if the entity becomes insolvent.

c. Continue Services During Insolvency

The DBPM must continue to cover services for members for the duration of time for which payment has been made, as well as for inpatient admissions up until discharge.

8. Merger, Reorganization, and Change of Ownership

a. The DBPM must submit notification to MLTC of a merger, reorganization, or change of ownership a minimum of one hundred, eighty (180) days prior to its proposed effective date. The DBPM must also submit a detailed merger, reorganization, or transition plan to MLTC for review a minimum of ninety (90) calendar days prior to the effective date of the proposed change. The purpose of the plan's review is to ensure uninterrupted services to members, evaluate the new entity's ability to maintain and support the contract requirements, and ensure that services to members are not diminished. In addition, the DBPM must provide adequate assurances to MLTC that the major components of its organization and programs are not adversely affected by such merger, reorganization, or change in ownership. Nothing in this provision limits in any way the State's ability to approve or refuse assignment of this contract, as provided herein.

b. A proposed merger, reorganization, or change in ownership of the DBPM requires prior approval of MLTC and will require a contract amendment.

9. Audit Requirements

a. The DBPM must:

i. Maintain books, records, documents, and other evidence pertaining to services rendered, equipment, staff, financial records, health records, and the administrative costs and expenses incurred pursuant to this contract as well as medical information relating to members as required for purposes of audit; or administrative, civil, or criminal investigations or prosecution per all retention requirements of this RFP. The DBPM must ensure that this provision also applies to subcontractors, providers, or other entities providing goods or services under this contract. The DBPM must provide MLTC with adequate assurances of its compliance with the immediately preceding sentence.

ii. Establish and maintain an internal audit function responsible for providing an independent review and evaluation of the DBPM's accuracy of financial recordkeeping, the reliability and integrity of information, the adequacy of internal controls, and compliance with applicable laws, policies, procedures, and regulations. The DBPM's internal audit function must perform audits to ensure the economical and efficient use of resources by all of its departments to accomplish the objectives and goals of each department. Further, the DBPM's internal audit department is responsible for performing the claims payment accuracy tests described in Section IV.R – Claims Management.

b. Audit Business Transaction

i. The DBPM must obtain an audit of its business transactions from a licensed certified public accountant (CPA), including but not limited to, the financial transactions made under this contract.

ii. No later than December 1 of each year, the DBPM must submit a copy of the fully executed engagement letter with the CPA to MLTC.

iii. No later than June 1 of each year, the DBPM must submit a full and complete copy of the audit report to MLTC.

c. MLTC and CMS may inspect and audit any records of the DBPM or its subcontractors. There is no restriction on the right of MLTC or the Federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness, or timeliness of services, and reasonableness of costs.

10. Access to Records

The DBPM must allow Federal agencies to require changes, remedies, changed conditions, access and records retention, suspension of work, and other clauses approved by the Office of Federal Procurement Policy. In addition, the US Department of Health and Human Services (DHHS) awarding agencies, the Federal DHHS Inspector General, the US Comptroller General, or any of their duly authorized representatives, have the right of timely and unrestricted access to any books, documents, papers, or other records of the DBPM that are pertinent to the contract, in order to make audits, examinations, excerpts, transcripts, and copies of such documents.

11. Compliance

The DBPM is responsible for compliance with all contract requirements, regardless of whether the DBPM enters into a subcontract to delegate performance of the contract requirements. The DBPM must submit all proposed subcontracts for the provision of any services under this RFP to MLTC for prior review and approval a minimum of one hundred, twenty (120) calendar days prior to their planned implementation. Prior to selecting a subcontractor, the DBPM must evaluate the prospective subcontractor's ability to perform the activities to be delegated a minimum of ninety (90) calendar days prior to the planned contract start date. MLTC reserves the right to participate in these evaluations, and the DBPM must submit a copy of its findings to MLTC a minimum of thirty (30) calendar days prior to the contract start date. The DBPM must monitor and formally review a subcontractor's performance on an ongoing basis.

12. Confidentiality

The DBPM must establish and implement procedures consistent with the confidentiality requirements in 45 CFR Parts §160 and §164 for health records and any other health and enrollment information that identifies a particular member, as well as any and all other applicable provisions of privacy law.

13. Protections Against Liability

Providers may not bill members any amount greater than would be owed if the DBPM provided the services directly (i.e., no balance billing by providers is permitted).

14. Data Certification

Data submitted by the DBPM to MLTC must be certified as required by 42 CFR §438.606:

a. The data that must be certified includes, but is not limited to, all documents specified by MLTC, enrollment information, encounter data, and other information contained in contracts and proposals. The certification must attest, based on best knowledge, information, and belief, to the accuracy, completeness, and truthfulness of the documents and data. The DBPM must submit this certification concurrently with the certified data and documents.

b. Data and documents the DBPM submits to MLTC must be certified by the DBPM Executive Director or an individual who has been delegated authority to sign for, and who reports directly to, the DBPM Executive Director.

15. Moral or Religious Objections

a. A DBPM that would otherwise be required to provide, reimburse for, or provide coverage of, a counseling or referral service is not required to do so if the DBPM objects to the service on moral or religious grounds.

b. If the DBPM elects to not provide, reimburse for, or provide coverage of a counseling or referral service because of an objection on moral or religious grounds, the bidder must furnish this information to MLTC with the bidder's proposal response to this RFP or whenever it adopts the policy during the term of the contract. The information provided must be consistent with the requirements of 42 CFR §438.10. The DBPM's members and potential members must be informed of this policy before and during enrollment and within ninety (90) calendar days after adopting the policy with respect to any particular service.

c. If the DBPM elects to not provide, reimburse for, or provide coverage of a counseling or referral service, the DBPM must inform the member where and how to access the covered service.

D. STAFFING REQUIREMENTS

1. General Requirements

a. The DBPM must have in place organizational, operational, managerial, and administrative systems capable of fulfilling all contract requirements. The DBPM must be staffed by qualified persons in numbers appropriate to the DBPM's enrollment.

b. For the purposes of this contract, the DBPM must not employ or contract with any individual who has been debarred, suspended, or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under regulations issued under Executive Order 12549 or under guidelines implementing Executive Order 12549 [42 CFR 438.610(a) and (b), 42 CFR 1001.1901(b), and 42 CFR 1003.102(a)(2)]. The DBPM must screen all employees and subcontractors to determine whether any of them have been excluded from participation in federal health care programs. The Federal DHHS Office of Inspector General website, which can be searched by the name of any individual, can be accessed at: https://oig.hhs.gov/exclusions/index.asp.

c. The DBPM must employ sufficient staff and utilize appropriate resources to achieve contractual compliance. The DBPM's resource allocation must be adequate to achieve required outcomes in all functional areas within the organization. Adequacy will be evaluated based on outcomes and

compliance with contractual and MLTC policy requirements, including the requirement for providing culturally competent services. If the DBPM does not achieve the desired outcomes or maintain compliance with contractual obligations, additional monitoring and regulatory action may be employed by MLTC, including but not limited to, requiring the DBPM to hire additional staff and application of monetary penalties as specified in this RFP.

d. The DBPM must perform criminal background checks on all employees of the DBPM and subcontractor staff assigned to, or proposed to be assigned to, any aspect of this contract and who have access to electronic protected health information on Medicaid applicants and recipients. The DBPM must, upon request, provide MLTC with a satisfactory criminal background check or an attestation that a satisfactory criminal background check has been completed for these DBPM staff or subcontractor staff.

e. The DBPM will be responsible for any additional costs associated with on-site audits or other oversight activities that result when required systems are located outside of the State.

f. The DBPM must remove or reassign, upon written request from MLTC, any DBPM employee or subcontractor's employee that MLTC deems at its sole discretion to be unacceptable. The DBPM must hold MLTC harmless for actions taken as a result hereto.

g. A minimum of 45 calendar days prior to the contract start date, the DBPM must submit to MLTC for review and approval a Human Resources and Staffing Plan. This plan must describe how the DBPM will obtain and maintain the staffing level needed to accomplish the duties outlined in this RFP. The DBPM is required to recruit, hire, train, supervise, and, if necessary, terminate, such professional and support personnel as are necessary to carry out the terms of this contract. All staff must have experience and expertise in working with the populations served by the Medicaid program.

h. The DBPM must provide to MLTC, in writing, a list of all officers and members of the DBPM's Board of Directors. This information must be provided to MLTC prior to the contract's start date. The DBPM must notify MLTC, in writing, within ten (10) business days of any change to its officers or Board members.

2. Key Staff Positions

a. The DBPM must comply with minimum key staffing requirements in Table 1 listed below.

i. For each key staff position marked with an asterisk in the table, the staff member must be based in the State.

All positions listed in the table must be full-time, i.e. a minimum of 40 hours per week.

ii. The DBPM must submit to MLTC the names and resumes for all proposed key staff, for review and approval, prior to hire.

iii. An individual Key Staff member may hold no more than two (2) positions, with the exception of Executive Director and Dental Director, which may hold no more than one (1) position.

b. The DBPM must submit to MLTC the names, resumes, and contact information for all key staff listed below a minimum of 30 calendar days prior to the contract's start date.

c. In the event of a change of any key staff at any point during the contract's duration, the DBPM must notify MLTC in writing within two business days of the change. The name of the interim contact person shall be included with this notification.

d. Replacement of key staff requires prior written approval from MLTC. This approval will not be unreasonably withheld, provided a suitable candidate is proposed. The DBPM must replace any key staff member with a person of equivalent experience, knowledge, and talent. The name and resume of the proposed employee must be submitted to MLTC, for review and approval, along with a proposed revised organizational chart complete with key staff time allocation to the MLTC contract.

Table 1. Key Staff

Title	Minimum Duties
Executive Director*	1. The Executive Director must hold a Senior Executive or Management position in the DBPM's organization 2. The Executive Director must be authorized and empowered to represent the DBPM regarding all matters pertaining to the contract prior to such representation. The Executive Director must act as liaison between the DBPM and MLTC and must have responsibilities that include, but are not limited to: 3. Ensuring the DBPM's compliance with the terms of the contract, including securing and coordinating resources necessary for such compliance. 4. Receiving and responding to all inquiries and requests made by MLTC related to the contract, in the timeframes and formats specified by MLTC. Where practicable, MLTC will consult with the DPBM to establish mutually acceptable timeframes and formats. 5. Attending and participating in regular meetings or conference calls with MLTC. 6. Making best efforts to promptly resolve any issues identified either by the DBPM or MLTC that may arise and are related to the contract. 7. Meeting with MLTC representative(s) on a periodic or as needed basis to review the DBPM's performance and resolve issues. 8. Meeting with MLTC at the time and place requested by MLTC, if MLTC determines that the DBPM is not in compliance with the requirements of the contract.
Dental Director*	1. The Dental Director must be currently licensed as a Doctor of Dentistry ("dentist") with no restrictions or other licensure limitations. 2. The Dental director must comply with applicable federal and state statutes and regulations. 3. The Dental Director must be available Monday through Friday, between 8am and 5pm CST for Utilization Review decisions, and must be authorized and empowered to represent the DBPM regarding clinical issues, Utilization Review and quality of care inquiries.
Operations Manager	The Operations Manager is responsible for: 1. Managing the day-to-day operations of the DBPM's departments, staff, and functions to ensure that performance measures and MLTC and Federal requirements are met. 2. May serve as the primary contact with MLTC for all DBPM operational issues.
Finance Manager	The Finance Manager is responsible for overseeing all financial-related supervision of activities implemented by the DBPM, including all audit activities, accounting systems, financial reporting, and budgeting.
Program Integrity Officer*	The Program Integrity Officer must have experience in health care and/or risk management and report directly to the Executive Director. The Program Integrity Officer is responsible for: 1. Overseeing all activities required by State and Federal rules and regulations related to the monitoring and enforcement of the fraud, waste, abuse, (FWA) and erroneous payment compliance program. 2. Developing/overseeing methods to prevent and detect potential FWA and erroneous payments. 3. Developing policies and procedures, investigating unusual incidents, and designing/implementing any corrective action plans. 4. Reviewing records and referring suspected member FWA to MLTC and other duly authorized enforcement agencies. 5. Managing the DBPM's Special Investigations Unit to communicate with the State's Medicaid Fraud Control Unit.
Grievance System Manager*	The Grievance System Manager is responsible for: 1. Managing/adjudicating member grievances, appeals, and requests for fair hearing. 2. Managing/adjudicating provider grievances and appeals.

Title	Minimum Duties
Business Continuity Planning and Emergency Coordinator	The Business Continuity Planning and Emergency Coordinator is responsible for: 1. Ensuring continuity of benefits and services for members who may experience evacuation to other areas of the State, or out-of-state, during disasters. 2. Managing and overseeing the DBPM's emergency management plan.
Contract Compliance Coordinator*	The Contract Compliance Coordinator will be the primary contact with MLTC on all DBPM contract compliance issues. This individual is responsible for: 1. Coordinating the preparation and execution of contract requirements. 2. Coordinating the tracking and submission of all contract deliverables. 3. Answering inquiries from MLTC. 4. Coordinating/performing random and periodic audits and ad hoc visits.
Performance and Quality Improvement Coordinator*	The Performance and Quality Improvement Coordinator must, at minimum, be a CPHQ or CHCQM or have comparable experience and education in data and outcomes measurement as described in 42 CFR 438.200 - 438.242. The Performance and Quality Improvement Coordinator serves as MLTC's contact person for quality performance measures. Primary responsibilities include: 1. Focusing organizational efforts on the improvement of clinical quality performance measures. 2. Utilizing data to develop intervention strategies to improve outcomes. 3. Developing and implementing performance improvement projects, both internal and across DBPMs. 4. Reporting quality improvement and performance outcomes to MLTC.
Provider Services Manager*	The Provider Services Manager is responsible for: 1. Provider contracting and credentialing activities. 2. Coordinating communications between the DBPM and its subcontracted providers. 3. Managing the Provider Services staff. 4. Working collaboratively with MLTC to establish methodologies for processing and responding to provider concerns. 5. Developing provider trainings in response to identified needs or changes in protocols, processes, and forms. 6. Enhancing DBPM-provider communication strategies. 7. Notifying MLTC of correspondence sent to providers for informational and training purposes.
Member Services Manager*	The Member Services Manager is responsible for: 1. Coordinating communications between the DBPM and its members. 2. Ensuring there are sufficient member services representatives, including sufficient culturally and linguistically appropriate services, to enable members to receive prompt resolution of their problems or questions and appropriate education about participation in the Medicaid managed care program. 3. Managing the Member Services staff.
Claims Administrator	The Claims Administrator is responsible for: 1. Developing, implementing, and administering a comprehensive Nebraska Medicaid Managed Care claims processing system capable of paying claims in accordance with State and Federal requirements and the terms of this contract. 2. Developing cost avoidance processes. 3. Meeting claims processing timelines. 4. Ensuring minimization of claims recoupments. 5. Meeting MLTC encounter reporting requirements.
Information Management and Systems Director	The Information Management and Systems Director must have relevant training and a minimum of seven (7) years of experience in information systems, data processing, and data reporting to oversee all DBPM information systems functions. The position is responsible for: 1. Establishing and maintaining connectivity with MLTC information systems. 2. Providing necessary and timely data and reports to MLTC.
Encounter Data Quality Coordinator	The Encounter Data Quality Coordinator is responsible for: 1. Organizing and coordinating services and communication between DBPM administration and MLTC for the purpose of identifying, monitoring, and resolving encounter data validation and management issues.

Title	Minimum Duties
	2. Serving as the DBPM's encounter expert to answer questions, provide recommendations, and participate in problem-solving and decision-making related to encounter data processing and submissions. 3. Analyzing activities related to the processing of encounter data and data validation studies to enhance accuracy and output.
Tribal Network Liaison*	The Tribal Network Liaison is responsible for: 1. Planning and working with Provider Services staff to expand and enhance physical and behavioral health services for American Indian members. 2. Serving as the single point of contact with tribal entities and all DBPM staff on American Indian issues and concerns. 3. Advocating for American Indian members with case management and member services staff.

3. Additional Required Staff
The DBPM must comply with additional staff requirements below:

a. The DBPM must have full-time clinical and support staff to conduct daily business in an efficient and effective manner. This includes, but is not limited to, administration; accounting and finance; fraud and abuse; utilization management; quality management and improvement; member services, education, and outreach; grievances and appeals; provider services; claims processing; and reporting.

b. Provider services staff to enable providers to receive prompt resolution of their problems and inquiries and appropriate education about participation in the DBPM program. There must be sufficient staff to maintain/enhance the DBPM's provider network to meet MLTC's network standards and work with grievances and appeals staff to resolve provider grievances and disputes on a timely basis.

c. Member services staff to enable members to receive prompt responses and assistance. There must be sufficient member services staff at all times to provide culturally and linguistically appropriate services.

d. Claims processing staff to ensure the timely and accurate processing/adjudication of original claims and resubmissions.

e. Encounter processing staff to ensure the timely and accurate processing and submission to MLTC of encounter data and reports.

f. FWA investigative staff to detect and investigate FWA activities. The staff is responsible for preparing and updating the fraud and abuse compliance plan, conducting DBPM employee training and monitoring, investigating a sample of paid claim discrepancies, and responding to provider investigation-related inquiries/issues. Each FWA investigator must have a Bachelor's degree; an Associate's degree plus a minimum of two (2) years' experience as a licensed health care provider or auditor; a minimum of four years' experience as a certified coder or billing specialist; or, a minimum of five (5) years law enforcement, health care oversight, compliance, or auditing experience. The DBPM must have a minimum of two investigators.

g. All additional required staff in this section must be located in the State with the exception of claims and encounter processing staff and customer service representatives staffing the toll-free call center.

4. Written Policies, Procedures, and Position Descriptions

a. The DBPM must develop and maintain written policies, procedures, and position descriptions for each functional area, consistent in format and style. The DBPM must have written guidelines for developing, reviewing and approving all policies, procedures, and job descriptions. All policies and procedures must be reviewed at a minimum on an annual basis to ensure that they reflect current practices. Once the policies are reviewed, they must be dated and signed by the DBPM's appropriate manager, coordinator, director, or administrator. Minutes reflecting the review and approval of the policies by the appropriate committee are also acceptable documentation. All medical and quality management policies must be approved and signed by the DBPM's Medical

Director. Job descriptions must be reviewed a minimum of annually to ensure that they reflect current duties.

b. Based on provider or member feedback, if MLTC determines that a DBPM policy or process is inefficient or places an unnecessary burden on the members or providers, the DBPM will be required to work with MLTC to change the policy or procedure within a time period specified by MLTC.

5. Staff Training and Meeting Attendance

a. The DBPM must ensure that all staff members, including subcontractors, have training, education, experience, and orientation to complete their job responsibilities. MLTC may require additional staffing for a DBPM that has substantially failed to maintain compliance with any provision of the contract and/or MLTC policies.

b. The DBPM must provide initial and ongoing staff training that includes an overview of MLTC and its policies, the contract, and State and Federal requirements specific to individual job functions. The DBPM must ensure that all staff members who have contact with members or providers receive initial and ongoing training with regard to program changes, prior authorization modifications, and the appropriate identification and handling of quality of care/service concerns.

c. The DBPM must educate staff concerning their policies and procedures on advance directives in accordance with 42 CFR 422.128.

d. A growing body of evidence points to a correlation between social factors and increased occurrences of specific health conditions and a general decline in health outcomes. All DBPM staff must be trained on how social determinants affect members' health and wellness. This training must include, but not be limited to, issues related to housing, education, food, physical and sexual abuse, violence, and risk and protective factors for behavioral health concerns. Staff must also be trained on finding community resources and making referrals to these agencies and other programs that might be helpful to members.

e. The DBPM must provide training for staff on the needs of the Long-Term Services and Supports (LTSS) population, including individuals with developmental disabilities and mental health concerns.

f. New and existing prior authorization, provider services, and member services staff must be trained in the geography of the State, as well as the culture and correct pronunciation of cities, towns, and surnames. Appropriate staff must have access to GPS or mapping search engines for the purposes of authorizing services, recommending providers, and transporting members to the most geographically appropriate location.

g. The DBPM must provide the appropriate staff representation in meetings or events scheduled by MLTC. All meetings are considered mandatory unless otherwise notified by MLTC.

h. MLTC reserves the right to attend any and all training programs and seminars conducted by the DBPM. The DBPM must provide MLTC a list of any training dates, times, and locations a minimum of 14 calendar days prior to their occurrence.

E. COVERED BENEFITS AND SERVICES

1. General Provisions

a. The DBPM must provide members, at a minimum, with those core dental benefits and services specified in the RFP and as defined in the Nebraska Medicaid State Plan. The DBPM must possess the expertise and resources to ensure the delivery of quality dental services to DBPM members in accordance with Nebraska Medicaid program standards and the prevailing dental community standards.

b. The DBPM must provide a mechanism to reduce inappropriate and duplicative use of dental services. Services must be furnished in an amount, duration, and scope that is not less than the amount, duration, and scope for the same services furnished to those that are eligible under FFS Medicaid, as specified in 42 CFR §§438.210(a)(1) and (2).

c. If new dental services are added to the Nebraska Medicaid Program, or if services are expanded, eliminated, or otherwise changed, the contract must be amended and MLTC will make every effort to give the DBPM sixty (60) days advance notice of the change. However, the DBPM must add, delete, or change any service as may be deemed necessary by MLTC within the timeframe required by MLTC if mandated by federal or state legislation or court order.

2. Amount, Duration, and Scope

a. The DBPM must ensure that services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished.

b. The DBPM must not arbitrarily deny or reduce the amount, duration, or scope of a required service because of diagnosis, type of illness, or condition of the member.

c. The DBPM may place appropriate limits on a service (a) on the basis of certain criteria, such as medical necessity; or (b) for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose.

d. The DBPM must not impose service limitations that are more restrictive than those that currently exist under the Nebraska Medicaid State Plan. Upward variances of amount, duration and scope of core covered benefits and services are allowed.

e. The DBPM may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care.

f. The DBPM must not portray core dental benefits or services as an expanded health benefit.

3. Medically Necessary Services

a. The DBPM must specify what constitutes "medically necessary services" in a manner that is no more restrictive than the State Medicaid program and addresses the extent to which the DBPM is responsible for covering services related to the following:

i. The prevention, diagnosis, and treatment of health impairments.

ii. The ability to achieve age-appropriate growth and development.

iii. The ability to attain, maintain, or regain functional capacity.

b. The DBPM may not limit services beyond the limitations in the State's Medicaid program.

4. Second Opinions

When requested by the member, the DBPM must provide for a second opinion from a qualified dental professional within the network, or arrange for the member to obtain one outside the network, at no cost to the member.

5. Core Medicaid Dental Benefits and Services

The core dental benefits and services listed in this section are described in 471 NAC 6-005.

a. Diagnostic Services

i. Oral Evaluations

ii. Radiographs

iii. Diagnostic Casts

b. Preventive Services

i. Prophylaxis

ii. Topical Fluoride

iii. Space Maintainers (Passive Appliances)

iv. Recementation of space maintainers

c. Restorative Services

i. Amalgam or Resin

ii. Crowns – Resin

iii. Crowns – Porcelain

iv. Recement inlay

v. Recement crown

vi. Prefabricated Stainless Steel Crowns

vii. Prefabricated Stainless Steel Crown with Resin Window

viii. Sedative filling

ix. Core buildup, including any pins

x. Pin retention

xi. Prefabricated Post and Core in Addition to Crown

xii. Temporary crown

xiii. Crown repair

xiv. Therapeutic Pulpotomy and Pupal Therapy

xv. Root Canal Therapy and Re-treatment of Previous Root Canals

xvi. Apicoectomy

xvii. Emergency Treatment to Relieve Endodontic Pain

xviii. Unspecified Restorative Procedure

d. Periodontic Services

i. Gingivectomy or Gingivoplasty per tooth or per quadrant

ii. Periodontal Scaling and Root Planing

iii. Full Mouth Debridement

iv. Periodontal Maintenance Procedure

e. Prosthodontic Services

i. Complete Dentures (Maxillary and Mandibular)

ii. Immediate Dentures (Maxillary and Mandibular)

iii. Maxillary Partial Resin Base

iv. Mandibular Partial Resin Base

v. Maxillary Partial Cast Metal Base

vi. Mandibular Partial Cast Metal Base

vii. Adjustments – Dentures and Partials

viii. Repairs to Dentures and Partials

ix. Rebase of Dentures and Partials

x. Reline of Dentures and Partials

xi. Interim Dentures (Maxillary and Mandibular)

xii. Flipper Partial Dentures (Maxillary and Mandibular)

xiii. Tissue Conditioning

xiv. Recement fixed partial denture

f. Oral and Maxillofacial Surgery Services

i. Extractions Routine and Surgical

ii. Tooth Reimplantation and/or Stabilization of an Accidentally Evulsed or Displaced Tooth and or Alveolus

iii. Surgical Exposure of Impacted or Unerupted Tooth for Orthodontic Reasons

iv. Biopsy of Oral Tissue (Hard or Soft)

v. Alveoloplasty

vi. Excisions

vii. Occlusal Orthotic Device

g. Orthodontic Services

i. Orthodontic Treatment

ii. Removable and Fixed Appliance Therapy (thumb sucking and tongue thrust)

iii. Repair of Orthodontic Appliances

iv. Orthodontic Retainers (Replacement)

v. Repair of Bracket and Standard Fixed Orthodontic Appliances

h. Adjunctive General Services

i. Palliative Treatment

ii. General Anesthesia

iii. Analgesia, Anxiolysis, Inhalation of Nitrous Oxide

iv. Intravenous Sedation/Analgesia

v. Non-Intravenous Conscious Sedation

vi. House Call, (Nursing Facility Call), Hospital Call, Ambulatory Surgical Center (ASC) Call

vii. Office Visit – After Regularly Scheduled Hours

viii. Occlusal Guard

i. Cosmetic dental procedures are not covered as a core benefit and/or service.

6. EPSDT Services

a. In accordance with 42 CFR §441.56(b)(1)(vi) and Attachment 2 – Dental Periodicity Schedule, the DBPM must provide dental screening services furnished by direct referral to a dentist for children beginning at 3 years of age.

b. In accordance with 42 CFR §441.56(c)(2), the DBPM must provide dental care, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health.

c. The DBPM must accurately report, via encounter data submissions, all dental screenings and access to preventive services as required for MLTC to comply with federally mandated CMS 416 reporting requirements contained in Attachment 3 – EPSDT Reporting.

7. Emergency Dental Services

The DBPM must make provisions for and advise all members of the provisions governing emergency use pursuant to 42 CFR §438.114. Emergency-related definitions are in the Glossary of this RFP.

Requirements for the DBPM to provide emergency dental services are as follows:

a. The DBPM must cover services as described in this Section. Provision of these services in an emergency context broadens the DBPM's responsibilities to include payment for these services to out-of-network providers.

b. The DBPM must be responsible for dental related services provided in an emergency context other than those described in this Section.

c. In providing for emergency dental services and care as a covered service, the DBPM must not:

i. Require prior authorization for emergency dental services and care.

ii. Indicate that emergencies are covered only if care is secured within a certain period of time.

iii. Use terms such as "life threatening" or "bona fide" to qualify the kind of emergency that is covered.

iv. Deny payment based on the member's failure to notify the DBPM in advance or within a certain period of time after the care is given.

d. The DBPM must not deny payment for emergency dental care.

e. The DBPM must not deny payment for treatment obtained when a member had an emergency dental condition, including cases in which the absence of immediate dental attention would not have had the outcomes specified in 42 CFR §438.114(a) of the definition of an emergency dental condition.

f. The hospital-based provider and the dental home may discuss the appropriate care and treatment of the member. Notwithstanding any other state law, a hospital may request and collect insurance or financial information from a patient in accordance with federal law to determine if the patient is a member of the DBPM, if emergency dental services and care are not delayed.

g. The DBPM must not deny emergency dental services claims submitted by a non-contracting provider solely based on the period between the date of service and the date of clean claim submission unless that period exceeds 365 days.

h. If third party liability (TPL) exists, payment of claims must be determined in accordance with this RFP.

i. The DBPM must review and approve or disapprove emergency service claims based on the definition of emergency dental services and care specified in the Glossary.

8. Value-Added Services

a. As permitted under 42 CFR §438.6(e), and to the extent consistent with provisions of State law, the DBPM may, in its discretion, offer expanded services and benefits to enrollees in addition to those benefits and services specified in this section of the RFP.

b. These expanded services and benefits must, in the judgment of the DBPM, be medically appropriate and cost-effective. The expanded services may include dental care services that are currently non-covered services by the Medicaid State Plan or which are in excess of the amount, duration, and scope in the Medicaid State Plan.

c. These services/benefits must be specifically defined by the DBPM with regard to amount, duration, and scope. MLTC will not provide any additional reimbursement to the DBPM for these services or benefits.

d. The DBPM must provide to MLTC a description of the expanded services or benefits to be offered by the DBPM for approval forty-five (45) calendar days prior to implementation. Additions, deletions, or modifications to value-added services made during the contract period must be submitted to MLTC for approval a minimum of forty-five (45) calendar days prior to their implementation.

e. The following MLTC priorities may be addressed through value-added services:

i. Reducing the occurrences of dental caries (tooth decay) through the use of risk assessment tools, provider incentives, and member education.

ii. Minimizing the occurrences of missed appointments through member incentives, technology-based appointment reminders, member education, or other mechanisms identified by the DBPM.

f. Value-added services are not Medicaid-funded and, as such, are not subject to appeal and fair hearing rights. A denial of these services will not be considered an action for purposes of grievances and appeals. The DBPM must send the member a notification letter if a value-added service is not approved.

g. Transportation to obtain these services or benefits is the responsibility of the member or the DBPM, at the discretion of the DBPM.

F. FEE-FOR-SERVICE (FFS) DENTAL CLAIMS MANAGEMENT AND PROCESSING

1. DBPM FFS Claims Services

The State is currently in the process of replacing its aged Medicaid Management Information System (MMIS). As part of this transition, the State is moving toward a model of contracting with risk-bearing entities for the provision of services for nearly all Medicaid members and services. As this transition continues, the State will be responsible for processing fewer FFS claims for fewer members. Rather than procure a standalone claims processing system for these remaining needs, the State intends to enter into a services agreement with the DBPM for the management and processing of remaining FFS dental claims.

In addition to the DBPM responsibilities outlined in this RFP, MLTC will pay the DBPM an administrative processing fee for each unique adjudicated FFS claim or adjustment on a monthly basis. MLTC will provide the per unique claim initial rate. Payment for FFS dental claims management services will be paid separately from managed care capitation payments.

The administrative processing fee will be adjusted yearly based on administrative expense for the FFS dental claims processing. Each year, the DBPM will report the PMPM costs for FFS dental claims by the following categories:

a. Provider Services
b. Care Coordination / Service Authorizations
c. Member Customer Services
d. Data Capture
e. Claim / Adjustment Processing and Adjudication
f. TPL/COB
g. Grievance and Appeals

All values in red below indicate a value that must be submitted by the DBPM.

Category	**Populations not covered by the DBP - All Services**
Provider Services	(1)
Care Coordination / Service Authorizations	(2)
Member Customer Services	(3)
Data Capture	(4)
Claim / Adjustment Processing and Adjudication	(5)
TPL/COB	(6)
Grievance/Appeals	(7)
Total	**(1)+(2)+(3)+(4)+(5)+(6)+(7) = (8)**
MMs	**(9)**
Annual Dollar Est.	**(8) * (9) = (10)**

The State will use the reported values to calculate an updated total dollar estimate by taking the total PMPM for each population and multiplying it by the corresponding MMs (as illustrated by (10), in the above table). This annual dollar estimate will be divided by the FFS claim volume for each year to determine the administrative price per claim for the next year.

MLTC will pay for a claim to be processed multiple times if the resubmission is due to provider error. If a claim is denied multiple times due to a DBPM error, MLTC will only pay to process the claim once. The DBPM must provide detailed reports to the State for validation of FFS payments and recoveries. The DBPM is responsible for all servicing aspects of FFS dental claims unless otherwise expressly identified as an exception by MLTC.

The DBPM must develop and maintain claims handling and payment policies and procedures in accordance with Nebraska Medicaid policy, CMS's National Correct Coding Initiative (NCCI) guidelines and Medicaid service limits. The DBPM must ensure accurate collection, processing, payment, and reporting of all FFS dental claims.

2. Reimbursement for DBPM FFS Payments

The DBPM must make payments for all FFS dental claims to providers. The DBPM must submit to MLTC a reconciliation report of all funds expended and received with remaining balance to be reimbursed for FFS

payments. The DBPM may submit a funding request on a weekly basis to MLTC to cover the cost of FFS dental claims payments. The report must be submitted with each funding request to justify the request.

3. Implementation Timeframe

MLTC anticipates that the implementation of the DBPM FFS claims processing functionality will occur during the second year of the contract. MLTC will identify the date for DBPM FFS claims services to begin and MLTC will coordinate with the DBPM throughout years one (1) and two (2) of the contract. The DBPM must submit to MLTC with its proposal the number of months that it will take to be ready to pay FFS claims. MLTC will provide the DBPM sufficient time to ensure a smooth implementation process.

4. Functionality

The DBPM must maintain the same functionality for FFS dental claims that is required for managed care claims as described in Section IV.R – Claims Management of this RFP. FFS claims must be processed even if the billing provider is not contracted with the DBPM. The DBPM claims processing system must handle retroactive member eligibility and process claims accordingly.

The DBPM must make system or operational changes for FFS dental claims processing within sixty (60) calendar days of notification by MLTC. The DBPM must correct all processing errors identified by MLTC immediately on notification. Recoupment of erroneous payments made to providers is the sole responsibility of the DBPM. MLTC will not reimburse the DBPM for uncollected recoupments for claims paid in error.

The DBPM FFS claims processing system must maintain functionality to process claims for services that require unique provider and member reimbursement methodologies that differ from standard processing protocol.

The DBPM must provide MLTC inquiry access to its FFS dental claims processing system to view claims and all information related to FFS claims processing. The DBPM must provide system user training to MLTC staff who support this scope of work.

5. Claims Processing

The DBPM must maintain the same claims processing standards for all FFS dental claims that is required for managed care claims, as described in Section IV.R – Claims Management of this RFP. Requirements for rejected claims, pended claims, adjustments, voids, and timely filing guidelines must mirror managed care requirements. Claim system edits for FFS dental claims must be maintained in the same manner as required for managed care claims. The DBPM should expect that FFS claims will have different editing and payment methodologies than managed care claims, and must maintain these edits and payment processes separately. The DBPM claims processing system must post all applicable edits to denied FFS claims during a single processing cycle.

6. Service Authorization Procedures

The DBPM must develop and administer prior authorization procedures for services paid as FFS in accordance with Nebraska Medicaid policy and the requirements of Section IV.N – Utilization Management of this RFP. FFS claims must be paid or denied in accordance with 471 NAC Chapter 6.

7. Payments to Providers

The DBPM must pay FFS dental claims at fee schedule rates set by MLTC.

8. Remittance Advice

The DBPM must adhere to the same remittance requirements for FFS dental claims as required for managed care claims as outlined in Section IV.R – Claims Management of this RFP.

9. Third Party Liability (TPL)

The DBPM must develop and maintain a process to identify and capture information regarding other insurance sources (TPL) for FFS members. Information regarding TPL must be maintained on the member file and utilized during claims payment to ensure that Medicaid is the payer of last resort. The DBPM will also perform recovery activities for claims that have been paid by Medicaid where third-party coverage was applicable. These payment recoveries will be returned to the State in full immediately upon receipt. The

DBPM must expend the same level of effort on the recovery and cost avoidance of casualty claims for FFS dental claims as is expended on managed care claims. Denial of FFS claims for TPL coverage must comply with all MLTC policies and applicable law. MLTC will retain responsibility for all estate recovery activities.

10. Member Services

The DBPM must provide member services call center activities to all eligible FFS members in the same manner as required for managed care members as outlined in Section IV.G – Member Services and Education of this RFP. MLTC will provide the DBPM with an interface that provides FFS member eligibility.

11. Provider Services

The DBPM must provide a provider toll-free telephone line to all providers who render dental services to FFS members, according to the requirements of Section IV.J – Provider Services of this RFP. These services must be available to providers even if they are not contracted with the DBPM. These activities include the management of electronic data interchange and trading partner agreements, as well as call center support for provider inquiries such as member eligibility and benefit limits, claims processing issues, or other program clarifications. The DBPM must make provider notifications, bulletins, newsletters, FAQs and other pertinent information available on its website to providers participating in the FFS dental program.

12. Paid Claims Sampling

The DBPM must adhere to the same paid claims sampling requirements for FFS dental claims as required for managed care claims outlined in Section IV.R – Claims Management of this RFP.

13. Claims Dispute Management

The DBPM must adhere to the same claims dispute management requirements for FFS dental claims as required for managed care claims outlined in Section IV.R – Claims Management of this RFP. FFS claims must be disputed through the State fair hearing process. The DBPM must support MLTC in claims disputes by providing all required documentation and subject matter representation in the manner specified by MLTC.

14. Claims Payment Accuracy

The DBPM must adhere to the same claims payment accuracy requirements for FFS dental claims as required for managed care claims as outlined in Section IV.R – Claims Management of this RFP.

15. Claims Data

The DBPM must submit all data relevant to the adjudication and payment of FFS dental claims to MLTC as required by the State. All claims data must be submitted to MLTC in standard HIPAA formats, as applicable. FFS dental claims data (including adjustments and recoupments) must be submitted a minimum of monthly on a date designated by MLTC. Claim data must be identified as FFS and must have the appropriate account code on the claim.

16. Audit Requirements

The DBPM must adhere to all audit requirements for managing FFS dental claims as required for managed care claims, as outlined in Section IV.R – Claims Management of this RFP. The DBPM must support MLTC by providing claims payment explanations, as requested.

G. MEMBER SERVICES AND EDUCATION

1. General Guidelines

a. Member education is defined as communication with an enrolled member of the DBPM.

b. Member education can be both verbal and written.

c. All member education guidelines are applicable to the DBPM, its agents, subcontractors, volunteers and/or providers.

d. All member education activities must be conducted in an orderly, non-disruptive manner and must not interfere with the privacy of beneficiaries or the general community.

e. All member education materials and activities must comply with the requirements in 42 CFR §438.10 and the MLTC requirements set forth in this RFP.

i. In accordance with 42 CFR §438.10(d), MLTC must provide the DBPM the prevalent non-English language spoken by enrollees in the state. Prevalent is defined as five percent of the population statewide.

ii. The DBPM, as required in 42 CFR §438.10(c)(3), must be responsible for providing to enrollees and potential enrollees written information in the prevalent non-English language in the DBPM's particular service area.

iii. In accordance with 42 CFR §438.10(c)(4)-(5) the DBPM must provide enrollees oral interpretation services available free of charge, to all non-English languages rather than to only those MLTC identifies as prevalent. The DBPM is responsible for providing all written materials in alternative formats and in a manner that considers the special needs of those who, for example, are visually limited or have limited reading proficiency.

f. The DBPM is responsible for creation, production and distribution of its own member education materials to its members.

g. All member education materials, in all mediums, must be reviewed and approved in writing by MLTC or its designee in accordance with Social Security Act § 1932 (d)(2)(A) and 42 CFR §438.104.

h. The DBPM must assure MLTC that member education materials are accurate and do not mislead, confuse, or defraud the member/potential member or MLTC as specified in Social Security Act § 1932 (d) and 42 CFR §438.104.

i. The DBPM must participate in the state's efforts to promote the delivery of services in a culturally competent manner to all members and comply with the Office of Minority Health, Department of Health and Human Services' "Cultural and Linguistically Appropriate Services Guidelines" at the following URL: http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15 and participate in the state's efforts to promote the delivery of services in a culturally competent manner to all enrollees.

2. Marketing and Member Education Plan

a. The DBPM must develop and implement a plan detailing the member education activities it will undertake and materials it will create during the contract period. The detailed plan must be submitted to MLTC for review and approval within thirty (30) calendar days from the date of award.

b. The DBPM must not begin member education activities prior to the approval of the member education plan.

c. The DBPM member education plan must:

i. List any subcontractors engaged in member education activities for the DBPM.

ii. State member education goals and strategies.

iii. Include the DBPM's plans to monitor and enforce compliance with all member education guidelines.

d. Any changes to the member education plan or included materials or activities must be submitted to MLTC for approval at least thirty (30) calendar days before implementation of the member education activity, unless the DBPM can demonstrate just cause for an abbreviated timeframe.

3. Member Education Materials Approval Process

a. The DBPM must obtain prior written approval from MLTC for all member education materials. This includes, but is not limited to, print, television and radio advertisements; handbooks, and provider directories; DBPM website screen shots; promotional items; brochures; letters and mass mailings and emails. Neither the DBPM nor its subcontractors may distribute any DBPM member education materials without MLTC consent.

b. DBPMs must obtain prior written approval for all materials developed by a recognized entity having no association with the DBPM that the DBPM wishes to distribute.

4. Member Education – Required Materials and Services

The DBPM must ensure all materials and services do not discriminate against DBP members on the basis of their health history, health status or need for healthcare services. This applies to enrollment, re-enrollment or disenrollment materials and processes from the DBPM.

a. Member Orientation

i. The DBPM must have written policies and procedures for the following, but not limited to:

a) Orienting new members of its benefits and services.

b) Role of the dental home.

c) What to do during the transition period.

d) How to utilize services.

e) What to do in a dental emergency or urgent dental situation.

f) How to a file a grievance and appeal.

ii. The DBPM must identify and educate members who access the system inappropriately and provide continuing education as needed.

iii. The DBPM may propose, for approval by MLTC, alternative methods for orienting new members and must be prepared to demonstrate their efficacy.

iv. The DBPM must have written policies and procedures for notifying newly identified members within ten (10) business days after receiving the Member File from MLTC. This notification must be in writing and include a listing of dental home names (and include locations, and office telephone numbers) that the member may choose as their primary dental care provider.

v. The DBPM must submit a copy of the procedures to be used to contact DBPM members for initial member education to MLTC for approval within thirty (30) calendar days following the date of award.

vi. New Medicaid eligible individuals who have not proactively selected a dental home or whose choice of dental home is not available will have the opportunity to select a dental home within the DBPM that: 1) has entered into a provider agreement with the DBPM; and 2) is within a reasonable commuting distance from their residence.

b. Welcome Packets

i. The DBPM must send a welcome packet to new members within ten (10) business days from the date of receipt of the Member File from MLTC.

ii. The DBPM must mail a welcome packet to each new member. When the name of the responsible party for the new member is associated with two (2) or more new members, the DBPM is only required to send one welcome packet.

iii. All contents of the welcome packet are considered member education materials and, as such, must be reviewed and approved in writing by MLTC prior to distribution according

to the provisions described in this RFP. Contents of the welcome packets must include those items specified in the contract. The welcome packet must include, but is not limited to:

a) A welcome letter highlighting major program features and contact information for the DBPM.

b) A Provider Directory when specifically requested by the member (also must be available in searchable format on-line).

iv. The DBPM must adhere to the requirements for the Provider Directory as specified below in Section IV.G.6, its attachments, and in accordance with 42 CFR §438.10.

5. Additional Member Educational Materials and Programs

The DBPM must prepare and distribute educational materials, not less than two (2) times a year, that provide information on preventive care, health promotion, access to care or other targeted dental related issues. This should include notification to its members of their right to request and obtain the welcome packet at least once a year and any change that MLTC defines as significant at least thirty (30) calendar days before the intended effective date. All materials distributed must comply with the relevant guidelines established by MLTC for these materials and/or programs.

6. Member Materials

a. The DBPM must include in all member materials the following:

i. The date of issue.

ii. The date of revision.

iii. If prior versions are obsolete.

7. Member Identification (ID) Cards

a. The DBPM must issue an ID card to each of its members. At a minimum, the card must include:
i. The member's name.
ii. The Member's Medicaid ID number, as assigned by DHHS.
iii. The DBPM's name and address.
iv. Instructions on what the members should do in the event of an emergency.
v. The member's Dental Home name and telephone numbers (including the after-hours number, if it is different.)
vi. The DBPM's toll-free number(s) for Member Services, filing a grievance, and reporting suspected fraud.

b. The DBPM may provide the DPM member ID card in a separate mailing from the welcome packet. However, the ID card must be sent no later than ten (10) business days from the date of receipt of the file from MLTC or the enrollment broker that identifies the new member. As part of the welcome packet information, the DBPM must explain the purpose of the card and how to use it.

c. The card may be issued without the Dental Home information if no Dental Home selection has been made as of the date of the card's mailing. One the Dental Home selection has been made by the member or through auto-assignment, the DBPM must reissue the card within ten (10) business days of the selection or auto-assignment. As part of the mailing of the reissued card, the DBPM must explain the purpose of the new card, the changes between the new and previous card, and that the member should destroy the previous card.

d. The DBPM must reissue the DBPM ID card to a member within ten(10) calendar days of notice that a member has lost his/her card, had a name or Dental Home change, or for any other reason that requires a change to the information on the current ID card.

e. If the DBPM has knowledge of any DBPM member permitting the use of his/her ID card by any other person, the DBPM must immediately report this information to the Special Investigation Unit

in the Department of Health and Human Services Division of Public Health at (402) 471-9407 (Lincoln and Greater Nebraska) or (402) 595-3789 (Omaha).

f. The DBPM must ensure that its subcontractors can identify members in a manner that will not result in discrimination against the members, in order to provide or coordinate the provision of all benefits and services, expanded services, and/or out-of-network services.

8. Provider Directory for Members

a. The DBPM must develop and maintain a Provider Directory in two (2) formats:

i. Web-based, searchable, online directory for members and the public.

ii. A hard copy directory for members upon request only.

b. MLTC or its designee must provide the file layout for the electronic directory to the DBPM after approval of the contract. The DBPM must submit templates of its provider directory to MLTC within thirty (30) days from the date of award.

c. The hard copy directory for members must be reprinted with updates at least annually. Inserts may be used to update the hard copy directories monthly for new members and to fulfill only requests. The web-based online version must be updated in real time, however no less than weekly.

d. In accordance with 42 CFR §438.10, the provider directory must include, but not be limited to:

i. Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the Medicaid enrollee's service area, including identification of providers, dental homes, specialists, and providers that are not accepting new patients at a minimum.

ii. Identification of dental homes, specialists, and dental groups in the service area.

iii. Identification of any restrictions on the enrollee's freedom choice among network providers.

iv. Identification of hours of operation including identification of providers with non-traditional hours (Before 8 a.m. or after 5 p.m. or any weekend hours).

9. Member Call Center

a. The DBPM must maintain a toll-free member service call center, physically located in the United States with all employees also physically located in the United States, The member service lines must be adequately staffed and individuals trained to accurately respond to questions regarding:

i. DBPM policies and procedures.

ii. Prior authorizations.

iii. Access information.

iv. Information on dental homes or specialists.

v. Referrals to participating specialists.

vi. Resolution of service and/or dental delivery problems.

vii. Member grievances.

b. The toll-free number must be staffed between the hours of 7:00 a.m. and 7:00 p.m., central time, Monday through Friday.

c. The toll-free line must have an automated system, available 24-hours a day, and seven (7) days a week, including all federal and state holidays. This automated system must include the

capability of providing callers with operating instructions on what to do in case of a dental emergency and the option to leave a message, including instructions on how to leave a message and when that message will be returned. The DBPM must ensure that the voice mailbox has adequate capacity to receive all messages and that member services staff return all calls by close of business the following business day.

d. The DBPM must have sufficient telephone lines to answer incoming calls. The DBPM must ensure sufficient staffing to meet performance standards listed in this RFP. MLTC reserves the right to specify staffing ratio and/or other requirements, if performance standards are not met or it is determined that the call center staffing/processes are not sufficient to meet member needs as determined by MLTC.

e. The DBPM must develop a contingency plan for hiring call center staff to address overflow calls and emails and to maintain call center access standards set forth for DBPM performance. The DBPM must develop and implement a plan to sustain call center performance levels in situations where there is high call/email volume or low staff availability. Such situations may include, but are not limited to, increases in call volume, emergency situations (including natural disasters such as hurricanes or tornadoes), staff in training, staff illnesses, and vacations.

f. The DBPM must develop telephone help line policies and procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards. The DBPM must submit these telephone help line policies and procedures, including performance standards, to MLTC for written approval prior to implementation of any policies. This must include a capability to track and report information on each call. The DBPM call center must have the capability to produce an electronic record to document a synopsis of all calls. The tracking must include sufficient information to meet the reporting requirements.

g. The DBPM must develop call center quality criteria and protocols to measure and monitor the accuracy of responses and phone etiquette as it relates to the toll- free telephone line. The DBPM must submit call center quality criteria and protocols to MLTC for review and approval at the Readiness Review and approval annually.

10. Automatic Call Distribution (ACD) System

a. The DBPM must install, operate and monitor an ACD system for the customer service telephone call center. The ACD system must:

i. Effectively manage all calls received and assign incoming calls to available staff in an efficient manner.

ii. Transfer calls to other telephone lines.

iii. Provide an option to speak to a live person (during call center hours of operation).

iv. Provide detailed analysis as required for the reporting requirements, as specified, including the quantity, length and types of calls received, elapsed time before the calls are answered, the number of calls transferred or referred; abandonment rate; wait time; busy rate; response time; and call volume.

v. Provide a message that notifies callers that the call may be monitored for quality control purposes.

vi. Measure the number of calls in the queue at peak times.

vii. Measure the length of time callers are on hold.

viii. Measure the total number of calls and average calls handled per day/week/month.

ix. Measure the average hours of use per day.

x. Assess the busiest times and days by number of calls.

xi. Record calls to assess whether answered accurately.

xii. Provide a backup telephone system that must operate in the event of line trouble, emergency situations including natural disasters, or other problems so that access to the telephone lines is not disrupted.

xiii. Provide interactive voice response (IVR) options that are user-friendly to members and include a decision tree illustrating IVR system.

xiv. Inform the member to dial 911 if there is an emergency.

11. Member Responsibilities

a. The DBPM must encourage each member to be responsible for his/her own healthcare by becoming an informed and active participant in his/her care. Members have the responsibility to cooperate fully with providers in following mutually acceptable courses of treatment, providing accurate dental, medical and personal histories, and being present at scheduled appointments and reporting on treatment progress, such as notifying their healthcare provider promptly if serious side effects and complications occur, and/or worsening of the condition arises.

b. The DBP members' responsibilities must include but are not limited to:

i. Presenting their Nebraska Medicaid issued Medicaid ID card when using dental services.

ii. Being familiar with the DBP procedures to the best of the member's abilities.

iii. Calling or contacting the DBPM to obtain information and have questions answered.

iv. Providing participating network providers with accurate and complete dental information.

v. Asking questions of providers to determine the potential risks, benefits and costs of treatment alternatives and following the prescribed treatment of care recommended by the provider or letting the provider know the reasons the treatment cannot be followed, as soon as possible.

vi. Living healthy lifestyles and avoiding behaviors know to be detrimental to their health.

vii. Following the grievance process established by the DBPM if they have a disagreement with a provider.

viii. Making every effort to keep any agreed upon appointments, and follow-up appointments; and accessing preventive care services, and contacting the provider in advance if unable to keep the appointment.

12. Notice to Members of Provider Termination

a. The DBPM must give written notice of a provider's termination to each member who received their primary care from, or was seen on a regular basis by the terminated provider. When timely notice from the provider is received, the notice to the member must be provided within fifteen (15) calendar days of the receipt of the termination notice from the provider.

b. Failure to provide notice prior to the dates of termination will be allowed when a provider becomes unable to care for members due to illness, a provider dies, the provider moves from the service area and fails to notify the DBPM, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster. Under these circumstances, notice must be issued immediately upon the DBPM becoming aware of the circumstances. The DBPM must document the date and method of notification of termination.

13. Oral and Written Interpretation Services

a. The DBPM must make real-time oral interpretation services available free of charge to each potential member and member. This applies to all non-English languages not just those that Nebraska specifically requires (Spanish). The member shall not to be charged for interpretation services. The DBPM must notify its members that oral interpretation is available for any language

and written information is available in Spanish and how to access those services. On materials where this information is provided, the notation should be written in Spanish.

b. The DBPM must ensure that translation services are provided for written marketing and member education materials for any language that is spoken as a primary language by more than five percent of the population statewide. Within 90 calendar days of notice from MLTC, materials must be translated and made available. Materials must be made available at no charge in that specific language to assure a reasonable chance for all members to understand how to access the DBPM and use services appropriately as specified in 42 CFR §438.10(c) (4) and (5).

H. GRIEVANCES AND APPEALS

1. General Requirements

a. The DBPM must have a grievance system for members that meet all Federal and State regulatory requirements, including a grievance process, an appeal process, and access to the State's fair hearing system. The DBPM must distinguish between a grievance, grievance system, and grievance process, as defined below:

i. A grievance is a member's expression of dissatisfaction with any aspect of care other than the appeal of actions.

ii. The grievance system includes a grievance process, an appeal process, and access to the State's fair hearing system. Any grievance system requirements apply to all three (3) components of the grievance system, not just to the grievance process.

iii. A grievance process is the procedure for addressing members' grievances.

b. The DBPM must:

i. Give members reasonable assistance in completing forms and other procedural steps, including but not limited to providing interpreter services and toll-free numbers with teletypewriter/telecommunications devices for deaf individuals and interpreter capability.

ii. Acknowledge receipt of each grievance and appeal in writing to the member within ten (10) calendar days of receipt.

iii. Ensure that individuals completing the review of grievances and appeals are not the same individuals involved in previous levels of review or decision-making, nor the subordinate of any such individual. The individual addressing a member's grievance must be a health care professional with clinical expertise in treating the member's condition or disease if any of the following apply:

a) The denial of service is based on lack of medical necessity.

b) Because of the member's medical condition, the grievance requires expedited resolution.

c) The grievance or appeal involves clinical issues.

iv. Take into account all comments, documents, records, and any other information submitted by the member or his/her representative without regard to whether such information was submitted or considered in the initial adverse benefit decision.

v. Provide access to MLTC and/or its designee for any information related to grievances or appeals filed by its members. MLTC will monitor enrollment and termination practices to ensure proper implementation of the DBPM's grievance procedures, in compliance with 42 CFR §§438.400-424.

2. Complaint and Grievance Processes

a. A member may file a grievance either verbally or in writing. A provider may file a grievance when acting as the member's authorized representative.

b. A member may file a grievance with the DBPM or the State at any time.

c. The DBPM must address each grievance and provide notice, as expeditiously as the member's health condition requires, within State-established timeframes and not to exceed 90 calendar days from the day on which the DBPM receives the grievance.

d. MLTC will establish the method the DBPM must use to notify a member of the disposition of a grievance.

3. Service Authorizations and Notices of Action

a. Service Authorization

i. The DBPM must provide a definition of service authorization that, at a minimum, includes the member's request for the provision of a service.

ii. The DBPM must assure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.

b. Notice of Adverse Action

i. The DBPM must notify the requesting provider, and give the member written notice, 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. The notice must meet the requirements of 42 CFR §438.400-42.

ii. The DBPM must give the member written notice of any action (not just service authorization actions) within the timeframes required for each type of action. The notice must explain:

a) The action the DBPM or its subcontractor has taken or intends to take.

b) The reason(s) for the action.

c) The member's right to receive, on request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's claim for benefits. Such information includes medical-necessity criteria and any processes, strategies, or evidentiary standards used in setting coverage limits.

d) The member's or the provider's right to file an appeal.

e) The member's right to request a State fair hearing.

f) Procedures for exercising a member's rights to appeal or grieve a decision.

g) Circumstances under which expedited resolution is available and how to request it.

h) The member's rights to have benefits continue pending the resolution of an appeal, how and the deadline by which to request that benefits be continued, and the circumstances under which the member may be required to pay the cost of these services.

iii. The notice must be in writing and must meet the language and format requirements described in Section IV.G – Member Services and Education.

c. Timeframes for Notice of Action

i. The DBPM must provide notice to the member a minimum of ten (10) days before the date of action when the action is a termination, suspension, or reduction of previously authorized Medicaid-covered services.

ii. The period of advanced notice required is shortened to five (5) days if probable member fraud has been verified.

iii. The DBPM must give notice by the date of the action under the following circumstances:

a) The death of a member.

b) A signed written member statement, which requests service termination or gives information requiring termination or reduction of services, if the statement reasonably indicates that the member understands the result of the statement will be a termination or reduction of services.

c) The member's admission to an institution where he or she is ineligible for further services.

d) The member's address is unknown and mail directed to him/her has no forwarding address.

e) The member has been accepted for Medicaid services by another state.

f) The member's dentist prescribes the change in the level of medical care.

g) The safety or health of individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the resident's urgent medical needs.

iv. The DBPM must provide notice on the date of action when the action is a denial of payment.

v. Standard Service Authorization Denial

The DBPM must give notice as expeditiously as the member's health condition requires, and within State-established timeframes, that may not exceed fourteen (14) calendar days following receipt of the request for service. The timeframe may be extended up to fourteen (14) additional calendar days if the member or the provider requests an extension or the DBPM justifies a need for additional information and the reason(s) why the extension is in the member's interest. If the DBPM extends the timeframe, the member must be provided written notice of the reason for the decision to extend the timeframe and the right to file an appeal if he or she disagrees with that decision. The DBPM must issue and carry out its determination as expeditiously as the member's health condition requires but no later than the date the extension expires.

vi. Expedited Service Authorization Denial

For cases in which a provider indicates or the DBPM determines that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the DBPM must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, and no later than seventy-two (72) hours after receipt of the request for service. The DBPM may extend the time period by up to fourteen (14) calendar days if the member requests an extension or if the DBPM justifies a need for additional information and the reason(s) why the extension is in the member's interest.

vii. Untimely Service Authorization Decisions

The DBPM must provide notice on the date that the timeframes expire when service authorization decisions are not reached within the timeframes for either standard or expedited service authorizations. An untimely service authorization constitutes a denial and, therefore constitutes an adverse action.

4. Appeal Process

a. A member may file a DBPM-level appeal. A provider, acting on behalf of the member and with the member's written consent, may also file an appeal.

b. The member or provider may file a DBPM-level appeal within sixty (60) calendar days from the date on the DBPM's Notice of Action.

c. The member or provider may file an appeal either verbally or in writing and must follow a verbal filing with a written signed appeal.

d. The DBPM must:

i. Ensure that verbal inquiries seeking to appeal an action are treated as appeals and confirm those inquiries in writing, unless the member or the provider requests expedited resolution.

ii. Ensure that there is only one level of appeal for members.

iii. Provide a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.

iv. Provide the member and his or her representative (free of charge and sufficiently in advance of the resolution timeframe for appeals) the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied on, or generated by the DBPM (or at the direction of the DBPM) in connection with the appeal of the adverse benefit determination.

v. Consider the member, representative, or estate representative of a deceased member as parties to the appeal.

e. The DBPM must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within thirty (30) calendar days from the day the DBPM receives the appeal. The DBPM may extend the timeframes by up to fourteen (14) calendar days if the member requests the extension or the DBPM shows that there is need for additional information and the reason(s) why the delay is in the member's interest. For any extension not requested by the member, the DBPM must:

i. Make reasonable efforts to give the member prompt verbal notice of the delay.

ii. Within two (2) calendar days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he/she disagrees with that decision.

iii. Resolve the appeal as expeditiously as the member's health condition requires but no later than the date on which the extension expires.

f. The DBPM must provide written notice of disposition, which must include:

i. The results and date of the appeal resolution.

ii. For decisions not wholly in the member's favor:

a) The right to request a state fair hearing.

b) How to request a state fair hearing.

c) The right to continue to receive benefits pending a hearing.

d) How to request the continuation of benefits.

e) If the DBPM action is upheld in a hearing, that the member may be liable for the cost of any continued benefit received while the appeal was pending.

5. Expedited Appeals Process

a. The DBPM must establish and maintain an expedited review process for appeals that the DBPM determines (at the request of the member or his/her provider) that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. Expedited appeals must follow all standard appeal regulations for expedited requests, except to the extent that any differences are specifically noted in the regulation for expedited resolution.

b. The member or provider may file an expedited appeal either verbally or in writing. No additional member follow-up is required.

c. The DBPM must inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and/or in writing, in the case of an expedited resolution.

d. The DBPM must resolve each expedited appeal and provide notice as expeditiously as the member's health condition requires and in no event longer than seventy-two (72) hours after the DBPM receives the appeal. The DBPM may extend the timeframes by up to fourteen (14) calendar days if the member requests the extension or the DBPM shows that there is need for additional information and the reason(s) why the delay is in the member's interest.

e. For any extension not requested by the member, the DBPM must give the member written notice of the reason for the delay.

f. In addition to written notice, the DBPM must also make reasonable efforts to provide verbal notice of resolution.

g. The DBPM must ensure that no punitive action is taken against a provider who either requests an expedited resolution or supports a member's appeal.

h. If the DBPM denies a request for expedited resolution of an appeal, it must:

i. Transfer the appeal to the standard timeframe of no longer than thirty (30) calendar days from the day the DBPM receives the appeal with a possible extension of fourteen (14) calendar days.

ii. Make a reasonable effort to give the member prompt verbal notice of the denial and a written notice within two (2) calendar days.

6. Continuation of Benefits

a. The DBPM must continue a member's benefits if any one of the following apply:

i. The appeal is filed timely, meaning on or before the later of the following:

a) Ten (10) calendar days after the DBPM mailing the Notice of Action; or

b) The intended effective date of the DBPM's proposed action.

ii. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.

iii. The services were ordered by an authorized provider.

iv. The authorization period has not expired.

v. The member requests an extension of benefits.

b. If the DBPM continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

i. The member withdraws the appeal.

ii. The member does not request an appeal within ten (10) calendar days from when the DBPM mails an adverse DBPM decision.

iii. A state fair hearing decision adverse to the member is made.

iv. The authorization expires or authorization service limits are met.

c. The DBPM may recover the cost of the continuation of services furnished to the member while the appeal was pending if the final resolution of the appeal upholds the DBPM action.

7. Access to State Fair Hearings

a. A member may request a state fair hearing. The provider may also request a state fair hearing if the provider is acting as the member's authorized representative. A member or his/her representative may request a state fair hearing only after receiving notice that the DBPM is upholding the adverse benefit determination.

b. If the DBPM takes action and the member requests a state fair hearing, the State must grant the member a state fair hearing. The right to a State fair hearing, how to obtain a hearing, and representation rules at a hearing must be explained to the member or the member's representative (if any) by the DBPM.

c. The member or the member's representative (if any) may request a state fair hearing within one hundred, twenty (120) calendar days from the date of the DBPM's notice of resolution.

d. The parties to the State fair hearing include the DBPM, and the member and his/her representative (if any), or (if instead applicable) the representative of a deceased member's estate.

e. The State must ensure that any member dissatisfied with a determination denying a member's request to transfer plans/disenroll is given access to a State fair hearing.

8. Reversed Appeals

a. If the DBPM or the state fair hearing process reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the DBPM must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours from the date the DBPM receives notice reversing the determination.

b. The DBPM must pay for disputed services if the DBPM or State fair hearing decision reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending.

9. Grievance and Appeal Recordkeeping Requirements

The DBPM must maintain records of grievances and appeals. The record of each grievance and appeal must contain, at a minimum, all of the following information:

a. A general description of the reason for the appeal or grievance.

b. The date the grievance or appeal was received.

c. The date of each review or, if applicable, review meeting.

d. Resolution at each level of the appeal or grievance process, as applicable.

e. Date of resolution at each level of the appeal or grievance process, as applicable.

f. Name of the covered person by or for whom the appeal or grievance was filed.

The DBPM is required to accurately maintain the record in a manner that is accessible to MLTC and available on request to CMS.

10. Information to Providers and Subcontractors

The DBPM must provide the following grievance, appeal, and fair hearing procedures and timeframes to all providers and subcontractors at the time of entering into or renewing a contract:

a. The member's right to a State fair hearing, how to obtain a hearing and representation rules at a hearing.

b. The member's right to file grievances and appeals and the requirements and timeframes for filing them.

c. The availability of assistance in filing grievances or appeals, and participating in State fair hearings.

d. The toll-free number(s) to use to file verbal grievances and appeals.

e. The member's right to timely request continuation of benefits during an appeal or State fair hearing filing and, if the DBPM action is upheld in a hearing, that the member may be liable for the cost of any continued benefits received while the appeal was pending.

f. Any State-determined provider appeal rights to challenge the failure of the organization to cover a service.

11. Reporting of Complaints, Grievances, and Appeals

The DBPM is required to submit to MLTC monthly data for the first six (6) months of the contract period, and then submit data quarterly thereafter, as specified by MLTC, about grievances and appeals. MLTC reserves the right to extend the monthly reporting requirement at its sole discretion. This information will be used by MLTC to measure the DBPM's performance.

I. PROVIDER NETWORK REQUIREMENTS

1. General Provider Network Requirements

a. The DBPM must maintain a network of qualified dental providers in sufficient numbers and locations to provide required access to covered services. The DBPM is expected to design a network that provides a geographically convenient flow of patients among network providers. The provider network must be designed to reflect the needs and service requirements of the DBPM's member population. The DBPM must design its dental provider network to maximize the availability of primary dental services and specialty dental services.

b. Services must be accessible to DBPM members in terms of timeliness, amount, duration and scope equal to services provided by FFS Medicaid at the time the DBPM is implemented [42 CFR §438.210(a)(2)]. If the network is unable to provide necessary services required under contract, the DBPM must ensure timely and adequate coverage of these services through an out of network provider until a network provider is contracted. The DBPM must ensure coordination with respect to authorization and payment issues in these circumstances [42 CFR §438.206(b)(4) and (5)].

c. All providers must be in compliance with Americans with Disabilities Act (ADA) requirements and provide physical access for Medicaid members with disabilities.

d. The DBPM must not discriminate with respect to participation in the DBP, reimbursement or indemnification against any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the provider's type of licensure or certification [42 CFR §§438.12(a)(1) and (2)]. In addition, the DBPM must not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment [42 CFR §438.214(c)].

e. For the first year of the contract period, the DBPM must accept into its network any dental provider participating in the Medicaid program provided the dental provider is licensed and in enrolled with DHHS and accepts the terms and conditions of the contract offered to them by the DBPM. This provision also does not interfere with measures established by the DBPM to control costs and quality consistent with its responsibilities under this contract nor does it preclude the

DBPM from using different reimbursement amounts for different specialties or for different practitioners in the same specialty [42 CFR §438.12(b)(1)].

f. The DBPM may terminate a contract with a provider for cause. The DBPM must provide written notice of termination to the provider within fourteen (14) calendar days. The DBPM must notify MLTC of the termination as soon as the written notification of cancelation is sent to the provider, but no later than seven (7) calendar days.

g. The DBPM must notify the DBPM members that their primary dental care provider's contract has been terminated. Notice must be sent within fifteen (15) calendar days after receipt of issuance of the termination notice, as specified in 42 CFR §438.10(f)(1). This notice must include a list of recommended network providers available to the member in their surrounding area.

h. The DBPM must also meet the following requirements:

i. Ensure the provision of all core dental benefits and services specified in the contract. Accessibility of benefits/services, including geographic access, appointments, and wait times must be in accordance with the requirements in this RFP. These minimum requirements do not release the DBPM from ensuring that all necessary covered dental benefits and services required by its members are provided pursuant to this RFP.

ii. Provide core dental services directly or enter into written agreements with providers or organizations that must provide core dental services to the members.

iii. Not execute contracts with individuals or groups of providers who have been excluded from participation in Federal healthcare programs under either section 1128 or section 1128A of the Social Security Act [42 CFR §438.214(d)] or state funded healthcare programs.

iv. Not prohibit, or otherwise restrict, a healthcare professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient for the following:

a) Member's health status, medical or behavioral healthcare, or treatment options, including any alternative treatment that may be self-administered.

b) Information the member needs in order to decide among all relevant treatment options.

c) The risk, benefits, and consequences of treatment and non-treatment.

d) The member's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions.

v. Monitor provider compliance with applicable access requirements, including but not limited to, appointment and wait times, and take corrective action for failure to comply. The DBPM must conduct appointment availability surveys annually. The surveys must be submitted within thirty (30) calendar days after the conclusion of each contract year. The survey results must be kept on file and be readily available for review by MLTC upon request. The DBPM may be subject to sanctions for noncompliance of providers with applicable appointment and wait time requirements set forth in this RFP.

vi. If a member requests a provider who is located beyond access standards, and the DBPM has an appropriate provider within the DBPM who accepts new patients, it must not be considered a violation of the access requirements for the DBPM to grant the member's request.

vii. The DBPM must require that providers deliver services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds and provide for interpreters in accordance with 42 CFR §438.206.

viii. The DBPM must at least quarterly validate provider demographic data to ensure that current, accurate, and clean data is on file for all contracted providers. Failure to do so

may result in monetary penalties against the DBPM; whether the data is clean, current or accurate shall be at the discretion of MLTC.

2. General Provider Access Requirements

The DBPM must ensure access to dental services (distance traveled, waiting time, length of time to obtain an appointment, after-hours care) in accordance with the provision of services under this RFP. MLTC will monitor the DBPM's service accessibility and may require that the DBPM obtain services from out-of-network providers as necessary for the provision of core dental benefits and services. The DBPM must provide available, accessible, and adequate numbers of service locations, service sites, and dental professionals for the provision of core dental benefits and services, and must take corrective action if there is failure to comply by any provider.

3. Appointment Availability and Referral Access Standards

a. Nebraska's appointment availability standards are included in Attachment 4 – Dental Access Standards. MLTC will monitor each DBPM's compliance with these standards through quarterly reporting per Attachment 5 – Reporting Requirements. Additionally, walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with appointment availability standards.

b. The DBPM must monitor the practice of placing members who seek any covered services on waiting lists. If the DBPM determines that a network provider has established a waiting list and the service is available through another network provider, the DBPM must stop referrals to the network provider until such time as the network provider has openings, and take action to refer the member to another appropriate provider.

4. Geographic Access Standards

a. The DBPM must comply with maximum travel times and/or distance requirements per Attachment 4 – Dental Access Standards. Requests for exceptions as a result of prevailing community standards or a lack of available providers must be submitted to MLTC in writing for approval. Such requests should include data on the local provider population available to the non-Medicaid population.

b. If there are gaps in the DBPM's provider network, the DBPM must develop a provider network availability plan to identify the gaps and describe the remedial action(s) that will be taken to address those gaps. When any gap is identified, the DBPM must document its efforts to engage any available providers (three good-faith attempts, for example) and must incorporate the circumstances of, and information to be gained by, this gap into its written plan to ensure adequate provider availability over time.

c. The DBPM must establish a program of assertive outreach to rural areas where covered services may be less available than in more urban areas, and must include any gaps in its availability plan. The DBPM must monitor utilization across the State to ensure access and availability, consistent with the requirements of the contract and the needs of its members.

5. Access to Specialty Providers

a. The DBPM must ensure the availability of access to specialty providers. The DBPM must ensure access standards and guidelines to specialty providers are met as specified in this Section in regard to timeliness and service area.

b. The DBPM must establish and maintain a provider network of dentist specialists that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the dental needs of its members (adults and children) without excessive travel requirements. This means that, at a minimum:

i. The DBPM has signed a contract with providers of the specialty types listed below who accept new members and are available on at least a referral basis.

ii. The DBPM is in compliance with access and availability requirements.

c. The DBPM must ensure, at a minimum, the availability of the following providers:

i. Endodontists

ii. Oral Surgeons

iii. Orthodontists

iv. Pedodontists

v. Periodontists

vi. Prosthodontists

d. The DBPM must use specialists with pediatric expertise when the need for pediatric specialty care is significantly different from the need for a general dentist.

e. The DBPM must meet standards for timely access to all specialists. In accordance with 42 CFR §438.208(c)(4) for members determined to need a course of treatment, the DBPM must have a mechanism in place to allow members to directly access a specialist as appropriate for the member's condition and identified needs.

6. Contracting with FQHCs and RHCs

A DBPM must offer to contract with all FQHCs and RHCs in the State. If a contract cannot be reached between the DBPM and a FQHC or RHC, the DBPM must notify MLTC.

7. Establishing Dental Homes

a. Dental Home Principles

The American Academy of Pediatric Dentistry defines Dental Homes as 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.

DHHS principles for Dental Homes include:

i. Care that is comprehensive and includes acute, corrective, and preventative services.

ii. Care that is individualized to each member based upon a dental exam for tooth decay and gum problems.

iii. Care that is preventative and includes information about proper care for the member's teeth and gums, and correct diet.

iv. For children, care that prepares parents and guardians with guidance about what to expect for their child's age for the growth of teeth and the jaw.

v. For children, care that is educational and helps parents and guardians learn about their child's dental health now and as their child grows.

vi. Care that is provided in a culturally competent manner.

b. Dental Home Requirements

i. The DBPM must include in its Provider Network Development Management Plan, detailed in this section, a plan for establishing Dental Homes for members. The Dental Home plan must, at a minimum, address the following topics:

a) Outreach to potential Dental Home participating providers.

b) Policies and procedures for establishing and monitoring the Dental Home program including, but not limited to:

1). Covered services in the amount, duration, and scope that the DBPM recommends should comprise the Dental Home package. This package of services will be finalized with MLTC input and approval prior to contract start.

2). Referrals to dental specialists when care cannot be provided directly within the Dental Home.

3). Education topics to be addressed in the Dental Home setting.

4). Guidelines for the management of acute dental trauma.

c) Strategies for encouraging member participation, with a particular focus on parents or guardians of members six (6) to thirty-five (35) months of age.

8. Provider Outreach and Application Processing

a. The DBPM must develop standardized provider application/credentialing forms and provider contracts for use with all providers, and utilize standardized processes.

b. The DBPM should submit its provider contract template(s) to MLTC with its proposal.

c. The DBPM must notify MLTC, a minimum of fifteen (15) calendar days in advance, if it decides to no longer accept provider applications for primary dental care or a certain specialty because member needs and MLTC access standards are being met otherwise. The DBPM must also notify MLTC a minimum of fifteen (15) calendar days in advance of resuming acceptance of those provider applications.

9. Credentialing and Re-credentialing of Providers and Clinical Staff

a. The DBPM must have a written credentialing and re-credentialing process that complies with 42 CFR §438.12, §438.206, §438.214, §438.224 and §438.230 for the review and credentialing and re-credentialing of licensed, independent providers and provider groups with whom it contracts or employs and with whom it does not contract but with whom it has an independent relationship. An independent relationship exists when the DBPM selects and directs it members to see a specific provider or group of providers. Changes to the process are permissible on an annual basis following review and approval by MLTC.

b. The process for periodic re-credentialing must be implemented at least once every thirty-six (36) months.

c. If the DBPM has delegated credentialing to a subcontractor, there must be a written description of the delegation of credentialing activities within the contract. The DBPM must require that the subcontractor ensure that all licensed dental professionals are credentialed in accordance with MLTC's credentialing requirements. MLTC will have final approval of the delegated entity.

d. The DBPM must develop and implement policies and procedures for approval of new providers, and termination or suspension of providers to assure compliance with the contract. The policies and procedures should include but are not limited to the encouragement of applicable board certification.

e. The DBPM must develop and implement a mechanism, with MLTC's approval, for reporting quality deficiencies which result in suspension or termination of a network provider(s). This process must be submitted for review and approval thirty (30) calendar days prior to contract start date.

f. The DBPM must develop and implement a provider dispute and appeal process, with MLTC's approval, for sanctions, suspensions, and terminations imposed by the DBPM against network provider(s) as specified in the contract.

This process must be submitted for review and approval thirty (30) calendar days from the date of award.

10. Provider Enrollment in Medicaid

a. The DBPM must require that all of its contracted providers enroll with MLTC as an approved service provider. For specific requirements on provider enrollment, refer to the MLTC website at: http://dhhs.ne.gov/medicaid/Pages/med_providerenrollment.aspx

b. The DBPM must begin its credentialing process concurrently with a provider's Medicaid provider enrollment rather than delaying its credentialing process until MLTC has approved a provider's enrollment in Medicaid.

11. Provider Network Development Management Plan

a. The DBPM must develop and maintain a provider Network Development and Management Plan which ensures that the provision of core dental benefits and services will occur [42 CFR §438.207(b)]. The Network Development and Management Plan must be submitted to MLTC within thirty (30) days from the date of award for review and approval, as well as when significant changes occur and annually thereafter within thirty (30) days of the start of each contract year. The Network Development and Management Plan must include the DBPM's process to develop, maintain and monitor an appropriate provider network that is supported by written agreements and is sufficient to provide adequate access of all required services included in the contract. When designing the network of providers, the DBPM must consider the following (42 CFR §438.206):

i. Anticipated maximum number of Medicaid members.

ii. Expected utilization of services, taking into consideration the characteristics and healthcare needs of the members in the DBPM.

iii. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish Medicaid core dental benefits and services.

iv. The numbers of DBPM providers who are not accepting new DBPM members.

v. The geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for Medicaid enrollees with disabilities.

b. The Network Provider Development and Management Plan must demonstrate the ability to provide access to core benefits and services as defined in this RFP, access standards in 42 CFR §438.206 and must include:

i. Assurance of Adequate Capacity and Services

ii. Establishing Dental Homes

iii. Access to Dental Homes

iv. Access to Specialists

v. Timely Access

vi. Service Area

vii. Second Opinion

viii. Out-of-Network Providers

c. The Network Provider Development and Management Plan must identify gaps in the DBPM's provider network and describe the process by which DBPM must assure all covered services are delivered to DBPM members. Planned interventions to be taken to resolve such gaps must also be included.

d. The DBPM must provide GEO mapping and coding of all network providers for each provider type by the deadline specified in Section IV.V – Transition and Implementation, to geographically

demonstrate network capacity. The DBPM must provide updated GEO coding to MLTC quarterly, or upon material change or upon request.

e. The DBPM must develop and implement Network Development and Management policies and procedure that comply with 42 CFR §438.214(a) and (b).

f. The DBPM must communicate and negotiate with the network regarding contractual and/or program changes and requirements.

g. The DBPM must monitor network compliance with policies and rules of MLTC and the DBPM, including compliance with all policies and procedures related to the grievance/appeal processes and ensuring the member's care is not compromised during the grievance/appeal processes.

h. The DBPM must evaluate the quality of services delivered by the network.

i. The DBPM must provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area.

j. The DBPM must monitor the adequacy, accessibility and availability of its provider network to meet the needs of its members, including the provision of care to members with limited proficiency in English.

k. The DBPM must provide training for its providers and maintain records of such training.

l. The DBPM must track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate.

m. The DBPM must ensure that provider calls are acknowledged within three (3) business days of receipt; resolve and/or state the result communicated to the provider within thirty (30) calendar days of receipt (this does not include inquiries from MLTC). If not resolved in thirty (30) days the DBPM must document why the issue goes unresolved; however, the issue must be resolved within ninety (90) calendar days.

n. Inquiries from MLTC must be acknowledged by the next business day and the resolution, or process for resolution, communicated to MLTC within twenty-four (24) hours.

12. Material Change to Provider Network

a. The DBPM must provide written notice to MLTC, no later than seven (7) business days of any network provider contract termination that materially impacts the DBPM's provider network, whether terminated by the DBPM or the provider, and such notice must include the reason(s) for the proposed action. A material change includes but is not limited to:

i. Any change that would cause more than five percent (5%) of members to change the location where services are received or rendered.

ii. A decrease in the total of individual dental homes by more than five percent (5%).

iii. A loss of any participating specialist which may impair or deny the members' adequate access to providers.

iv. Other adverse changes to the composition of which impair or deny the members' adequate access to providers.

b. The DBPM must also submit, as needed, an assurance when there has been a significant change in operations that would affect adequate capacity and services. These changes would include, but would not be limited to, changes in expanded services, payments, or eligibility of a new population.

c. When the DBPM has advance knowledge that a material change will occur, the DBPM must submit a request for approval of the material change in their provider network, including a copy of draft notification to affected members, sixty (60) days prior to the expected implementation of the change.

d. The request must include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them.

e. Changes and alternative measures must be within the contractually agreed requirements. The DBPM must within thirty (30) calendar days give advance written notice of provider network material changes to affected members. The DBPM must notify MLTC of emergency situation and submit request to approve material changes. MLTC will act to expedite the approval process.

f. The DBPM must notify MLTC within seven (7) calendar days of any unexpected changes (e.g., a provider becoming unable to care for members due to provider illness, a provider dies, the provider moves from the service area and fails to notify the DBPM, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster) that would impair its provider network [42 CFR §438.207(c)]. The notification must include:

i. Information about how the provider network change will affect the delivery of covered services.

ii. The DBPM's plan for maintaining the quality of member care, if the provider network change is likely to affect the delivery of covered services.

13. Coordination with Other Service Providers

The DBPM must encourage network providers and subcontractors to cooperate and communicate with other service providers who serve Medicaid members in the coordination and delivery of health care services. Such other service providers may include: Heritage Health MCOs; FQHCs and RHCs; dental schools; dental hygiene programs; school systems; and non-emergency transportation providers.

J. PROVIDER SERVICES

1. Provider Relations

a. The DBPM must, at a minimum, provide a Provider Relations function to provide support and assistance to all providers in their DBPM network. This function must:

i. Be available Monday through Friday from 7:00 am to 5:00 pm (central time) to address non-emergency provider issues or requests.

ii. Ensure all providers in the DBPM's network are provided all rights outlined in the DBPM's provider handbook.

iii. Provide ongoing provider training, respond to provider inquiries and provide general assistance to providers regarding program operations and requirements.

iv. Ensure regularly scheduled visits to provider sites, as well as ad hoc visits as circumstances dictate.

b. Provider Toll-free Telephone Line

i. The DBPM must operate a toll-free telephone line to respond to provider questions, comments and inquiries.

ii. The provider access component of the toll-free telephone line must be staffed between the hours of 7:00 am and 7:00 pm (central time) Monday through Friday to respond to provider questions in all areas, including but not limited to prior authorization requests, provider appeals, provider processes, provider complaints, and regarding provider responsibilities.

iii. The DBPM's call center system must have the capability to track provider call management metrics.

iv. After normal business hours, the provider service component of the toll-free telephone line must include the capability of providing information regarding normal business hours and instructions to verify enrollment for any DBPM member with an emergency or urgent

dental condition. This must not be construed to mean that the provider must obtain verification before providing emergency/urgent care.

c. Provider Website

i. The DBPM must have a provider website. The provider website may be developed on a page within the DBPM's existing website (such as a portal) to meet these requirements.

ii. The DBPM provider website must include general and up-to-date information about the DBPM and the DBP. This must include, but is not limited to:

a) DBPM provider manual.

b) DBPM-relevant MLTC bulletins.

c) Information on upcoming provider trainings.

d) A copy of the provider training manual.

e) Information on the provider grievance system.

f) Information on obtaining prior authorization and referrals.

g) Information on how to contact the DBPM Provider Relations.

iii. The DBPM provider website is considered marketing material and, as such, must be reviewed and approved by MLTC in writing within thirty (30) calendar days of the date of award.

iv. The DBPM must notify MLTC when the provider website is in place and when any approved changes are made.

v. The DBPM must remain compliant with HIPAA and any other (e.g., 42 CFR Part 31, Subpart F) applicable privacy and security requirements when providing any member eligibility or member identification information on the website.

vi. The DBPM website must be in compliance with the Americans with Disabilities Act, and specifically meet all standards the Act sets for people with visual impairments and disabilities that make usability a concern, as well as any other applicable laws.

d. Provider Handbook

i. The DBPM must make available to MLTC for approval a provider handbook specific to the Nebraska DBP, no later than thirty (30) calendar days from the date of award.

ii. The DBPM may choose not to distribute the provider handbook via regular mail, provided it submits a written notification to all providers that explains how to obtain the provider handbook from the DBPM's website. This notification must also detail how the provider can request a hard copy from the DBPM at no charge to the provider.

iii. All provider handbooks and bulletins must be in compliance with state and federal laws. The provider handbook must serve as a source of information regarding DBPM covered services, policies and procedures, statutes, regulations, telephone access, and special requirements to ensure all DBPM requirements are met.

iv. At a minimum, the provider handbook must include the following information:

a) Description of the DBPM.

b) Core dental benefits and services the DBPM must provide.

c) Emergency dental service responsibilities.

d) Policies and procedures that cover the provider complaint system. This information must include, but not be limited to, specific instructions regarding how to contact the DBPM to file a provider complaint and which individual(s) has the authority to review a provider complaint.

e) Information about the DBPM's Grievance System, that the provider may file a grievance or appeal on behalf of the member with the member's written consent, the time frames and requirements, the availability of assistance in filing, the toll-free telephone numbers and the member's right to request continuation of services while utilizing the grievance system.

f) Medical necessity standards as defined by MLTC and practice guidelines.

g) Practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions.

h) Dental home responsibilities.

i) Other provider responsibilities under the subcontract with the DBPM.

j) Prior authorization and referral procedures.

k) Dental records standards.

l) Claims submission protocols and standards, including instructions and all information necessary for a clean and complete claim and samples of clean and complete claims.

m) DBPM prompt pay requirements.

n) Notice that provider complaints regarding claims payment must be sent to the DBPM.

o) Quality performance requirements.

p) Provider rights and responsibilities.

v. The DBPM must disseminate bulletins as needed to incorporate any changes to the provider handbook.

e. Provider Outreach, Education and Training

i. The DBPM must provide training to all providers and their staff regarding the requirements of the contract. The DBPM must make initial training available within thirty (30) calendar days of contracting with a provider.

ii. The DBPM must also conduct ongoing training throughout the duration of this contract, as deemed necessary by the DBPM or MLTC, in order to ensure compliance with program standards and the contract. Training sessions must include, but not be limited to:

a) Face-to-face and tele- or web-conference training sessions.

b) Recorded provider training sessions on or available from the DBPM's website.

c) Documentation of training sessions and attendance, available to MLTC on request.

iii. The DBPM must submit a copy of the provider training handbook and training schedule to MLTC for review and approval a minimum thirty (30) calendar days from the date of award. Any changes to the handbook must be submitted to MLTC a minimum of forty-five (45) calendar days prior to scheduled changes and dissemination of such changes.

iv. The DBPM must develop and offer specialized initial and ongoing training in billing procedures, service authorization requirements, and other procedures it deems appropriate for network providers who/that have traditionally billed and obtained service authorization primarily from Medicaid. MLTC must be advised of these sessions and appropriate staff must be allowed to attend at their discretion.

v. The DBPM must develop, establish, and maintain a provider advisory committee. The committee must have representation from the major provider organizations in the state, as well as individual providers. Whenever feasible, DBPM staff must work collaboratively with the provider advisory committee, as well as established provider organizations, to create network development and management strategies and procedures.

vi. The DBPM must meet with providers and provider associations on a regular basis and at various locations throughout the state. In addition, the DBPM must hold a provider forum no less frequently than quarterly, at various locations across the state. The forums must be facilitated by the DBPM Executive Director or designee. The purpose of the forums is to improve communication between the DBPM and its providers. The forums must be open to all providers within the DBPM's network. The forums must not be the only venue by which the DBPM communicates and participates in a discussion and review of the issues affecting its provider network. Provider forum meeting agendas and minutes must be made available to MLTC on request. The DBPM must report information discussed during these meetings and forums to the DBPM's corporate leadership team and MLTC.

f. Provider-Patient Communication/Anti-Gag Clause

i. Subject to the limitations described in 42 CFR §438.102(a)(2), the DBPM must not prohibit or otherwise restrict a health care provider, acting within the lawful scope of his/her/its practice, from advising or advocating on behalf of a member, who is a patient of the provider, regardless of whether benefits for such care or treatment are provided under the contract, for the following:

a) The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

b) Any information the member needs in order to decide among relevant treatment options.

c) The risks, benefits, and consequences of treatment or non-treatment.

d) The member's right to participate in decisions regarding his/her health care, including the right to refuse treatment or to express preferences about future treatment decisions.

ii. If the DBPM violates the anti-gag provisions set forth in 42 U.S.C. §438.102(a)(1), it will be subject to intermediate sanctions.

iii. The DBPM must comply with the provisions of 42 CFR §438.102(a)(1)(ii) concerning the integrity of professional advice to members, including no interfering with providers' advice to members and information disclosure requirements related to provider incentive plans.

g. Provider Complaint System

i. The DBPM must establish a Provider Complaint System (PCS) for in-network and out-of-network providers to dispute the DBPM's policies, procedures, or any aspect of the DBPM's administrative functions. As part of the PCS, the DBPM must:

a) Have dedicated provider relations staff for providers to contact via telephone, electronic mail, surface mail, and in person, to ask questions, file a provider complaint and resolve problems.

b) Identify a staff person specifically designated to receive and process provider complaints.

c) Thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and provider subcontract provisions, collecting all pertinent facts from all parties and applying the DBPM's written policies and procedures.

d) Ensure that DBPM executives with the authority to require corrective action are involved in the provider complaint process as necessary.

ii. The DBPM must have and implement written policies and procedures which detail the operation of the PCS. The DBPM must submit its PCS policies and procedures to MLTC for review and approval within thirty (30) calendar days of the date of award. The policies and procedures must include, at a minimum:

a) Allowing providers thirty (30) calendar days to file a written complaint and a description of how providers file complaint with the DBPM and the resolution time.

b) A description of how and under what circumstances providers are advised that they may file a complaint with the DBPM for issues that are DBPM provider complaints and under what circumstances a provider may file a complaint directly to MLTC for those decisions that are not a unique function of the DBPM.

c) A description of how provider relations staff are trained to distinguish between a provider complaint and a member grievance or appeal in which the provider is acting on the member's behalf with the member's written consent.

d) A process to allow providers to consolidate complaints of multiple claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or payment claims included in the bundled complaint.

e) A process for thoroughly investigating each complaint using applicable sub-contractual provisions, and for collecting pertinent facts from all parties during the investigation.

f) A description of the methods used to ensure that DBPM executive staff with the authority to require corrective action are involved in the complaint process, as necessary.

g) A process for giving providers (or their representatives) the opportunity to present their cases in person.

h) Identification of specific individuals who have authority to administer the provider complaint process.

i) A system to capture, track, and report the status and resolution of all provider complaints, including all associated documentation. This system must capture and track all provider complaints, whether received by telephone, in person, or in writing.

j) A provision requiring the DBPM to report the status of all provider complaints and their resolution to MLTC on a monthly basis in the format required by MLTC.

iii. The DBPM must include a description of the PCS in the Provider Handbook and include specific instructions regarding how to contact the DBPM's Provider Relations staff; and contact information for the person from the DBPM who receives and processes provider complaints.

iv. The DBPM must distribute the DBPM's policies and procedures to in-network providers at time of subcontract and to out-of-network providers with the remittance advice. The DBPM may distribute a summary of these policies and procedures to providers if the summary includes information about how the provider may access the full policies and

procedures on the DBPM's website. This summary must also detail how the in-network provider can request a hard copy from the DBPM at no charge to the provider.

K. SUBCONTRACTING REQUIREMENTS

1. As required by 42 CFR §§438.6 and 438.230, the DBPM is responsible for oversight of all subcontractors' performance and must be held accountable for any function and responsibility that it delegates to any subcontractor, including, but not limited to:

a. The DBPM must evaluate the prospective subcontractor's ability to perform the activities to be delegated.

b. The DBPM must ensure that the prospective subcontractor is financially stable, according to the DBPM's standards.

c. The DBPM must have a written contract between the DBPM and the subcontractor that specifies the activities and reporting responsibilities delegated to the subcontractor; it must provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

d. The DBPM must monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards.

e. If necessary, the DBPM must identify deficiencies or areas for improvement, and take corrective action.

2. The DBPM must submit all subcontracts for the provision of any services under this RFP to MLTC for prior review and approval a minimum of ninety (90) calendar days prior to their planned implementation. MLTC must have the right to review and approve or disapprove all subcontracts entered into for the provision of any services under this RFP.

3. The DBPM must not execute a subcontract with any entity that has been excluded from participation in the Medicare and/or Medicaid program pursuant to Section 1128 of the Social Security Act (42 U.S.C. §1320a-7), or who/which is otherwise barred from participation in the Medicaid or Medicare programs. The DBPM must not enter into any relationship with anyone or any entity debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.

L. CARE COORDINATION

1. Care Transition

In the event a member is receiving medically necessary covered dental services the day before the effective date of this contract, the DBPM must authorize the continuation of services without any form or prior approval and regardless of whether the services are being provided by a provider within or outside the DBPM's provider network. In order to ensure uninterrupted service delivery, the DBPM must accept authorization files from MLTC or its designee as directed to identify enrollees for whom prior approvals were issued prior to the effective date of this contract. The DBPM must accept and honor those prior approvals for the first ninety (90) days of this contract.

2. DBPM and MCO Coordination

a. The DBPM must designate a staff member to serve as the lead for coordination of services with each MCO. This staff member's contact information must be shared with the MCOs.

b. With respect to specific enrollee services, resolution of problems must be carried out between the MCO coordinator and the DBPM coordinator. Should systemic issues arise, the DBPM must make every reasonable effort to resolve the issue with the respective MCO. In the event that such issues cannot be resolved, the MCO and the DBPM must meet with MLTC to reach final resolution of matters involved. Final resolution of system issues must occur within ninety (90) days from referral to MLTC.

M. QUALITY MANAGEMENT

1. Quality Assessment and Performance Improvement (QAPI) Program

a. The DBPM must establish and implement a Quality Assessment and Performance Improvement (QAPI) program, as described in 42 CFR §438.330 to:

i. Objectively and systematically monitor and evaluate the quality and appropriateness of care and services and promote improved patient outcomes through monitoring and evaluation activities.

ii. Incorporate improvement strategies that include, but are not limited to:

a) Performance improvement projects.

b) Dental record audits.

c) Performance measures.

d) Surveys.

iii. Detect underutilization and overutilization of services.

iv. Assess the quality and appropriateness of dental care furnished to enrollees with special healthcare needs.

b. The QAPI Program's written policies and procedures must address components of effective healthcare management and define processes for ongoing monitoring and evaluation that will promote quality of care. High risk and high volume areas of patient care should receive priority in selection of QAPI activities.

c. The QAPI Program must define and implement improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcome management achieving the highest level of success.

d. The DBPM must submit its QAPI Program description to MLTC for written approval within sixty (60) calendar days prior to the contract start date.

e. The DBPM's governing body must oversee and evaluate the impact and effectiveness of the QAPI Program. The role of the DBPM's governing body must include providing strategic direction to the QAPI Program, as well as ensuring the QAPI Program is incorporated into the operations throughout the DBPM.

2. QAPI Committee

a. The DBPM must form a QAPI Committee that must, at a minimum include:

i. The DBPM Dental Director must serve as either the chairman or co-chairman.

ii. DBPM staff representing the various departments of the organization will have membership on the committee.

iii. The DBPM is encouraged to include a member advocate representative on the QAPI Committee.

b. QAPI Committee Responsibilities

i. The committee must:

a) Meet on a quarterly basis.

b) Direct and review quality improvement (QI) activities.

c) Ensure than QAPI activities are implemented throughout the DBPM.

d) Review and suggest new and or improved QI activities.

e) Direct task forces and committees to review areas of concern in the provision of healthcare services to members.

f) Designate evaluation and study design procedures.

g) Conduct individual dental home and dental home practice quality performance measure profiling.

h) Report findings to appropriate executive authority, staff, and departments within the DBPM.

i) Direct and analyze periodic reviews of members' service utilization patterns.

j) Maintain minutes of all committee and sub-committee meetings and submit a summary of the meeting minutes to MLTC with other quarterly reports.

k) Report an evaluation of the impact and effectiveness of the QAPI Program to MLTC annually. This report must include, but is not limited to, all care management activities.

c. QAPI Work Plan

The QAPI Committee must develop and implement a written QAPI plan which incorporates the strategic direction provided by the governing body. The QAPI plan must be submitted to MLTC within sixty (60) calendar days prior to the contract start date, by the DBPM and annually thereafter, and prior to revisions. The QAPI plan, at a minimum, must:

i. Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results.

ii. Include processes to evaluate the impact and effectiveness of the QAPI Program.

iii. Include a description of the DBPM staff assigned to the QAPI Program, their specific training, how they are organized, and their responsibilities.

iv. Describe the role of its providers in giving input to the QAPI Program.

d. QAPI Reporting Requirements

i. The DBPM must submit QAPI reports annually to MLTC which, at a minimum, must include:

a) Quality improvement (QI) activities.

b) Recommended new and/or improved QI activities.

c) Evaluation of the impact and effectiveness of the QAPI program.

ii. MLTC reserves the right to request additional reports as deemed necessary. MLTC will notify the DBPM of additional required reports no less than sixty (60) days prior to due date of those reports.

3. Performance Measures

a. The DBPM must report clinical and administrative performance measure (PM) data on at least an annual basis, as specified by MLTC.

i. The DBPM must report on PMs listed in Attachment 6 – Performance Measures which include, but are not limited to, Healthcare Effectiveness Data and Information Set (HEDIS) measures, CMS measures, Dental Quality Alliance (DQA) measures, and other measures as determined by MLTC.

ii. The DBPM must have processes in place to monitor and report all performance measures.

iii. Clinical PM outcomes must be submitted to MLTC at least annually and upon MLTC request.

iv. Administrative PMs must be submitted to MLTC at least quarterly and upon MLTC request.

v. The reports and data must demonstrate adherence to clinical practice guidelines and must demonstrate changes in patient outcomes.

vi. Performance measures may be used to create Performance Improvement Projects (PIP) which are the DBPM's activities to design, implement and sustain systematic improvements based on their own data.

b. Performance Measures Reporting

i. All Administrative PMs are reporting measures.

a) Administrative measure reporting is required at least quarterly and upon MLTC's request.

b) Clinical Performance measures must be reported at least annually and upon MLTC request 12 months after services begin.

ii. MLTC may add or remove PM reporting requirements with a sixty (60) day advance notice.

c. Performance Indicator Reporting Systems

i. The DBPM must utilize MLTC-approved systems, operations, and performance monitoring tools and/or automated methods for monitoring. Access to such systems and tools must be granted to MLTC as needed for oversight.

ii. The monitoring tools and reports must be flexible and adaptable to changes in the quality measurements required by MLTC.

iii. The DBPM must provide individual dental home clinical quality profile reports.

d. Performance Measure Monitoring

i. MLTC will monitor the DBPM's performance using national performance benchmarks, identified in Attachment 6, and other benchmarks identified by MLTC.

ii. During the course of the contract, MLTC or its designee must communicate with the DBPM regarding the data and reports received as well as meet with representatives of the DBPM to review the results of performance measures.

iii. The DBPM must comply with the EQR review of the QAPI Committee meeting minutes and annual dental audits to ensure that it provides quality and accessible healthcare to DBPM members, in accordance with standards contained in the contract. Such audits must allow MLTC or its duly authorized representative to review individual dental records, identify and collect management data, including but not limited to, surveys and other information concerning the use of services and the reasons for member disenrollment.

iv. The standards by which the DBPM must be surveyed and evaluated will be at the sole discretion and approval of MLTC. If deficiencies are identified, the DBPM must formulate a CAP incorporating a timetable within which it will correct deficiencies identified by such evaluations and audits. MLTC must prior approve the CAP and will monitor the DBPM's progress in correcting the deficiencies.

e. Performance Measure Corrective Action Plan

i. A CAP must be required for performance measures that do not reach the Department's performance benchmark.

ii. The DBPM must submit a CAP, within thirty (30) calendar days of the date of notification or as specified by MLTC, for the deficiencies identified by MLTC.

iii. Within thirty (30) calendar days of receiving the CAP, MLTC will either approve or disapprove the CAP. If disapproved, the DBPM must resubmit, within fourteen (14) calendar days, a new CAP that addresses the deficiencies identified by MLTC.

iv. Upon approval of the CAP, whether the initial CAP or the revised CAP, the DBPM must implement the CAP within the time frames specified by MLTC.

v. MLTC may impose liquidated damages and/or sanctions pending attainment of acceptable quality of care.

4. Performance Improvement Projects

a. The DBPM must conduct a minimum of one clinical and one non-clinical PIP. PIPs must meet all relevant CMS requirements and be approved by MLTC prior to implementation.

b. PIPs must be addressed in the DBPM's annual QAPI Program Description, Work Plan, and Program Evaluation. The DBPM must report the status and results of each project to MLTC as outlined in the Quality Strategy. PIPs must comply with CMS requirements, including:

i. A clear study topic and question as determined or approved by MLTC.

ii. Clear, defined, and measurable goals and objectives that the DBPM can achieve in each year of the project.

iii. A study population.

iv. Measurements of performance using quality indicators that are objective, measurable, clearly defined, and allow tracking of performance over time. The DBPM must use a methodology based on accepted research practices to ensure an adequate sample size and statistically valid and reliable data collection practices. The DBPM must use measures that are based on current scientific knowledge and clinical experience. Qualitative or quantitative approaches may be used as appropriate.

v. The methodology for evaluation of findings from data collection.

vi. Implementation of system interventions to achieve quality improvement.

vii. A methodology for the evaluation of the effectiveness of the chosen interventions.

viii. Documentation of the data collection methodology used (including sources) and steps taken to ensure the data is valid and reliable.

ix. Planning and initiation of activities for increasing and sustaining improvement.

c. The DBPM must submit to MLTC the status or results of its PIPs in its annual QAPI Program Evaluation. Next steps must also be addressed, as appropriate, in the QM Program Description and Work Plan.

d. The DBPM must implement the PIP recommendations on approval by MLTC and the QAPI committee.

e. Each PIP must be completed in a reasonable time period to allow the results to guide its quality improvement activities. Information about the success and challenges of PIPs must be also available to MLTC for its annual review of the DBPM's quality assessment and performance improvement program [42 CFR §438.330(d)].

f. CMS, in consultation with the State and other stakeholders, may specify additional performance measures and PIPs to be undertaken by the DBPM.

g. MLTC reserves the right to request additional reports from the DBPM. The DBPM will be notified of additional reporting requirements no less than thirty (30) calendar days prior to the due date of a report.

5. Annual Member Satisfaction Survey

a. The DBPM must conduct annual Consumer Assessment of Healthcare Providers and Subsystems (CAHPS) surveys and methodology to assess the quality and appropriateness of care to members each contract year.

b. Survey results and a description of the survey process must be reported to MLTC separately for each required CAHPS survey.

c. The survey must be administered to a statistically valid random sample of clients who are enrolled in the DBPM at the time of the survey.

d. The surveys must provide valid and reliable data for results statewide and by parish.

e. Analyses must provide statistical analysis for targeting improvement efforts and comparison to national and state benchmark standards.

f. The most current CAHPS DBPM Survey for Medicaid enrolled individuals must be used and include:

i. Getting Needed Care

ii. Getting Care Quickly

iii. How Well Providers Communicate

iv. DBPM Customer Service

v. Global Ratings

vi. Member Satisfaction Survey Reports are due one hundred, twenty (120) calendar days after the end of the contract year.

6. Provider Satisfaction Surveys

a. The DBPM must conduct an annual provider survey to assess satisfaction with provider enrollment, provider communication, provider education, provider complaints, claims processing, claims reimbursement, and utilization management processes. The Provider Satisfaction survey tool and methodology must be submitted to MLTC for approval prior to administration.

b. The DBPM must submit an annual Provider Satisfaction Survey Report that summarizes the survey methods and findings and provides analysis of opportunities for improvement. Provider Satisfaction Survey Reports are due one hundred, twenty (120) days after the end of the plan year.

7. MLTC Oversight of Quality

a. MLTC must evaluate the DBPM's QAPI, PMs, and PIPs at least one (1) time per year at dates to be determined by MLTC, or as otherwise specified by the contract.

b. If MLTC determines that the DBPM's quality performance is not acceptable, the DBPM must submit a CAP for each unacceptable performance measure. If the DBPM fails to provide a CAP within the time specified, MLTC will sanction the DBPM in accordance with the provisions of sanctions set forth in the contract.

c. Based on unacceptable performance, MLTC may impose sanctions or terminate the contract.

d. The DBPM must cooperate with MLTC, the External Quality Review Organization (EQRO), and any other MLTC designees during monitoring.

8. External Quality Review

a. The DBPM is subject to annual, external, independent reviews of the quality outcomes of, timeliness of, and access to, services covered under the contract, per 42 CFR §438.350. The EQR is conducted by MLTC's contracted EQRO or other designee. The EQR will include, but is not be limited to, annual operational reviews, PIP assessments, encounter data validation, focused studies, and other tasks requested by MLTC.

b. The DBPM must provide the necessary information requested for these reviews, provide working space and internet access for EQRO staff, and make its staff available for interviews.

N. UTILIZATION MANAGEMENT

1. The DBPM must develop and maintain policies and procedures with defined structures and processes for a Utilization Management (UM) program that incorporates Utilization Review and Service Authorization, which include, at minimum, procedures to evaluate medical necessity and the process used to review and approve the provision of dental services. The DBPM must submit an electronic copy of the UM policies and procedures to MLTC for written approval within thirty (30) calendar days from the date of award, annually thereafter, and prior to any revisions.

2. The UM Program policies and procedures must meet all NCQA standards or equivalent and include medical management criteria and practice guidelines that:

a. Are adopted in consultation with a contracting dental care professionals.

b. Are objective and based on valid and reliable clinical evidence or a consensus of dental care professionals in the particular field.

c. Are considering the needs of the members.

d. Are reviewed annually and updated periodically as appropriate.

3. The policies and procedures must include, but not be limited to:

a. The methodology utilized to evaluate the medical necessity, appropriateness, efficacy, or efficiency of dental care services.

b. The data sources and clinical review criteria used in decision making.

c. The appropriateness of clinical review must be fully documented.

d. The process for conducting informal reconsiderations for adverse determinations.

e. Mechanisms to ensure consistent application of review criteria and compatible decisions.

f. Data collection processes and analytical methods used in assessing utilization of dental care services.

4. The DBPM must disseminate the practice guidelines to all affected providers and, upon request, to members. The DBPM must take steps to encourage adoption of the guidelines.

5. The DBPM must identify the source of the dental management criteria used for the review of service authorization requests, including but not limited to:

a. The vendor must be identified if the criteria were purchased.

b. The association or society must be identified if the criteria are developed/recommended or endorsed by a national or state dental care provider association or society.

c. The guideline source must be identified if the criteria are based on national best practice guidelines.

d. The individuals who will make medical necessity determinations must be identified if the criteria are based on the dental/medical training, qualifications, and experience of the DBPM Dental Director or other qualified and trained professionals.

6. UM Program dental management criteria and practice guidelines must be disseminated to all affected providers, and members upon request. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines.

7. The DBPM must have written procedures listing the information required from a member or dental care provider in order to make medical necessity determinations. Such procedures must be given verbally to the covered person or healthcare provider when requested. The procedures must outline the process to be followed in the event the DBPM determines the need for additional information not initially requested.

8. The DBPM must have written procedures to address the failure or inability of a provider or member to provide all the necessary information for review. In cases where the provider or member will not release necessary information, the DBPM may deny authorization of the requested service(s).

9. The DBPM must have sufficient staff with clinical expertise and training to apply service authorization medical management criteria and practice guidelines

10. The DBPM must make medical necessity determinations that are consistent with the parameters in this Section.

11. The DBPM must submit written policies and processes for MLTC approval, within thirty (30) calendar days from the date of award, on how the core dental benefits and services the DBPM provides ensure:

a. The prevention, diagnosis, and treatment of health impairments.

b. The ability to achieve age-appropriate growth and development.

c. The ability to attain, maintain, or regain functional capacity.

12. The DBPM must identify the qualification of staff who will determine medical necessity.

13. Determinations of medical necessity must be made by qualified and trained practitioners in accordance with state and federal regulations.

14. The DBPM must ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease must determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested.

15. The individual(s) making these determinations must have no history of disciplinary action or sanctions; including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional or moral character.

16. The individual making these determinations is required to attest that no adverse determination will be made regarding any dental procedure or service outside of the scope of such individual's expertise.

17. The DBPM must provide a mechanism to reduce inappropriate and duplicative use of healthcare services. Services must be sufficient in an amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished and that are no less than the amount, duration or scope for the same services furnished to Medicaid eligible individuals under the Medicaid State Plan. The DBPM must not arbitrarily deny or reduce the amount, duration or scope of required services solely because of diagnosis, type of illness or condition of the member. The DBPM may place appropriate limits on a service on the basis of medical necessity or for the purposes of utilization control (with the exception of EPSDT services), provided the services furnished can reasonably be expected to achieve their purpose in accordance with 42 CFR §438.210.

18. The DBPM must ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member in accordance with 42 CFR §438.6, 42 CFR §422.208, and 42 CFR §422.210.

19. The DBPM must report fraud and abuse information identified through the UM program to MLTC's Program Integrity Unit in accordance with 42 CFR §455.1(a)(1).

20. In accordance with 42 CFR §456.111 and §456.211, the DBPM Utilization Review plan must provide that each enrollee's record includes information needed for the UR committee to perform UR required under this section. This information must include, but not limited to the following:

a. Identification of the enrollee.

b. The name of the enrollee's dentist.

c. Date of admission, and dates of application for and authorization of Medicaid benefits if application is made after admission.

d. The plan of care required under 42 CFR §456.80 and §456.180;

e. Initial and subsequent continued stay review dates described under 42 CFR §456.128, §456.133; §456.233 and §456.234.

f. Date of operating room reservation, if applicable.

g. Justification of emergency admission, if applicable.

21. Utilization Management Committee

a. The UM program must include a Utilization Management (UM) Committee that integrates with other functional units of the DBPM as appropriate and supports the QAPI Program (refer to the Quality Management subsection for details regarding the QAPI Program).

b. The UM Committee must provide utilization review and monitoring of UM activities of both the DBPM and its providers and is directed by the DBPM Dental Director. The UM Committee must convene no less than quarterly and must submit a summary of the meeting minutes to MLTC with other quarterly reports. UM Committee responsibilities include:

i. Monitoring providers' requests for rendering healthcare services to its members.

ii. Monitoring the dental appropriateness and necessity of healthcare services provided to its members utilizing provider quality and utilization profiling.

iii. Reviewing the effectiveness of the utilization review process and making changes to the process as needed.

iv. Approving policies and procedures for UM that conform to industry standards, including methods, timelines and individuals responsible for completing each task.

v. Monitoring consistent application of "medical necessity" criteria.

vi. Application of clinical practice guidelines;

vii. Monitoring over- and under-utilization.

viii. Review of outliers.

ix. Dental Record Reviews.

c. Dental record reviews must be conducted to ensure that Dental Homes provide high quality healthcare that is documented according to established industry standards. The DBPM must establish and distribute to providers standards for record reviews that include all dental record documentation requirements addressed in the contract.

d. The DBPM must maintain a written strategy for conducting dental record reviews, reporting results, and the corrective action process. The strategy must be provided within thirty (30)

calendar days from the date of award for MLTC review and approval, and annually thereafter. The strategy must include, but not limited to, the following:

i. Designated staff to perform this duty.

ii. The method of case selection.

iii. The anticipated number of reviews by practice site.

iv. The tool the DBPM must use to review each site.

v. How the DBPM must link the information compiled during the review to other DBPM functions (e.g. QI, credentialing, peer review, etc.)

e. The DBPM must conduct reviews at all primary dental services providers that have treated more than 100 unduplicated members in a calendar year, including individual offices and large group facilities. The DBPM must review each site at least one (1) time during each five (5) year period.

f. The DBPM must review a reasonable number of records, in a random process, at each site to determine compliance. A minimum of ten percent (10%) or up to ten (10) records per site must be reviewed.

g. The DBPM must report the results of all record reviews to MLTC quarterly with an annual summary.

22. Utilization Management Reports

The DBPM must submit reports as specified in Attachment 5 – Reporting Requirements. MLTC reserves the right to request additional reports as deemed by MLTC. MLTC will make every effort to notify the DBPM of additional required reports no less than thirty (30) calendar days prior to due date of those reports. However, there may be occasions the DBPM will be required to produce reports in a shorter time frame.

23. Service Authorization

a. Service authorization includes, but is not limited to, prior authorization.

b. The DBPM UM Program policies and procedures must include service authorization policies and procedures consistent with 42 CFR §438.210 and state laws and regulations for initial and continuing authorization of services that include, but are not limited to, the following:

i. Written policies and procedures for processing requests for initial and continuing authorizations of services, where a provider does not request a service in a timely manner or refuses a service.

ii. Mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider as appropriate.

iii. Requirement that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by the DBPM Dental Director.

iv. Provide a mechanism in which a member may submit, whether oral or in writing, a service authorization request for the provision of services. This process must be included in its member manual and incorporated in the grievance procedures.

v. The DBPM's service authorization system must provide the authorization number and effective dates for authorization to participating providers and applicable non-participating providers.

vi. The DBPM’s service authorization system must have capacity to electronically store and report all service authorization requests, decisions made by the DBPM regarding the service requests, clinical data to support the decision, and time frames for notification of providers and members of decisions.

c. The DBPM must not deny continuation of higher level services for failure to meet medical necessity unless the DBPM can provide the service through an in-network or out-of-network provider at a lower level of care.

24. Timing of Service Authorization Decisions

a. Standard Service Authorization

i. The DBPM must make eighty percent (80%) of standard service authorization determinations within two (2) business days of obtaining appropriate dental information that may be required regarding a proposed admission, procedure, or service requiring a review determination. Standard service authorization determinations must be made no later than fourteen (14) calendar days following receipt of the request for service unless an extension is requested. The DBPM must maintain documentation system to report to MLTC on a monthly basis all service authorizations provided in the format specified by MLTC.

ii. An extension may be granted for an additional fourteen (14) calendar days if the member or the provider or authorized representative requests an extension or if the DBPM justifies to MLTC a need for additional information and the extension is in the member's best interest. In no instance must any determination of standard service authorization be made later than twenty-five (25) calendar days from receipt of the request.

b. Expedited Service Authorization

i. In the event a provider indicates, or the DBPM determines, that following the standard service authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the DBPM must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service.

c. Post Authorization

i. The DBPM may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the member or if the DBPM justifies to MLTC a need for additional information and how the extension is in the member's best interest.

ii. The DBPM must make retrospective review determinations within thirty (30) calendar days of obtaining the results of any appropriate dental or medical information that may be required, but in no instance later than one hundred, eighty (180) calendar days from the date of service.

iii. The DBPM must not subsequently retracts its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was based upon a material omission or misrepresentation about the member's health condition made by the provider.

d. Timing of Notice

i. Approval

a) For service authorization approval for a non-emergency admission, procedure or service, the DBPM must notify the provider of as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and must provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.

b) For service authorization approval for extended stay or additional services, the DBPM must notify the provider rendering the service, whether a healthcare

professional or facility or both, and the member receiving the service within one (1) business day of the service authorization approval.

ii. Adverse Action

a) The DBPM must notify the member, in writing using language that is easily understood, of decisions to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in this RFP. The notice of action to members must be consistent with requirements in 42 CFR §438.10(c) and (d), 42 CFR §438.404(c), and 42 CFR §438.210(b)(c)(d) and in this RFP for member written materials.

b) The DBPM must notify the requesting provider of a decision to deny an authorization request or to authorize a service in an amount, duration, or scope that is less than requested.

iii. Informal Reconsideration

a) As part of the DBPM appeal procedures, the DBPM must include an Informal Reconsideration process that allows the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.

b) In a case involving an initial determination, the DBPM must provide the member or a provider acting on behalf of the member and with the member's written consent an opportunity to request an informal reconsideration of an adverse determination by the dentist or clinical peer making the adverse determination.

c) The informal reconsideration should occur within one (1) business day of the receipt of the request and should be conducted between the provider rendering the service and the DBPM's dentist authorized to make adverse determinations or a clinical peer designated by the Dental Director if the dentist who made the adverse determination cannot be available within one (1) business day. The Informal Reconsideration will in no way extend the 30 day required timeframe for a Notice of Appeal Resolution.

iv. Exceptions to Requirements

a) The DBPM must not require service authorization for emergency dental services as described in this Section whether provided by an in-network or out-of-network provider.

b) The DBPM must not require service authorization or referral for EPSDT dental screening services.

c) The DBPM must not require service authorization for the continuation of covered services of a new member transitioning into the DBPM, regardless of whether such services are provided by an in-network or out-of-network provider, however, the DBPM may require prior authorization of services beyond thirty (30) calendar days.

O. PROGRAM INTEGRITY

1. General Requirements

a. The DBPM must comply with all State and Federal laws and regulations relating to Fraud, Waste and Abuse (FWA) in the Medicaid program, including but not limited to 42 CFR.

b. The Nebraska Medicaid Program Integrity Unit (NMPI) is the entity within MLTC charged with identifying and investigating allegations of FWA and erroneous payments.

c. The Medicaid Fraud and Patient Abuse Unit (MFPAU), of the Nebraska Attorney General's office, has primary responsibility to investigate and prosecute provider fraud for the Nebraska Medicaid program.

d. The DBPM must certify that all statements, reports, and claims, financial and otherwise, are true, accurate, and complete. The DBPM must not submit for payment purposes those claims, statements, or reports that it knows, or has reason to know, are not properly prepared or payable pursuant to Federal and State law, applicable regulations, its contract with MLTC, and MLTC policy.

e. The DBPM must immediately report to NMPI any suspicion or knowledge of fraud including, but not limited to, the false or fraudulent filings of claims and the acceptance of or failure to return reimbursement for claims known to be fraudulent.

f. The DBPM must pursue all recovery of payments identified as FWA or erroneous and reflect the recovery on the claim record. In the event that the DBPM does not pursue all recoveries, including third-party liability (TPL), MLTC will pursue them and recoup the money.

g. In accordance with 42 CFR §433 and MLTC policies and procedures, the DBPM must report overpayments made by MLTC to the DBPM as well as overpayments made by the DBPM to a provider or subcontractor.

h. The DBPM, as well as its subcontractors and providers, whether contracted or non-contracted, must comply with all Federal requirements (42 CFR §455) about disclosure reporting. All tax-reporting provider entities that bill or receive Nebraska Medicaid funds as a result of this contract must submit routine disclosures in accordance with timeframes specified in 42 CFR §455(B), including at the time of initial contracting, contract renewal, within 45 calendar days of any change to the information on the disclosure form, a minimum of annually, and at any time on request.

i. The DBPM must require that all its providers and subcontractors take all the necessary actions to permit the DBPM to comply with the FWA and erroneous payments requirements included in this RFP, its contract with MLTC, and State and Federal regulations. To the extent that the DBPM delegates oversight responsibilities to a third party, the DBPM must require that the third party complies with all provisions of the contract relating to FWA and erroneous payments. Although all providers with whom the DBPM contracts are enrolled in the Medicaid program and subject to its regulations, the DBPM agrees to require, via contract, that those providers comply with regulations and any enforcement actions directly initiated by MLTC under its regulations, including but not limited to, termination and restitution.

j. The DBPM must have a FWA and erroneous payments unit within the organization comprised of experienced staff members. The unit's primary purpose is to prevent, detect, investigate, and report suspected FWA and erroneous payments that may be committed by network providers, members, employees, or other third parties with whom/which the DBPM contracts.

k. The DBPM and its employees must cooperate fully with centralized oversight agencies responsible for FWA and erroneous payments detection and prosecution activities. This cooperation must include providing access to all necessary case information, computer files, and appropriate staff. In addition, this cooperation may include participating in periodic FWA and erroneous payments training sessions, meetings, and joint reviews of network providers or members. The DBPM must participate in the quarterly Nebraska Health Care Fraud Task force meeting by sending one of its dedicated FWA staff.

l. The DBPM must cooperate fully in any investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. This cooperation must include providing, on request, information, access to records, and access to interview the DBPM's employees and consultants, including but not limited to those with expertise in program administration, medical or pharmaceutical issues, or any other matter related to the investigation.

m. MLTC will not transfer its law enforcement functions to the DBPM.

n. When NMPI requests access to or copies of any records or data maintained by the DBPM or its providers, the response must be in the form and manner and by the due date requested by NMPI.

o. The DBPM must confirm in writing, by completing a form that MLTC will provide during the readiness review and on an annual basis during the duration of the contract that the DBPM's Compliance Officer(s) understand all requirements related to the DBPM's receipt of State and Federal funds. The DBPM must confirm that its officers understand that they are subject to criminal prosecution, civil action, or administration actions for any intentional false statements or other fraudulent conduct related to their contractual obligations.

p. NMPI will seek all appropriate remedies for fraud, abuse and violation of law if it determines that the DBPM, a provider, employee, or subcontractor has committed fraud or abuse as defined in this contract, or has otherwise violated applicable law.

2. Policies and Procedures

a. The DBPM must have policies and procedures that are designed to prevent, reduce, detect, correct, and report known or suspected FWA and erroneous payments in accordance with State and Federal requirements and its contract with the State. Requirements for these policies and procedures are described in this section.

b. All FWA and erroneous payment policies, and the designation of the compliance officer and committee must be submitted to MLTC for review and approval a minimum of 45 calendar days prior to the contract start date and a minimum of thirty (30) calendar days prior to the intended implementation of any material changes. The DBPM's submission of new or revised policies and procedures for review and approval by MLTC will not void any existing policies and procedures that have been approved by MLTC previously. Unless otherwise required by law, the DBPM may continue to operate under existing policies and procedures until MLTC approves the new or revised policies for prospective application. The DBPM must develop and use a certification process that demonstrates the policies and procedures were reviewed and approved by the DBPM's senior management.

c. To remain in compliance with its contract with MLTC, the DBPM must comply with current FWA and erroneous payments policies and procedures.

3. Prohibited Affiliations

a. In accordance with 42 CFR §438.610, a DBPM may not knowingly have a relationship with and must have a proactive method to prevent the following relationship(s):

i. An individual or entity who/that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549;

ii. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation, of:

a) A director, officer, or partner of the DBPM.

b) A person with beneficial ownership of 5% or more of DBPM equity.

c) A person or entity with an employment, consulting, or other arrangement with the DBPM under its contract with the State.

iii. Any individual or entity excluded for cause from participation in any state Medicaid program or the Medicare program.

iv. Any individual or entity listed on the Federal System for Award Management, the Office of Inspector General's (OIG) List of Excluded Individuals and Entities database, or the Nebraska Medicaid Excluded Providers list.

b. The DBPM must conduct a search of the then-current version of these lists monthly to capture exclusions and reinstatements that have occurred since the previous search.

c. When the DBPM identifies a relationship with a debarred or excluded individual or entity, it must report it to NMPI within three (3) business days. The DBPM must initiate efforts to sever the

relationship with the debarred or excluded individual or entity immediately. Any individual or entity that employs or contracts with an excluded provider/individual cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider or individual. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded. For example, a pharmacy that fills a prescription written by an excluded provider for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription.

d. If MLTC finds the DBPM is not in compliance with these requirements, NMPI will notify the Federal DHHS Secretary of noncompliance and may not renew or otherwise extend the duration of the existing contract with the DBPM unless the Secretary provides to the State and to the Congress a written statement describing the compelling reasons that support renewing the contract.

4. Excluded Providers

The DBPM may not contract with or reimburse providers that are excluded by the Medicare, Medicaid, or Children's Health Insurance Programs (CHIP).

5. Federal Financial Participation

Federal financial participation (FFP) is not available for:

a. Funds paid to providers excluded by the Medicare, Medicaid, or CHIP. The DBPM is responsible for the return of any money paid for services provided by an excluded provider.

b. Payments made to a provider or fiscal agent that fails to disclose ownership or control information.

c. Expenditures for services furnished by providers who/that fail to comply with a request made by the Federal DHHS Secretary or MLTC. As applicable, FFP will be denied for expenditures for services furnished beginning the day following the date the information was due to the Federal DHHS Secretary or MLTC and ending on the day before the date the information was supplied.

6. The DBPM and MFPAU

a. The DBPM and the DBPM's subcontractors or providers, whether contracted or non-contracted, must make available to MFPAU, on request or as required by this contract, State or Federal law, any and all administrative, financial, or medical records relating to the delivery of services for which Nebraska Medicaid funds are expended.

b. The DBPM must comply promptly with the MFPAU requests for data stored or formulated by the DBPM or its subcontractors, including but not limited to, claims data, encounter data, eligibility information, and enrollment data, if MFPAU determines it is necessary to carry out its responsibilities.

c. When responding to a request for data, the DBPM must certify that the data supplied to MFPAU is true, accurate, and complete. This data must be supplied without charge and in the form and time frames requested by MFPAU.

d. The DBPM must allow MFPAU staff access to its location(s) of business, whether within or outside of the state. Access to the DBPM's places of business must be allowed during normal business hours, and also at other times under special circumstances when after-hour admission is required. Special circumstances are at the sole discretion of MFPAU.

e. MFPAU has the right to recover inappropriately expended Medicaid funds directly from participating and non-participating providers, the DBPM, its subcontractors, and any third party in the DBPM network in criminally and civilly prosecuted cases or settlements. The DBPM is not entitled to any part of recovered funds.

f. The DBPM must subrogate to DHHS any and all claims it has or may have, related to Nebraska Medicaid, against pharmaceutical companies, retailers, providers, or other subcontractors, medical device makers, or durable medical equipment manufacturers in the marketing or pricing of their products.

g. In the event that the DBPM conducts a hearing or review of its decision to institute interventions or sanctions against a provider, MFPAU must be provided adequate notice of the hearing, and furnished copies, at that time, of any and all pleadings and evidence. MFPAU has the right to intervene in these proceedings. If necessary for MFPAU's investigative purposes, MFPAU may suspend these proceedings until MFPAU's investigation is complete.

h. Regardless of any monetary settlement, payment, intervention, sanction, or other agreement between the DBPM and any provider suspected of fraud, MFPAU retains the right to pursue any and all appropriate civil or criminal actions against the provider.

7. National Provider Identifier

The DBPM must require each of its contracted dental providers to have a national provider identifier. This identifier must be included on the provider file submitted to the State.

8. Compliance Plan

a. The DBPM must submit a written FWA and erroneous payments compliance plan to MLTC for review and approval a minimum of forty-five (45) calendar days prior to the contract start date, and annually thereafter by December 31st of each year. The initial compliance plan must be approved by MLTC before it can be implemented. Requests for revision(s) to the plan must be submitted in writing to MLTC a minimum of thirty (30) calendar days prior to the requested implementation date of the revision(s). MLTC will respond in writing with approval or questions within fifteen (15) calendar days. Revisions must be approved by MLTC prior to their implementation.

b. The FWA and erroneous payments compliance plan must include the following components:

i. Written policies, procedures, and standards of conduct that articulate the DBPM's commitment to comply with all applicable State and Federal requirements.

ii. Agreement to report all allegations of fraud to the NMPI. The policies and procedures must designate those staff members responsible for reporting fraud.

iii. The designation of a Program Integrity Officer and compliance committee that is accountable to senior management and must ensure an adequately staffed compliance office.

iv. Discussion of the compensation and qualifications of the staff, who must be adequate in number and training, to effectively monitor the Nebraska Medicaid contract.

v. Effective lines of communication between the Program Integrity Officer and the DBPM's employees, providers, and subcontractors.

vi. Effective training and education for the Program Integrity Officer, DBPM employees, and subcontractors.

vii. Detailed information about the False Claims Act and the other provisions described in Section 1902(a)(68)(A) of the Social Security Act. A description of the methodology and standard operating procedures used to prevent, identify, intervene, and investigate FWA and erroneous payments, and to recover overpayments or otherwise sanction providers.

viii. Enforcement of standards through guidelines included in member and provider handbooks, trainings, and member and provider newsletters.

ix. A description of the proactive specific controls in place to detect FWA and erroneous payments, including an explanation of the technology used to identify aberrant billing patterns, claims edits, post-processing review of claims, and record reviews.

x. Provision that the DBPM's FWA and erroneous payments unit has access to provider records.

xi. Procedures for ongoing monitoring and auditing of DBPM systems, including but not limited to, claims processing, billing and financial operations, enrollment functions, member services, provider services, and continuous quality improvement (CQI); and the DBPM's providers, subcontractors, employees, and any others, as appropriate.

xii. Procedures for timely, complete, and consistent exchange of information and collaboration with NMPI, MFPAU, and MLTC's contracted EQRO regarding suspected fraud and abuse.

xiii. Provisions for the confidential reporting of plan violations, such as a hotline to report violations, and a clearly designated individual, such as the Program Integrity Officer, to receive them. Several independent reporting paths must be created for the reporting of fraud so that such reports cannot be diverted by any supervisors or other personnel.

xiv. Protections to ensure that no individual who reports program integrity-related violations or suspected FWA is retaliated against by anyone who is employed by or contracts with the DBPM. The DBPM must ensure that the identity of individuals reporting violations or suspected violations of the compliance plan must be kept confidential to the extent possible. Anyone who thinks that s/he has been retaliated against may report this violation to MLTC or the Federal DHHS OIG.

xv. Provisions for a prompt response to detected offenses and for development of corrective action initiatives related to the contract in accordance with 42 CFR §438.608.

xvi. Agreement to and the method the DBPM will use to suspend all provider payments when notified by MLTC to suspend payments because of a credible allegation of fraud.

xvii. The method the DBPM will use to comply with requests from NMPI or the MFPAU for access to and copies of any records kept by the DBPM, computerized data stored by the DBPM, or information maintained by DBPM providers to which MLTC is authorized to have access.

xviii. The method the DBPM will use to prevent payments to international accounts.

9. Employee Education

a. The DBPM must comply with Federal law to educate employees about FWA, the compliance plan, and false claims recoveries (Deficit Reduction Act of 2005 – Section 6032). This includes:

i. Evidence of completed, effective education for the Program Integrity Officer and the organization's employees, DBPM providers, and members about the compliance plan, FWA, and erroneous payments and how to report any allegations regarding any of them.

ii. Effective lines of communication between the compliance officer and the DBPM employees, DBPMs, providers, and MLTC and its designee(s).

iii. Established written policies for all employees (including management), and any subcontractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A) of the Social Security Act. The DBPM must include detailed information about the DBPM's policies and procedures for detecting and preventing FWA. The DBPM must also include in any employee handbook a specific discussion of the laws described in the written policies, and the whistleblower rights and protections of and for employees.

b. This training must be conducted annually for all employees and within thirty (30) calendar days of employment for new hires.

c. The DBPM must require new employees to complete training within thirty (30) calendar days of hire related to the following in accordance with State and Federal laws:

i. DBPM code of conduct training.

ii. Privacy and security (including but not limited to HIPAA).

iii. FWA and erroneous payments.

iv. Procedures for the timely, consistent exchange of information and collaboration with MLTC.

v. Organizational chart, including the Program Integrity Officer and program integrity investigator(s).

vi. Provisions of 42 CFR §438.610 and all relevant State and Federal laws, regulations, policies, procedures and guidance (including CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks) issued by MLTC, DHHS, CMS, the OIG, including updates and amendments to these documents or any such standards established by the State.

d. The DBPM must maintain a toll-free provider compliance hotline number and ensure that the number and an accompanying explanatory statement are distributed to its members and providers through its member and provider handbooks.

e. The DBPM must create and disseminate written materials for educating employees, managers, providers, and subcontractors about health care fraud laws, the DBPM's policies and procedures for preventing and detecting FWA and the rights of employees to act as whistleblowers. The DBPM's education must comply with all requirements of Section 1902(a) (68) of the Social Security Act.

10. Service Verification

a. The DBPM must regularly verify that services have been actually provided. This verification may be conducted by mail, electronic correspondence, or telephone. Sampling criteria may include a representative sample or a targeted sample. The DBPM must report the results of this monitoring to NMPI quarterly.

b. The DBPM must immediately notify NMPI of any providers who/that are excluded from the DBPM network or that leave the network to avoid a for-cause termination.

11. Audit Requirements

a. Twice each year as stated in Attachment 5, the DBPM must complete an error rate measurement data processing, medical necessity, and provider documentation audit of a statistically valid random sample of paid claims. The DBPM must prepare an error rate measurement audit plan and submit it to MLTC for review and approval a minimum of 45 calendar days prior to the audit's planned completion date. The findings of the audit plan must be submitted to NMPI when completed. MLTC may require a CAP based on the audit results.

b. The DBPM must also complete quarterly audits to identify services paid after the recipient's death or incarceration.

12. Nebraska Medicaid Program Integrity Oversight

a. The DBPM must notify NMPI if it identifies patterns of data mining outliers, audit concerns, critical incidences, hotline calls, or other internal and external tips with potential implications about provider billing anomalies and/or the safety of Nebraska Medicaid members (42 CFR §455.15). This notification must be made on a minimum of an every two (2) week basis, unless circumstances warrant earlier notification. Along with such notification, the DBPM must take steps to triage or substantiate these tips and provide timely updates to NMPI.

b. The DBPM must report all tips and make all referrals to MLTC, in writing, a minimum of every two (2) weeks. The DBPM must include all relevant documentation within this notification.

13. Monthly Reporting to MLTC

a. The DBPM must submit the following reports to NMPI in the format, reporting period, and timeframe specified below. The DBPM must also have documented policies and processes to collect the information necessary for the following reports:

i. A monthly cumulative report of all new referrals of potential FWA and erroneous payments received by the DBPM. The report must be submitted electronically in an Excel spreadsheet that includes the following details: provider name, provider national provider identifier (NPI), Nebraska Medicaid Provider ID number, provider type, provider address, date the referral was received, a summary of the allegations, the previous calendar year's net payments to the provider, the current calendar years to-date net payments to the provider, the DBPM staff person assigned to the referral, the source of the referral, the potential amount at risk, and a summary of investigative activities completed since receipt of the referral. The report is due by the second Friday of each month to report the previous month's information, if any.

ii. A monthly update of all previously reported referrals of provider FWA and erroneous payments under review by the DBPM. The report must be sent electronically in an Excel spreadsheet and include the details from the new referrals report (described in the previous section) with updates to all investigative activities that have been completed since the receipt of the referral. This report is due by the second Friday of each month to report the previous month's information, if any.

iii. Monthly reports of claims adjudicated to finalization by the DBPM in the previous calendar month. The report must include the number and dollar amount of claims submitted, the amount disallowed and reduced, the amount of payments by other sources, and net payments. This information must be reported by claim type, provider type, and the disallowed or reduced reason. The report must be sent electronically in an Excel spreadsheet. It is due by the second Friday of each month to report the previous month's information, if any.

iv. A monthly report of all overpayments identified and collected. The report must be sent electronically in an Excel spreadsheet. It is due by the second Friday of each month to report the previous month's information, if any.

v. A monthly report of all providers that have left the DBPM provider network, including the provider's name, NPI, Medicaid Provider ID number, provider type, address, and reason. The report must be sent electronically in an Excel spreadsheet. It is due by the second Friday of each month to report the previous month's information, if any.

vi. A monthly report of the DBPM's efforts to detect and prevent FWA. The report is due by the second Friday of each month to report the previous month's information, if any. The content of the report must include, but is not limited to:

a) Utilization review activities.

b) Member and provider hotline complaints.

c) DBPM QA/QI meeting minutes and reports.

d) All site-visit reports.

14. Collaboration with NMPI

The DBPM's Program Integrity Officer will serve as the primary point of contact for all issues related to FWA and erroneous payments. NMPI will hold regular meetings with the DBPM to review and discuss investigations, compliance, prevention, and other Program Integrity-related activities. These meetings will be attended, at a minimum, by the DBPM's state-based Dental Director and Executive Director. The DBPM's Program Integrity Officer and other compliance-related staff may be required to attend at the discretion of NMPI.

15. Investigative Collaboration

a. The DBPM must cooperate with all appropriate State and Federal agencies, including the MFPAU and the federal DHHS OIG, in investigating fraud.

b. Once the DBPM discovers potential fraud, it must promptly perform an investigation of all incidents of suspected or confirmed fraud that occurred in the ten years preceding the

precipitating event. The DBPM must promptly provide the results of any preliminary investigations to NMPI.

c. The DBPM must not notify the provider of an investigation when there is a potential credible allegation of fraud.

d. The DBPM must cooperate and assist MLTC and any State or Federal agency charged with the duty of identifying, investigating, or prosecuting suspected FWA or erroneous payments. At any time during normal business hours, MLTC, MFPAU, the State Auditor's Office, the Office of the Attorney General, General Accounting Office (GAO), Comptroller General, federal DHHS, or any of their designees, and as often as they deem necessary during the contract period and for a period of six (6) years from the termination or expiration date of the contract (including any contract extensions/renewals), have the right, power, and authority to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the contract or any other applicable laws.

e. The DBPM and its subcontractors must make all program and financial records and service delivery sites open to the representative or any designees listed immediately above. MLTC, MFPAU, GAO, the State Auditor's Office, the Office of the Attorney General, and/or the designees of any of the above must be provided access upon request and have the right, power, and authority to examine and make copies, excerpts, or transcripts from any books, documents, papers, or records that are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts, and transcripts; contact and conduct private interviews with DBPM clients, employees, and contractors; and complete on-site reviews of all matters relating to service delivery as specified by the contract. The rights of access in this subsection are not limited to the required retention period, but will last as long as records are retained. The DBPM must provide originals or copies (at no charge) of all records and information requested. Requests for information must be compiled in the form and language requested.

f. The DBPM's employees and its contractors and their employees must cooperate fully and be available in person for interviews and consultation regarding grand jury proceedings, pre-trial conferences, hearings, trials, and in any other process.

g. The DBPM must notify NMPI when it denies a provider credentialing application, disenrolls a provider for program integrity-related reasons, or otherwise limits the ability of a provider to participate in the program, for program integrity reasons.

16. Payment Suspension Due to Credible Allegations of Fraud

a. The DBPM must comply with federal laws and regulations (such as 42 CFR §455.23) that require the suspension of Medicaid payments when there is a credible allegation of fraud. NMPI will determine whether payments should be suspended or if an exception is appropriate. NMPI will notify the DBPM of payment suspensions and the DBPM must then suspend payments. The DBPM must ensure that no Nebraska Medicaid dollars are received by a provider whose payments have been suspended or who/that has been terminated by MLTC.

b. In cases involving potential or confirmed risk to patients, NMPI and the MFPAU may allow the DBPM to engage in actions that would otherwise be prohibited. Any prior approval will be provided to the DBPM in writing, from NMPI and the MFPAU, and will detail the action or actions the DBPM may take. The DBPM may not take any action against the provider at issue that is not specified by NMPI and the MFPAU.

c. After a credible allegation of fraud, unless prior written approval is obtained from NMPI in coordination with the MFPAU, the DBPM must not take any of the following actions:

i. Contact the subject of the investigation concerning any matter related to the investigation.

ii. Institute any interventions, sanctions, or remedial procedures towards the subject of the investigation, including but not limited to hearings, suspension, or termination.

iii. Take any actions to recoup or withhold improperly paid funds already paid or potentially due to the provider.

iv. File any civil action based upon the suspected fraud against the subject of the investigation.

v. Enter into or attempt to negotiate any settlement or agreement regarding the suspected fraud.

vi. Accept any money or other thing of value offered by the subject of the investigation in connection with suspected fraud.

17. Recoupments

If the DBPM thinks that it is appropriate to initiate a recoupment or withholding action against a provider under these circumstances, the DBPM must consult with both NMPI and the MFPAU to ensure that such action is permissible. In the event that the DBPM obtains funds from an action when recoupment or withholding is prohibited, the DBPM must return the funds to the provider.

P. DBPM REIMBURSEMENT

1. General Requirements

a. The State will make monthly capitation payments to the DBPM to cover all services in the contract. Capitation payments will be made prospectively for prospective enrollment and retrospectively to the first day of the member's enrollment, and based on the DBPM's electronic enrollment file.

b. The DBPM must agree to accept, as payment in full, the capitation rate and supplemental payments established by MLTC pursuant to the contract, and must not seek additional payment from a member or MLTC for any unpaid cost.

c. The DBPM must assume 100% liability for any expenditures above the monthly capitation rate.

d. Payment for items or services provided under this contract may not be made to any entity located outside of the United States. The term "United States" means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

e. The DBPM must have written policies and procedures for receiving and processing payments and adjustments. Any charges or expenses imposed by financial institutions for transfers or related actions must be borne by the DBPM.

2. Capitation Rate Determination Process

a. MLTC will develop cost-effective and actuarially sound rates in accordance with generally accepted actuarial principles and CMS rules and regulations, appropriate for the populations covered and the services provided, as described in this RFP.

b. MLTC will not use a competitive bidding process to determine the DBPM capitation rates.

c. Capitation rates will be in effect for the initial twelve (12) month contract period beginning at the contractor start date.

d. MLTC will use a single, statewide set of capitation rates.

e. The categories of aid (COA) are:

i. Age 0-1
ii. Age 2-5
iii. Age 6-18
iv. Age 19-24
v. Age 25-54
vi. Age 55-64
vii. Age 65 and over

Capitation rates are developed using fee-for-service data and supplementary financial information for the eligible populations from State fiscal years 2014 and 2015. The following is a list of adjustments considered in the rate development:

i. Utilization trend

ii. Unit cost trend

iii. Medicaid program changes

iv. Coordinated care savings

v. DBPM administrative allowance

f. Attachment 7 – Dental Databook include databooks, provided by MLTC's contracted actuary.

g. The DBPM must provide any information requested by MLTC to assist in the determination of DBPM rates. MLTC will give the DBPM reasonable time to respond to the request, and the DBPM must fully cooperate. MLTC will make the final determination as to what is considered reasonable on a case by case basis.

h. A minimum of annually, MLTC and its actuary will jointly review the information necessary to develop actuarially-sound capitation rates. This review will include an analysis of any anticipated fee schedule changes or other programmatic changes to the DBP, claims experience cost reporting information collected from the DBPM, Department of Insurance annual statements, various trend data sources, and administrative experience.

i. Any adjusted rates will be actuarially sound and consistent with requirements set forth in 42 CFR §438.6(c). Adjusted rates will require an amendment to the contract, mutually agreeable by both parties.

j. MLTC reserves the right to adjust the capitation rate more frequently than annually as program changes dictate. Circumstances precipitating a rate change include and are not limited to:

i. Changes to benefits and services included in the monthly capitation rates.

ii. Changes in Federal law, Federal regulations, State law, State regulations, State policies, or the Medicaid State Plan.

iii. Changes to Medicaid population groups eligible to enroll in DBP.

iv. Legislative appropriations and budgetary constraints.

k. MLTC's actuary will provide, as part of its certification of capitation rates, a narrative that identifies the specific data, assumptions, and methodologies behind the specific payment rates for each rating region. This narrative will address any DBPM-specific factors that influence provision of services to Medicaid members, including but not limited to, reserve contributions and capital costs.

3. Capitation Rates and Payment

a. MLTC will pay the DBPM in accordance with the monthly capitation rates specified in Attachment 8 – Dental Rates.

b. The monthly capitation payment is based on member enrollment for the month. This is determined by the total number of Medicaid members assigned to the DBPM as of the last working day of the previous month. For age group assignment purposes, age is determined at the beginning of the month for which the payment is intended. The DBPM will receive capitation payments to cover the cost of services retroactive to the first day of the month of the member's enrollment.

c. The entire monthly capitation payment will be paid during the month of birth, the month of death, and the first month of any incarceration.

4. Payment Adjustments

a. In the event an erroneous payment is made to the DBPM, MLTC will reconcile the error by adjusting the DBPM's next monthly capitation payment or future capitation payments on a schedule determined by MLTC.

b. Adjustments to prior capitation payments may occur if it is determined that a member's aid category or eligibility has changed.

c. In cases of a retroactive effective date for Medicare enrollment of a member, the DBPM must recoup payments made to its providers. The DBPM must initiate recoupments within 60 calendar days of the date the DBPM becomes aware of Medicare enrollment. The DBPM must instruct the provider to resubmit the claim(s) to Medicare.

d. The DBPM must refund payments received from MLTC for a deceased member after the month of death and an incarcerated member the month after entering involuntary custody. MLTC will recoup the payment within 30 calendar days of the date MLTC notifies the DBPM of death or incarceration. The DBPM must notify MLTC should the DBPM become aware of a member's death or incarceration.

5. MLTC Quality Performance Program

a. The DBPM must participate in the MLTC Quality Performance Program (QPP), effective as of contract start date. The MLTC QPP must be implemented in accordance with Neb. Rev. Stat. §71-831 and any successor statutes.

b. Pursuant to Neb. Rev. Stat. §71-831, the DBPM must hold back 2% of the aggregate of all income and revenue earned by the DBPM and related parties under the contract in a separate account. The hold-back constitutes the maximum amount available to the DBPM to earn via the quality performance program.

c. QPP measures for which the DBPM is eligible to earn hold-back funds are included in Attachment 9 – Quality Performance Program Measures – Contract Year One.

d. The DBPM must report its performance measures that affect the DBPM's eligibility to earn holdback funds monthly, quarterly, semi-annually, annually, and upon the request by MLTC.

e. All earned hold-back funds become the property of the DBPM.

f. The DBPM must return unearned (forfeited) hold-back funds to MLTC. MLTC will reimburse the Federal share of the forfeited funds to CMS. The remaining State share of the forfeited hold-back funds will be retained by MLTC.

g. No interest will be due to either party on hold-back funds retained by the DBPM or returned to MLTC.

h. MLTC reserves the right to modify annually the measures and criteria for earning the hold-back funds. In the event MLTC modifies the measures or criteria, MLTC will provide the DBPM 60 calendar days advance written notice. These measures may include operational or administrative measures that reflect DBPM business processes and may lead to improved access to and quality of care, HEDIS measures, Agency for Healthcare Research and Quality Review (AHRQ) measures, Dental Quality Alliance (DQA) measures, and any other MLTC-identified measures that represent opportunities for improvement as indicated by DBP historical performance.

i. Any earned hold-back will not be included in the DBPM's income for the year nor considered part of the medical loss ratio (MLR) calculation.

6. Health Insurance Providers Fee

a. Pursuant to Section 26 CFR Part 47 (the applicable regulations providing guidance about section 9010 of the Affordable Care Act), the DBPM must pay the Health Insurance Providers Fee (HIPF) annually. The full cost of the HIPF includes both the HIPF and the allowance for the federal income tax liability related to the HIPF.

b. MLTC will pay the portion of the HIPF specifically related to the DBPM's performance of this contract, with an adjustment for federal and state income tax, as described below:

i. The DBPM is required to submit Internal Revenue Service Form 8963, pursuant to the federal regulations referenced immediately above, to MLTC by September 5th of each year.

ii. All documents listed above and any additional data or information requested by MLTC must be submitted with an attestation by the reporting DBPM in accordance with the certification requirements specified in Section IV.T – Reporting and Deliverables.

iii. Following the determination of the amount to be reimbursed and the federal and state income tax impact related to the HIPF fee, the capitation rate PMPM for each aid category will be reprocessed. The capitation payment will include the prorated HIPF payment through December 31st. After January 1st, MLTC will determine a settlement, approved by MLTC's actuary, showing the amount already paid by the State for its portion of the HIPF tax. If the settlement calculation indicates MLTC owes the DBPM, the amount due will be paid in a retroactive capitation payment.

iv. The DBPM and MLTC's actuary will each calculate the HIPF, and compare the results. The DBPM must provide MLTC with verification of payment to the IRS.

c. The Consolidated Appropriations Act of 2016, Title II, § 201, Moratorium on Annual Fee on Health Insurance Providers, suspends collection of the HIPF for the 2017 calendar year.

7. Medical Loss Ratio

The DBPM must provide an annual Medical Loss Ratio (MLR) report to MLTC, in a form, manner, and pursuant to a timeline prescribed by MLTC. If the MLR (cost for health care benefits and services and specified quality expenditures) is less than eighty-five percent (85%), the DBPM must refund MLTC the difference. (See Attachment 1 – Medical Loss Ratio Requirements for the MLR calculation methodology and classification of costs.)

8. Return of Funds

a. All amounts owed by the DBPM to MLTC, as identified through routine or investigative reviews of records or audits conducted by MLTC or other State or Federal agencies, are due no later than thirty (30) calendar days following DBPM notification, unless otherwise authorized in writing by MLTC. MLTC reserves the right to collect amounts due by withholding and applying all balances due to MLTC from future payments. MLTC reserves the right to collect interest on unpaid balances beginning thirty (30) calendar days from the date of initial notification. Any unpaid balances after the refund is due are subject to interest at the current Federal Reserve Board lending rate or an annualized rate of ten percent (10%), whichever is higher.

b. The DBPM must reimburse MLTC for any federal disallowances or sanctions imposed on the State as a result of any failure by the DBPM to abide by the terms of the contract. The DBPM is subject to any additional conditions or restrictions placed on MLTC by the federal DHHS as a result of the disallowance. Instructions for the return of funds would be provided by written notice.

Q. PROVIDER REIMBURSEMENT

1. Minimum Reimbursement to In-Network Providers

The DBPM must provide reimbursement for defined core dental benefits and services provided by an in-network provider. For the first year of the contract, the DBPM rate of reimbursement must be no less than the published Medicaid fee-for-service rate in effect on July 1, 2016, unless MLTC has granted an exception for a provider-initiated alternative payment arrangement.

2. Provider Rate Increases

The DBPM must ensure that any rate increases for providers of services under the State Medical Assistance Act required by legislative appropriation are passed on in their entirety to participating providers.

3. Payment for Emergency Dental Services

a. The DBPM must reimburse providers for emergency dental services rendered without a requirement for service authorization of any kind.

b. The DBPM's protocol for provision of emergency dental services must specify that emergency dental services will be covered when furnished by a provider with which the DBPM does not have a subcontract or referral arrangement.

c. The DBPM may not limit what constitutes an emergency dental condition on the basis of diagnoses or symptoms or refuse to cover emergency dental services based on the provider notifying the member's primary dentist of the member's screening and treatment within ten (10) calendar days of presentation for emergency dental services.

d. The DBPM must not deny payment for treatment when a representative of the DBPM instructs the member to seek emergency dental services.

e. The DBPM must not deny payment for treatment obtained when a member had an emergency dental condition and the absence of immediate medical attention would not have had the outcomes specified in 42 CFR §438.114(a) of the definition of emergency dental condition.

f. The DBPM must be financially responsible for emergency dental services and must not retroactively deny a claim for emergency dental services to a provider because the condition, which appeared to be an emergency dental condition under the prudent layperson standard, was subsequently determined to be non-emergency in nature.

g. Expenditures for emergency dental services as previously described must be factored into the capitation rate described in this RFP

4. Indian Health Protections

a. Per Section 5006(d) of the American Recovery and Reinvestment Act of 2009, Public Law 111-5, the DBPM must:

i. Provide Indian Health Services/Tribal 638/Urban Indian Health (I/T/U) providers, whether participating in the network or not, payment for covered services provided to Indian members who are eligible to receive services from these providers either:

a) At a rate negotiated between the DBPM and the I/T/U provider, or

b) If there is not a negotiated rate, at a rate not less than the level and amount of payment that would be made if the provider were not an I/T/U provider.

ii. Make prompt payment to all I/T/U providers in its network in compliance with Federal regulations regarding payments to practitioners in individual or group practices, per 42 CFR §447.45 and §447.46.

5. Provider Incentive Plans

a. The DBPM's provider incentive plans must meet the requirements of 42 CFR §422.208 and §422.210.

b. A provider incentive plan cannot make a payment, directly or indirectly, to a dentist or dental group as an inducement to reduce or limit medically necessary services furnished to a member.

c. The DBPM must submit any contract templates that include an incentive plan to MLTC for review and approval a minimum of sixty (60) calendar days prior to their intended use. Any provider incentive plan must receive prior MLTC approval. The DBPM must disclose the following information in advance to MLTC:

i. Services furnished by dentist/groups that are covered by any incentive plan.

ii. Type of incentive arrangement (e.g., withhold, bonus, or capitation).

iii. Percent of withhold or bonus (if applicable).

iv. Panel size, and if patients are pooled, the method used.

v. If the dentist/group is at substantial financial risk, documentation that the dentist/group has adequate stop-loss coverage, including the amount and type of stop-loss.

d. If the dentist/group is put at substantial financial risk for services not provided by the dentist/group, the DBPM must ensure adequate stop-loss protection for individual dentists and conduct annual member and provider satisfaction surveys.

e. The DBPM must provide the information specified in 42 CFR §422.210(b) regarding its provider incentive plan to any Medicaid member on request.

f. If required to conduct member and provider satisfaction surveys (as described in Sections IV.G – Member Services and Education and IV.J – Provider Services), survey results must be disclosed to MLTC and, on request, to members.

6. Reimbursement to FQHCs and RHCs

a. The DBPM must reimburse FQHCs and RHCs in accordance with 471 NAC Chapters 29 and 34.

b. The DBPM must not enter into alternative reimbursement arrangements with FQHCs or RHCs, if initiated by the FQHC or RHC, without prior approval from MLTC.

c. If a DBPM enters into a contract for the provision of services with a FQHC or RHC, the DBPM must provide payment that is not less than the level and amount of payment which the DBPM would make for the services if the services were furnished by a provider which is not a FQHC or RHC.

d. Per Section IV.I – Provider Network Requirements, the DBPM must offer to contract with all FQHCs and RHCs (both freestanding and hospital-based) and include them in its provider network. If the DBPM does not enter into a contract with the FQHCs and/or RHCs within the geographic services area and within the time and distance travel standards of the primary dental care provider, the DBPM is not required to reimburse for out-of-network services. Exception is given when it is determined that the services provided were considered emergency services and in compliance with 42 CFR §438.114 emergency.

e. The DBPM may stipulate that reimbursement is contingent on receiving a clean claim and all dental information required to update the member's dental record.

f. The DBPM must inform members of these rights in its member handbook.

7. University of Nebraska Medical Center (UNMC) College of Dentistry Practitioner Payments

In compliance with State regulatory requirements, the DBPM must pass-through supplemental payments for services provided or supervised by a faculty or staff member of the University of Nebraska Medical Center (UNMC) College of Dentistry when that faculty or staff member is providing or supervising the treatment as part of an approved program of the University. These payments are calculated into the capitation rate on a quarterly basis.

8. Effective Date of Payment for New Members

The DBPM is responsible for benefits and services in the core benefits package from and including the effective date of a member's Medicaid eligibility. The DBPM must reimburse a provider and that provider must reimburse a member for payments already made by a member for Medicaid covered services during the retroactive eligibility period. The date of enrollment in a DBPM will match the Medicaid eligibility date.

9. Inappropriate Payment Denials

If the DBPM demonstrates a pattern of inappropriately denying or delaying provider payments for covered services, the DBPM may be subject to suspension of new enrollments, sanctions, contract cancellation, or refusal to contract in a future time period. This applies not only to situations in which MLTC has ordered

payment after appeal but also to situations in which no appeal has been made (i.e., MLTC learns of the documented abuse from other sources.)

10. Payments to Out-of-Network Providers

a. If the DBPM is unable to provide necessary services to a member within its network, the DBPM must adequately and timely arrange for the provision of these services out-of-network. In these circumstances, the DBPM must ensure that any prior authorization and payment issues are resolved expeditiously.

b. The DBPM must ensure that, if applicable, the cost to the member is no greater than it would have been if the services were furnished within the network.

c. For services that do not meet the definition of emergency services, the DBPM is not required, unless otherwise provided for in this contract, to reimburse out-of-network providers at more than ninety percent (90%) of the Medicaid rate in effect on the date of service to providers with whom/which it has made a minimum of three (3) documented attempts to contract.

d. The DBPM must pay for covered emergency and post-stabilization services that are furnished by providers that have no arrangements with the DBPM for the provision of these services. The DBPM must reimburse emergency service providers one hundred percent (100%) of the Medicaid rate in effect on the date of service. In compliance with Section 6085 of the Deficit Reduction Act of 2005, this requirement also applies to out-of-network providers.

e. During the initial ninety (90) calendar days of the contract, the DBPM must pay out-of-network providers at one hundred percent (100%) of the Medicaid FFS rate, to support member continuity of care.

f. The DBPM may require prior authorization for out-of network services, unless those services are required to treat an emergency medical condition.

R. CLAIMS MANAGEMENT

1. General Requirements

The DBPM must develop and maintain claims processes that ensure the correct collection and processing of claims, as well as analyzes, integrates, and reports data. These processes must result in information about service utilization, claims disputes, and appeals that can be used for process and program improvement.

2. Functionality

a. The DBPM must maintain an electronic claims management (ECM) system that will:

i. Uniquely identify the attending and billing provider of each service.

ii. Identify the date of receipt of the claim (the date the DBPM receives the claim as indicated by the date stamp on the claim).

iii. Identify real-time accurate history with dates of adjudication, results of each claim, such as paid, denied, pended, adjusted, voided, appealed, etc., and follow-up information about disputed claims.

iv. Identify the date of payment, (the date of the check or other form of payment), and the number of the check or electronic funds transfer (EFT).

v. Identify all data elements as required by MLTC for encounter data submission, as described in this RFP.

vi. Have the ability to integrate member claim and diagnosis history for use when adjudicating claims to override edit checks (such as prior authorization), based on the existence of a diagnosis or prior claim history.

vii. Accept submission of paper-based claims and electronic claims by participating providers, and non-participating providers according to the DBPM policies as approved by MLTC.

viii. Accept submission of electronic and paper adjustment and void transactions.

ix. Have the capability to pay claims at $0.00.

x. For the purpose of this section, identify means to capture, edit and retain.

b. The ECM capability must function in compliance with the systems and data management requirements specified in Section IV.S – Systems and Technical Requirements of this RFP.

c. The DBPM must have ECM capability that can handle online submission of individual claims as well as accept and process batches of claims submitted electronically, with the exception of claims that require written documentation to justify payment.

d. The DBPM must support an automated clearinghouse mechanism that allows providers to request and receive EFTs for claims payment.

e. The DBPM must support a Council for Affordable Quality Healthcare (CAQH)/Committee on Operating Rules for Information Exchange compliant interface to the automated clearinghouse that allows providers to request and receive EFTs of claims payments.

f. The DBPM's claims processing system must be available at any time, except for scheduled downtime as agreed to by MLTC.

g. The DBPM must adhere to national standards and standardized instructions and definitions that are consistent with industry norms. These must include, but are not limited to, HIPAA-based standards and federally-required safeguards, including signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR §455.18 and §455.19.

h. The DBPM must include nationally-recognized methodologies to correctly pay claims, including but not limited to:

i. Medicaid Correct Coding Initiative for professional, ambulatory surgical center, and outpatient services.

ii. Multiple procedure/surgical reductions.

iii. Global day evaluation and management bundling standards.

i. The DBPM must provide online and telephone-based capabilities to obtain claim processing status information.

j. The DBPM must comply at all times with standardized paper billing forms/formats and all future updates.

k. The DBPM must not employ off-system or gross adjustments when processing corrections for payment errors, unless the DBPM requests and receives prior written approval from MLTC.

l. The DBPM agrees that if MLTC presents recommendations concerning claims billing and processing that are consistent with industry norms, the DBPM must comply with these recommendations within ninety (90) calendar days.

m. The DBPM must not derive financial gain from a provider's use of electronic claims filing functionality and/or services offered by the DBPM or a third party.

n. The DBPM must assume all costs associated with claims processing, including costs for reprocessing encounters due to errors caused by the DBPM, or due to systems within the DBPM's span of control.

3. Claims Processing

a. The DBPM must ensure that all provider claims are processed according to the following timeframes:

i. Within five (5) business days of receipt of a claim, the DBPM must provide an initial screening and either reject the claim, or assign a unique control number and enter it into the system for processing and adjudication.

ii. Process and pay or deny, as appropriate, a minimum of ninety percent (90%) of all clean claims for medical services provided to members within fifteen (15) business days of the date of receipt. The date of receipt is the date the DBPM receives the claim.

iii. Process and pay or deny, as appropriate, a minimum of ninety-nine percent (99%) of all clean claims for medical services provided to members within sixty (60) calendar days of the date of receipt.

iv. Fully adjudicate (pay or deny) all other claims within six (6) months of the date of receipt.

b. Rejected Claims

i. The DBPM may reject claims because of missing or incomplete information. In those circumstances, the original claim must be returned to the provider accompanied by a rejection letter.

ii. A rejected claim should not appear on a remittance advice because it will not have been entered into the DBPM's claims processing system.

iii. The rejection letter must indicate why the claim is being returned, including all defects or reasons known at the time the determination is made. The letter must contain, at a minimum, the following information:

a) Member name and Medicaid ID number.

b) Provider ID number.

c) Date of service.

d) Total billed charges.

e) A list of known defects or reasons for rejection.

f) DBPM's name.

g) The date the letter was generated.

c. Pended Claims

If a clean claim is received, but additional information is required for adjudication, the DBPM may pend the claim and request in writing (notification via e-mail, website/provider portal, or an interim explanation of benefits (EOB) satisfies this requirement) all necessary information so the claim can be adjudicated within established timeframes.

d. Adjustments and Voids

i. Incorrect claims payments must be adjusted or voided electronically.

ii. Only a paid claim may be adjusted or voided.

iii. Incorrect provider numbers or member Medicaid ID numbers cannot be adjusted. The claim must be voided and then resubmitted.

e. Timely Filing Guidelines

i. The DBPM must not deny provider claims on the basis of untimely filing for claims that involve coordination of services or subrogation (when the provider is pursuing payment from a third party). In situations of third party benefits, the timeframes for filing a claim must begin on the date that the third party completes resolution of the claim.

ii. The DBPM must not deny claims solely for failure to meet timely filing guidelines due to an error by MLTC or its subcontractors. If a provider files erroneously with another DBPM but produces documentation verifying that the initial filing of the claim occurred timely, the DBPM must process the provider's claim and not deny for failure to meet timely filing guidelines.

iii. For purposes of DBPM reporting on payments to providers, an adjustment to a paid claim must not be counted as a claim and electronic claims must be treated as identical to paper claims.

f. Claim System Edits

i. The DBPM must perform system edits, including but not limited to:

a) Confirming eligibility and DBPM enrollment for each member.

b) Validating member name.

c) Validating unique member identification number.

d) Confirming benefit package variations.

e) Identifying invalid, missing, and/or mismatched NPIs and/or tax identification numbers that could result in improper payments.

f) Performing system edits for valid dates of service, including ensuring that the dates of services are not in the future or outside the member's Medicaid eligibility span.

g) Ensuring that timeliness standards are met.

h) Ensuring data accuracy.

i) Determining medical necessity, as defined by qualified, medically trained, and appropriately licensed personnel, consistent with NCQA accreditation standards, whose primary duties are to assist in evaluating claims for medical necessity.

j) Determining whether a covered service requires prior authorization and if so, whether the DBPM gave its approval.

k) Flagging, in an automated manner, a claim as being an actual or possible duplicate and either denying or pending the claim as necessary.

l) Ensuring that the service is covered and eligible for payment.

m) Ensuring that the system approves only those claims received from providers eligible to render services for which the claims were submitted and that the provider has not been excluded from receiving Medicaid payments.

n) Ensuring that the system evaluates claims for services provided to members to ensure that any applicable benefit limits are applied and that over-utilization standards are considered.

ii. The DBPM must have the ability to update current procedural terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS), International

Classification of Diseases, Tenth Revision (ICD-10-CM), and other codes based on HIPAA standards and move to future versions as required.

iii. In addition to CPT, ICD-10-CM, ICD-10-PCS, and any other national coding standards, the use of applicable HCPCS Level II and Category II CPT codes are mandatory, aiding both the DBPM's and MLTC's evaluation of performance measures.

iv. The DBPM must perform post-payment review on a sample of claims to ensure services provided were medically necessary and were provided in accordance with State and Federal requirements. This must include, as applicable, a review of provider documentation.

4. Payments to Providers

a. The DBPM must have procedures, approved by MLTC, available to providers in written and electronic form for the acceptance of claim submissions that include:

i. The process for documenting the date of actual receipt of non-electronic claims and the date and time of electronic claims.

ii. The process for reviewing claims for accuracy and acceptability.

iii. The process for preventing the loss of claims.

iv. The process for reviewing claims to determine if they are complete, correct, and payable.

b. At a minimum, the DBPM must run one (1) provider payment cycle weekly.

c. The DBPM must encourage its providers, as an alternative to the filing of paper claims, to submit and receive claims information through electronic data interchange.

d. The DBPM must notify all contracted providers to file claims associated with covered services directly to the DBPM or its subcontractors (as applicable), on behalf of Nebraska Medicaid members.

e. The DBPM must pay providers interest at an annualized rate of twelve percent (12%), calculated daily for the full period in which a payable clean claim remains unpaid beyond the 60-day claims processing deadline. Interest owed to the provider must be paid the same day that the claim is adjudicated, and reported on the encounter submission to MLTC or its designee.

5. Remittance Advice (RA)

a. The DBPM must produce a remittance advice that reflects the DBPM's payments or denials to providers. Each remittance advice generated by the DBPM to a provider must clearly identify for each claim:

i. Name of the member.

ii. Unique member Medicaid identification number.

iii. Patient claim number or patient account number.

iv. Date of service.

v. Total provider charges.

vi. Member liability, specifying any coinsurance, deductible, copayment, or non-covered amount.

vii. Amount paid by the DBPM and/or the amount denied and the HIPAA-compliant reasons for denial.

viii. An attachment to the RA if the claim was denied due to a TPL, including but not be limited to, TPL carrier information such as carrier code, policy number, and mailing address.

ix. A description of provider rights for claims disputes.

b. Adjustments and voids must appear on the RA under "Adjusted or Voided Claims" as either approved or denied.

c. The related remittance advice must be sent with the payment, unless the payment is made by EFT. Any remittance advice related to an EFT must be sent to the provider no later than the date of the EFT.

d. If a claim is partially or totally denied because the provider did not submit required information or documentation with the claim, then the remittance advice must specifically identify all the required information and documentation not submitted. Resubmission of a claim with the necessary information/documentation must constitute a new claim for purposes of establishing the time frame for claims processing.

e. In compliance with 42 CFR §455.18 and §455.19, the following statement must be included on each remittance advice sent to providers: "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 material fact, may be prosecuted under applicable Federal and/or State laws."

6. Paid Claims Sampling

a. On a monthly basis, the DBPM must conduct service verification surveys including providing members' own individual EOB notices or information to a sample group of members in a manner that complies with 42 CFR §455.20 and §433.116(e). In easily understood language, the required notice must specify:

i. The description of the service furnished.

ii. The name of the provider furnishing the service.

iii. The date on which the service was furnished.

iv. The amount of payment made for the service

b. The DBPM must stratify the sample group to ensure that all provider types (or specialties) and all claim types are proportionally represented in the sample pool from the entire range of services available under the contract. To the extent that the DBPM or MLTC considers a particular specialty (or provider) to warrant closer scrutiny, the DBPM may oversample this group. The paid claims sample should be a minimum of two percent (2%) of claims per month. The results must be reported to MLTC on a quarterly basis, per the requirements in Attachment 5 – Reporting Requirements.

c. The service verification surveys may be conducted at any point after a claim has been paid, but no more than 45 calendar days after the date of payment. This sampling may be performed by mail, telephonically, or in person (e.g., during case management on-site visits). Concurrent review will be allowed when tied back to a successfully adjudicated claim.

d. The DBPM must track any complaints received from members and resolve the complaints according to its established policies and procedures. The resolution may be member education, provider education, or referral to MLTC. The DBPM must use the feedback received through this process to modify or enhance the verification of receipt of paid services sampling methodology.

e. Within three business days, results indicating that paid services may not have been received by the member, must be referred to MLTC and the DBPM's fraud and abuse department for review.

f. The DBPM must report the total number of service verification surveys sent out to members, the total number of surveys completed, the total number of services requested for validation, the number of services validated, and an analysis of interventions related to complaints or other issues, all according to the interval listed in Attachment 5 – Reporting Requirements.

7. Claims Dispute Management

a. The DBPM must develop an internal claims dispute process for those claims or group of claims that have been denied or underpaid. The process must be submitted to MLTC for approval a minimum of sixty (60) calendar days prior to the contract start date.

b. The claims dispute process must give providers the option to request binding arbitration for claims that have been denied, underpaid, or bundled, by a private arbitrator who is certified by a nationally-recognized association that provides training and certification in alternative dispute resolution. If the DBPM and the provider are unable to agree on an association, the rules of the American Arbitration Association apply. The arbitrator must have experience and expertise in the health care field and must be selected according to the rules of his/her certifying association. Arbitration conducted pursuant to this section must be binding on all parties. The arbitrator must conduct a hearing and issue a final ruling within ninety (90) calendar days of being selected, unless the DBPM and the provider mutually agree to extend this deadline. All costs of arbitration, not including attorneys' fees, must be shared equally by the parties. Each party must bear its own attorneys' fees, if any.

c. The DBPM must systematically capture the status and resolution of all claim disputes, as well as all associated documentation.

d. The DBPM must adjudicate each disputed claim to a paid or denied status within 30 business days of receipt.

8. Claims Payment Accuracy

a. On a monthly basis, the DBPM must submit claims payment accuracy percentage reports to MLTC, in a format determined by MLTC.

b. The report must be based on an audit conducted by the DBPM. The audit must be conducted by an entity or staff independent of claims management.

c. The audit must utilize a random sample of all processed or paid claims on initial submission in each month. A statistically-valid sample, with provider and financial stratification, must be selected from the entire population of electronic and paper claims processed or paid on initial submission.

d. The minimum attributes to be tested for each claim selected must include:

i. Claim data is correctly entered into the claims processing system.

ii. The claim is associated with the correct provider.

iii. Proper authorization was obtained for the service.

iv. Member eligibility on the processing date was correctly applied.

v. The allowed payment amount agrees with the contracted rate and the terms of the provider agreement between the DBPM and the provider.

vi. Duplicate payment of the same claim did not occur.

vii. The denial reason, if applicable, was applied appropriately.

viii. Copayments were considered and applied if applicable.

ix. Patient liability was correctly identified and applied.

x. Modifier codes were correctly applied.

xi. Other insurance was properly considered and applied if present.

xii. Proper benefit limits were applied.

xiii. Proper coding including bundling and unbundling was applied.

e. The results of testing should be documented, at a minimum, to include:

i. Results of each attribute tested for each claim selected.

ii. The amount of any overpayment or underpayment for claims processed or paid in error.

iii. An explanation of the erroneous processing for each claim processed or paid in error.

iv. A determination of whether any error is the result of keying errors or errors in the configuration or table maintenance of the claims processing system.

v. Documentation that any claims processed or paid in error have been corrected.

f. If the DBPM subcontracts for the provision of any covered services and the subcontractor is responsible for processing claims, the DBPM must submit a claims payment accuracy percentage report for the claims processed by the subcontractor. The report must be based on an audit conducted in compliance with the requirements of this section of the RFP.

9. Encounter Data

a. The DBPM must submit encounter data that meets established MLTC data quality standards. These standards are defined by MLTC to ensure receipt of complete and accurate data for program administration and will be closely monitored and strictly enforced. MLTC will revise and amend these standards as necessary to ensure CQI.

b. The DBPM must submit encounter data accurately, meeting the standard of ninety-five percent (95%) correct encounters. The DBPM must make an adjustment to encounter claims when the DBPM discovers the data is incorrect, no longer valid, or some element of the claim not identified as part of the original claim needs to be changed.

c. The DBPM must make changes or corrections to any systems, processes, or data transmission formats as needed to comply with MLTC data quality standards as originally defined or subsequently amended. The DBPM must comply with industry-accepted clean claim standards for all encounter data, including submission of complete and accurate data for all fields required on standard billing forms or electronic claim formats to support proper adjudication of a claim.

d. In the event that the DBPM denies provider claims for reimbursement due to lack of sufficient or accurate data required for proper adjudication, the DBPM must submit all available claims data to MLTC without alteration or omission.

e. When the DBPM has entered into capitated reimbursement arrangements with providers, the DBPM must require submission of all utilization or encounter data to the same standards of completeness and accuracy, including pricing information, as required for proper adjudication of FFS claims. The DBPM must require this submission from providers as a condition of the capitation payment and must make every effort to enforce this contractual provision to ensure timely receipt of complete and accurate data.

f. The DBPM must submit all data relevant to the adjudication and payment of claims in sufficient detail, as defined by MLTC, in order to support comprehensive financial reporting and utilization analysis.

g. The DBPM must submit encounter data according to standards and formats as defined by MLTC, complying with standard code sets and maintaining integrity with all reference data sources, including provider and member data.

h. All encounter data submissions are subject to systematic data quality edits and audits on submission to verify not only the data content but also the accuracy of claims processing. Any batch submission that contains fatal errors that prevent processing or that does not satisfy defined threshold error rates will be rejected and returned to the DBPM for immediate correction. Re-submittals of rejected files, or notification of when the file will be resubmitted, must be completed within one (1) business day of receipt.

i. MLTC will reject or report individual claims or encounters failing certain edits, as deemed appropriate and necessary by MLTC, to ensure accurate processing or encounter data quality, and will return these transactions to the DBPM for research and resolution. MLTC will require expeditious action on the part of the DBPM to resolve errors or problems associated with these claims or the adjudication of these claims, including any necessary changes or corrections to any systems, processes, or data transmission formats. Generally the DBPM must, unless otherwise directed by MLTC, address ninety percent (90%) of reported errors within thirty (30) calendar days and address ninety-nine percent (99%) of reported errors within sixty (60) calendar days. These errors will be considered acceptably addressed when the DBPM has either confirmed and corrected the reported issue or disputed the reported issue with supporting information or documentation that substantiates the dispute.

j. MLTC may require resubmission of the transaction with reference to the original in order to document resolution. Failure to promptly research and address reported errors, including submission of and compliance with an acceptable CAP as required, may result in damages and sanctions as described in Section IV.U – Contract Monitoring.

k. The DBPM must collect and submit to MLTC complete and accurate data on member characteristics, provider characteristics, and services furnished to members through an encounter data system, per the State's specifications.

l. The DBPM must submit all data relevant to the adjudication and payment of claims in sufficient detail, as defined by the State, to support comprehensive financial reporting and utilization analysis.

m. The DBPM must adhere to applicable Federal and MLTC payment rules in the definition and treatment of certain data elements, such as units of service.

n. The NPI is required on all claims and encounter submissions from providers who are eligible for an NPI. The DBPM must assist providers to obtain an NPI, if necessary.

o. The DBPM must ensure that encounter files contain settled claims, adjustments, denials, and voids, including but not limited to, adjustments necessitated by payment errors, processed during that payment cycle, as well as encounters processed during that payment cycle from providers with whom/which the DBPM has a capitation arrangement. The DBPM must ensure that the level of detail associated with encounters from providers with whom/which the DBPM has a capitation arrangement must be equivalent to the level of detail associated with encounters for which the DBPM receives and settles as a FFS claim.

p. The DBPM Executive Director or his/her designee must attest to the truthfulness, accuracy, and completeness of all encounter data submitted.

q. All institutional and professional encounters must be submitted electronically in the standard HIPAA transaction formats, specifically the American National Standards Institute X12N 837. Compliance with all applicable Federal (including but not limited to HIPAA) and State requirements, as amended, is required. MLTC and the DBPMs will coordinate the timing of the transition to future HIPAA standard transaction formats, as appropriate.

r. The DBPM must have the capability to convert all information that enters its claims system via hard copy paper claims to electronic encounter data, for submission into the appropriate HIPAA-compliant formats.

s. Encounter records must be submitted so that payment for discrete services that may have been submitted in a single claim can be ascertained.

t. Encounter data must be submitted a minimum of monthly on a date designated by MLTC and include all clean claims adjudicated and/or adjusted by the DBPM.

u. Within two (2) business days of the end of a payment cycle, the DBPM must generate encounter data files for that payment cycle from its claims management system(s) and/or other sources. If the DBPM has more than one (1) payment cycle within the same calendar week, the encounter data files may be merged and submitted within two (2) business days of the end of the last payment cycle during the calendar week.

v. The DBPM must institute processes to ensure the validity and completeness of the data it submits to MLTC. At its sole discretion, the State will conduct general data validity and completeness audits using industry-accepted statistical sampling methods. Data elements that will be audited include, but are not limited to: member ID, date of service, provider ID (including NPI number and Medicaid ID number), category and sub-category (if applicable) of service, diagnoses codes, procedure codes and modifiers, revenue codes, adherence to hard benefit limits, date of claim processing, and date of claim payment. Control totals will also be reviewed and verified. Additionally, the DBPM must reconcile all encounter data submitted to the State to control totals and to the DBPM's MLR reports and supply this reconciliation to MLTC with each MLR report submission as specified in Attachment 5 – Reporting Requirements.

10. Audit Requirements

a. The DBPM must ensure that its systems facilitate the auditing of individual claims. Adequate audit trails must be provided throughout the systems. To facilitate claims auditing, the DBPM must ensure that the systems follow, at a minimum, the guidelines and objectives of the American Institute of Certified Public Accountants Statement on Standards for Attestation Engagements (SSAE) No. 16, Reporting on Controls at a Service Organization.

b. State Audits

i. The DBPM must provide to any State auditor (including but not limited to the Auditor of Public Accounts), or his/her designee, on written request, files for any specified accounting period for which a valid contract exists or has expired, in a file format or audit-defined media required by the auditor. The DBPM must provide information necessary to assist the auditor in processing or using the files.

ii. If the auditor's findings point to discrepancies or errors, the DBPM must provide a written CAP to MLTC within ten (10) business days of receipt of the audit report.

c. Audit Coordination and Claims Reviews

i. The DBPM must coordinate audits with MLTC or its designee and respond within thirty (30) calendar days of a request by MLTC regarding the DBPM's review of a specific provider and/or claim(s), and the issue reviewed.

ii. In the event MLTC or its designee identifies a mispayment, the DBPM has thirty (30) calendar days from the date of notification of the mispayment to determine if the claim(s) were corrected or adjusted prior to the date of MLTC notification. On receipt of this notification, the DBPM must not correct the claims, unless directed to do so by MLTC.

iii. MLTC reserves the right to review any claim paid by the DBPM or its designee. The DBPM has the right to collect or recoup any overpayments identified by the DBPM from providers of service in accordance with existing laws or regulations. However, if an overpayment is identified by the State or its designee one year or later from the date of payment, the DBPM will collect and remit the overpayment to MLTC. In the event the DBPM does not collect mispayments from the provider within 30 calendar days of notification of the overpayment, the DBPM must refund the overpayment to MLTC. Failure by the DBPM to collect an overpayment from a provider does not relieve the DBPM from remitting the identified overpayment to MLTC.

11. Claims Processing Reports

a. The DBPM will report to MLTC, on a monthly basis, summary data on claims payment activity and reasons for claims denials. The reporting requirements will be provided by MLTC.

b. In concert with its claims payment cycle, the DBPM must provide an electronic status report indicating the disposition of every adjudicated and adjusted claim for each claim type submitted by providers seeking payment as well as capitated payments generated and paid by the DBPM. The status report must contain appropriate explanatory remarks related to payment or denial of the claim, including but not limited to, TPL data.

12. Third-Party Liability

a. General TPL Information

i. Pursuant to applicable law, the Medicaid program is the payer of last resort. All other available TPL resources must meet their legal obligation to pay claims before the DBPM pays for the care of a Medicaid member.

ii. The DBPM must exercise full assignment rights as applicable; must make every reasonable effort to determine any TPL to pay for services rendered to members under this contract; and, cost avoid or recover this liability from the third party(ies).

iii. At the request of MLTC, the DBPM must demonstrate that reasonable effort has been made to seek, collect, and report TPL, and the DBPM's cost avoidance and recovery efforts.

iv. MLTC has the sole responsibility for determining whether or not reasonable efforts have been demonstrated. This determination will consider reasonable industry standards and practices.

v. The DBPM must coordinate benefits in accordance with 42 CFR §433.135, et seq., and 471 NAC 3-004 in order to avoid costs and recover payments from liable parties as appropriate. For purposes of complying with the Federal regulations referenced in the immediately preceding sentence, the term "state" means "DBPM". However, the DBPM must pay and chase claims for which third-party liability is derived from an absent parent whose obligation to pay support is being enforced by the DHHS Division of Children and Family Services.

vi. The DBPM may utilize subcontractors to comply with coordination-of-benefit efforts for services provided under this contract. The two methods for coordinating benefits are cost avoidance and post-payment recovery.

vii. TPL is established when the DBPM receives confirmation that another party is, by statute, contract, or agreement, legally responsible for the payment of a claim for a health care item or service delivered to a member.

viii. If the probable existence of TPL cannot be established, the DBPM must adjudicate the claim. The DBPM must recover payments if TPL is later determined to exist.

ix. The DBPM must identify the existence of potential TPL to pay for covered services through the use of diagnosis and trauma code editing in accordance with 42 CFR §433.138(e).

x. If a TPL insurer requires the member to pay any co-payments, coinsurance, or deductibles, the DBPM is responsible for making these payments even if the services are provided outside of the DBPM network.

xi. The DBPM, or its subcontractors or providers, must not pursue collection from the member, but directly from the liable third party(ies), except as allowed in 468 NAC Chapter 4-002 and 471 NAC Chapter 3-004.

xii. MLTC may require a MLTC-contracted TPL vendor to review paid claims that are over ninety (90) calendar days old and pursue TPL (excluding subrogation) for those claims that do not indicate recovery amounts in the DBPM's encounter data.

xiii. MLTC is solely responsible for estate recovery activities and will retain any and all funds recovered through these activities.

b. Cost Avoidance

i. The DBPM must cost-avoid a claim if it establishes the probable existence of TPL at the time the claim is filed.

ii. The DBPM may “pay and chase” the full amount allowed under the DBPM payment schedule for the claim and then seek reimbursement for any liable TPL if:

a) Preventive pediatric services (including EPSDT).

b) The claim is for a service that is provided to an individual on whose behalf child support enforcement is being carried out by the state Title IV-D child support agency. The DBPM must seek recovery of reimbursement within sixty (60) calendar days after the end of the month in which the payment was made.

c. Post-Payment Recovery

i. Post-payment recovery is necessary in cases in which the DBPM has not established the probable existence of TPL at the time services were rendered or paid for, or was unable to cost avoid.

ii. The DBPM must seek recovery within sixty (60) calendar days after the end of the month it learns of the existence of a liable third party after a claim is paid.

iii. The DBPM must have established procedures for recovering post-payments for MLTC’s review and approval during the readiness review.

iv. The DBPM must void encounters for claims that are recouped in full. For recoupments that are not recouped in full, the DBPM must submit adjusted encounters.

v. The DBPM must seek reimbursement in accident/trauma-related cases when claims in the aggregate equal or exceed $250.00, as required by the Medicaid State Plan.

vi. The amount of any recoveries collected by the DBPM outside of the claims processing system must be treated by the DBPM as offsets to medical expenses for the purposes of reporting.

d. Distribution of TPL Recoveries

i. The DBPM may retain up to one hundred percent (100%) of its TPL collections if all of the following conditions exist:

a) Total collections received do not exceed the total amount of the DBPM financial liability for the member.

b) There are no payments made by MLTC related to FFS claims, reinsurance, or administrative costs (i.e., lien filing, etc.).

c) Such recovery is not prohibited by applicable law.

ii. MLTC will utilize TPL data in calculating future capitation rates.

e. TPL Reporting Requirements

i. The DBPM must provide TPL information to MLTC weekly in a format required by MLTC and must cooperate in any manner necessary with MLTC or its cost recovery vendor.

ii. Any money recovered from third parties will be retained by the DBPM and reported monthly to MLTC.

iii. The DBPM must post all third-party payments to claim level detail by member. The DBPM must include the collections and claims information in the encounter data submitted to MLTC, including any retrospective findings via encounter adjustments.

iv. At the request of MLTC, the DBPM must provide information not included in encounter data submissions that may be necessary for the administration of TPL activity. This information must be provided within thirty (30) calendar days of MLTC’s request. This information may include, but is not limited to, individual medical records to determine liability for the services rendered.

v. The DBPM must report members with third party coverage to MLTC on a monthly basis, reporting additions and updates of TPL information in a format and medium specified by MLTC.

vi. The DBPM must submit an annual report of all health insurance collections for its members plus copies of any Form 1099s received from insurance companies for that period of time.

f. Right to Conduct Identification and Pursuit of TPL

i. MLTC may pursue recovery if the DBPM fails to recover reimbursement from the third party, to the limit of legal liability, three hundred, sixty-five (365) days from the date of service of the claim(s).

ii. The DBPM must seek subrogation amounts regardless of the amount believed to be available as required by Federal law. The amount of any subrogation recoveries collected by the DBPM outside of the claims processing system must be treated by the DBPM as offsets to medical expenses for the purposes of reporting.

13. Coordination of Benefits Data

a. MLTC or its designee will provide the DBPM with a list of known third party resources for its members via the enrollment file, based on information made available to MLTC at the time of eligibility determination or re-determination. If the DBPM operates or administers any non-Medicaid HMO, health plan, or other lines of business, the DBPM must assist MLTC with the identification of members with access to other insurance.

b. The DBPM must provide, to MLTC, any third party resource information, in a format requested by MLTC, and must cooperate with MLTC or its cost-recovery vendor.

14. Coordination of Benefits for Dual Eligible Members

a. The DBPM is responsible for providing medically necessary covered services to members who are also eligible for Medicare if the service is not covered by Medicare. The DBPM must ensure that services covered and provided under this contract are delivered without charge to members who are dually eligible for Medicare and Medicaid. The DBPM must coordinate with Medicare payers, Medicare Advantage Plans, and Medicare providers as appropriate to coordinate the care and benefits of members who are also eligible for Medicare. The DBPM should propose strategies, in its RFP response, to coordinate care for dually-eligible members.

b. The DBPM must sign a Coordination of Benefits Agreement and participate in the automated crossover process administered by Medicare. Under this crossover process, a Medicare provider, who may or may not be part of the DBPM's network, must submit a claim to Medicare and there is an automatic crossover to MLTC for whatever Medicaid payment is due.

c. The DBPM must include in all of its provider agreements provisions to ensure continuation of benefits. In addition, the provider agreement must specify the provider's responsibility regarding TPL, including:

i. Identifying TPL coverage, including Medicare and long-term care insurance as applicable.

ii. Seeking TPL payments before submitting claims to the DBPM.

S. SYSTEMS AND TECHNICAL REQUIREMENTS

1. General Requirements

a. The DBPM must maintain a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, enrollment, care management, utilization, claims adjudication and payment, grievances and appeals, and disenrollments for reasons other than loss of Medicaid eligibility. Reporting formats and other requirements will be determined by MLTC after contract award.

b. The DBPM must provide documentation about its health information system that ensures data received from providers is accurate and complete by:

i. Verifying the accuracy and timeliness of reported data.

ii. Screening the data for completeness, logicalness, and consistency.

iii. Collecting service information in standardized formats to the extent feasible and appropriate.

c. The DBPM must provide MLTC with live access to all its systems at any time.

2. HIPAA Standards and Code Sets

The DBPM must be able to perform the following functions electronically including electronic claims management capabilities:

a. Receive enrollment verification via a HIPAA-compliant 834 format.

b. Receive electronic premium payments remittance advices via a HIPAA-compliant 820 format.

c. Provide enrollment verification in a HIPAA-compliant 270/271 format.

d. Accept prior authorization requests in a HIPAA-compliant 278 format.

e. Allow claims inquiry and response in a HIPAA-compliant 276/277 format.

f. Accept electronic claims transactions in a HIPAA-compliant 837 format.

g. Generate HIPAA-compliant electronic remittance advices in the 835 format.

h. Submit encounter data via the HIPAA-compliant 837 formats.

i. Make claims payments via EFT.

3. Resource Availability and Systems Changes

a. Resource Availability

i. The DBPM must provide systems help desk (SHD) services for all DBPM, MLTC and other State agency staff who may have direct access to DBPM systems.

ii. The DBPM's SHD must be available via local and toll-free telephone service and via e-mail from 7:00 am to 7:00 pm, central time, Monday through Friday. If requested by MLTC, the DBPM must staff the Systems Help Desk (SHD) on a Saturday or Sunday.

iii. The DBPM's SHD staff must be able to answer user questions regarding DBPM system functions and capabilities; report any recurring programmatic and operational problems to appropriate DBPM or MLTC staff for follow-up; redirect problems or queries that are not supported by the SHD, as appropriate, via a telephone transfer or other agreed upon methodology; and redirect problems or queries specific to data access authorization to the appropriate MLTC login account administrator.

iv. The DBPM must ensure that individuals who place calls to the SHD between the hours of 7:00 pm to 7:00 am, central time, Monday through Friday, are able to leave a message. The SHD must respond to messages by noon of the following business day.

v. The DBPM must ensure that recurring problems, not specific to system unavailability, identified by the SHD are documented and reported to DBPM management within one (1) business day of recognition so that deficiencies are promptly corrected.

vi. The DBPM must have information systems (IS) service management system that provides an automated method to record, track, and report all questions or problems reported to the SHD.

b. Systems Policies and Procedures

i. The DBPM must have in place written systems policies and procedures that document all manual and automated processes for its IS, including the safeguarding of all its information.

ii. The DBPM must maintain and distribute to all users (including MLTC) distinct systems design and management manuals, user manuals, and quick reference guides.

iii. The DBPM must ensure that the systems user manuals contain information about, and instructions for, using applicable systems functions and accessing applicable system data.

iv. The DBPM must ensure that all manuals and reference guides are available in printed form and on the DBPM's website.

v. The DBPM must update the electronic version of these manuals immediately on taking effect, and make printed versions available within ten (10) business days of the update taking effect.

c. System Changes

i. The DBPM's systems must conform to future federal and/or MLTC-specific standards for encounter data exchange a minimum of ninety (90) calendar days prior to the standard's effective date, as directed by CMS or MLTC.

ii. If a system update or changes are necessary, the DBPM must draft the appropriate revisions to the documentation, and forward them to MLTC for review and approval a minimum of forty-five (45) calendar days prior to intended implementation. Upon MLTC approval, the DBPM must prepare revisions to the appropriate manuals before implementing the system changes, and must have printed manual revisions made within ten (10) business days of the system revision.

The DBPM must notify MLTC of changes to its system a minimum of ninety (90) calendar days prior to the projected date of the change. These changes include major upgrades, modifications, or updates to application or operating software associated with the following core production systems:

a) Claims processing.

b) Eligibility and enrollment processing.

c) Service authorization management.

d) Provider enrollment and data management.

e) Conversions of core transaction management systems.

iii. The DBPM must respond to notification from MLTC of IS problems, excluding IS unavailability, in the following timeframes:

a) Within five (5) calendar days of notification from MLTC, the DBPM must respond in writing regarding system problems.

b) Within fifteen (15) calendar days, the correction must be made or a requirements analysis and specifications document must be provided to MLTC.

c) The DBPM must correct the deficiency by an effective date to be determined by MLTC.

d) The DBPM's systems must have a system-inherent mechanism for recording any change to a software module or subsystem.

iv. Unless otherwise agreed to in advance by MLTC, the DBPM must not schedule systems unavailability to perform system maintenance, repair, or upgrade activities to take place during hours that could compromise or prevent critical business operations.

v. The DBPM must work with MLTC on any testing initiative required by MLTC and must provide sufficient system access to allow MLTC staff to participate in the testing activities.

4. Systems Refresh Plan

The DBPM must provide to MLTC an annual systems refresh plan. This plan must outline how ISs within the DBPM's span of control will be systematically assessed to determine the need to modify, upgrade, or replace application software, operating hardware and software, telecommunications capabilities, or information management policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover, or any other relevant issues. The systems refresh plan must also indicate how the DBPM will ensure that the version and/or release level of all IS components (application software, operating hardware, and operating software) are always formally supported by the original equipment manufacturer (OEM), software development firm (SDF), or a third party authorized by the OEM or SDF to support the IS component.

5. Eligibility and Enrollment Data Exchange

The DBPM must:

a. Receive, process, and update enrollment files sent daily by MLTC or its designee.

b. Update its eligibility and enrollment databases within twenty-four (24) hours of receipt of these files.

c. Transmit to MLTC, in the formats and methods specified by MLTC, member address and telephone number changes.

d. Use the member's Medicaid ID number to identify each member across multiple populations and systems within its span of control.

e. Be able to identify potential duplicate records for a single member and, upon confirmation of this duplicate record by MLTC, resolve the duplication so that the enrollment, service utilization, and member interaction histories of the duplicate records are linked or merged.

6. Other Electronic Data Exchange

a. The DBPM's system must scan, house, and retain indexed electronic images of documents used by members and providers to interact with the DBPM. These documents must be housed in appropriate database(s) and document management systems to maintain the logical relationships to certain key data such as member identification numbers, provider identification numbers, and claim identification numbers. The DBPM must ensure that records associated with a common event, transaction, or member service issue have a common index that will facilitate the search, retrieval, and analysis of related activities, such as interactions with a particular member about a reported problem.

b. The DBPM must implement optical character recognition technology that minimizes manual indexing and automates the retrieval of scanned documents.

7. Electronic Messaging

a. The DBPM must provide a continuously available electronic mail communication link (email system) to facilitate communication with MLTC. This email system must be capable of attaching and sending documents created using software compatible with MLTC's installed version of Microsoft Office and any subsequent upgrades as adopted.

b. As needed, the DBPM must be able to communicate with MLTC over a secure virtual private network (VPN).

c. The DBPM must comply with national standards for submitting protected health information (PHI) electronically and must set up a secure email system that is password protected for both sending and receiving any PHI.

8. Provider Enrollment

On the effective date of the DBPM contract and weekly thereafter, MLTC or its designee will furnish to the DBPM a list of Nebraska Medicaid provider types and specialty codes. In order to coordinate provider enrollment records, the DBPM must utilize these codes in all provider data communications with MLTC. The DBPM will provide the following:

a. A weekly provider file to include provider name, address, licensing information, Tax ID, NPI, taxonomy, contract information, and any other data as required by MLTC and in a format specified by MLTC.

b. All relevant provider ownership information as prescribed by MLTC, Federal, or State laws.

c. Performance of all Federal- or State-mandated exclusion background checks on providers (owners and managers). The providers must perform the same checks on all of their employees a minimum of annually.

d. Provider enrollment systems must include, at a minimum, the following functionality:

i. Audit trail and history of changes made to the provider file.

ii. Automated interfaces with all licensing and medical boards.

iii. Automated alerts when provider licenses are nearing expiration.

iv. Retention of NPI requirements.

v. System-generated letters to providers when their licenses are nearing expiration.

vi. Linkages of individual providers to groups.

vii. Credentialing information.

viii. Provider office hours.

ix. Provider languages spoken.

x. Provider disability accommodations.

9. Information Security and Access Management

a. The DBPM's systems must utilize an access management function that restricts access to varying hierarchical levels of system functionality and information. The access management function must:

i. Restrict access to information on a "least privilege" basis (e.g., users who are permitted inquiry privileges only will not be permitted to modify information).

ii. Restrict access to specific system functions and information based on an individual user profile, including inquiry only capabilities. Global access to all functions must be restricted to specified staff, with approval of MLTC.

iii. Restrict unsuccessful attempts to access system functions to three attempts, with a system function that automatically prevents further access attempts and records those occurrences.

b. The DBPM must make system information available to duly authorized representatives of MLTC and other State or Federal agencies to evaluate, through inspections or other means, the quality, appropriateness, and timeliness of services performed.

c. The DBPM's systems must contain controls to maintain information integrity. These controls must be in place at all appropriate points of processing. The controls must be tested in periodic and spot audits using a methodology to be developed jointly by MLTC and the DBPM.

d. Audit trails must be incorporated into all systems to allow information about source data files and documents to be traced through the processing stages to the point at which the information is finally recorded. The audit trails must:

i. Contain a unique log-on or terminal ID, the date, and time of any create/modify/delete action and, if applicable, the ID of the system job that effected the action.

ii. Have the date and identification "stamp" displayed on any online inquiry.

iii. Have the ability to trace data from the final place of recording back to its source data file or document.

iv. Be supported by listings, transaction reports, update reports, transaction logs, or error logs.

v. Facilitate auditing of individual records as well as batch audits.

vi. Be maintained online for no less than two (2) years and be retrievable within 48 hours.

e. The DBPM's systems must have inherent functionality that prevents the alteration of finalized records.

f. The DBPM must provide for the physical safeguarding of its data processing facilities and the systems and information housed within those facilities. The DBPM must provide MLTC with access to data facilities on request. The physical security provisions must be in effect for the duration of this contract.

g. The DBPM must restrict perimeter access to equipment sites, processing areas, and storage areas through a key card or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access.

h. The DBPM must include physical security features designed to safeguard processor site(s) including fire-retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel.

i. The DBPM must put in place procedures, measures, and technical security to prohibit unauthorized access to the regions of the data communications network inside the DBPM's span of control. This includes but is not limited to ensuring that no provider or member services applications can be directly accessible over the internet and must be appropriately isolated to ensure appropriate access.

j. The DBPM must ensure that remote access users of its ISs can only access these systems through two-factor user authentication and by methods including VPN, which must be approved in writing and in advance by the State.

k. The DBPM must comply with recognized industry standards governing security of State and Federal automated data processing systems and information processing. At a minimum, the DBPM must conduct a security risk assessment and communicate the results in an IS security plan provided prior to the start date of operations. This risk assessment must also be made available to appropriate Federal agencies.

10. Systems Availability, Performance, and Problem Management Requirements

a. The DBPM must ensure that critical member and provider Internet and/or telephone-based functions and information, including but not limited to confirmation of DBPM enrollment (CME), electronic claims management (ECM), and self-service member and provider services functions

are available to the applicable IS users at any time, except during periods of scheduled system unavailability agreed to by the State and the DBPM. Unavailability caused by events outside of a DBPM's control is outside the scope of this requirement.

b. The DBPM must ensure that, at a minimum, all other system functions and information are available to the appropriate system users between the hours of 7:00 am and 7:00 pm, central time, Monday through Friday.

c. The DBPM must ensure that the systems and processes within its span of control associated with its data exchanges with the State are available and operational according to specifications and the data exchange schedule.

d. In the event of a declared major failure or disaster, the DBPM's eligibility/enrollment and claims processing systems must be back online within seventy-two (72) hours of the failure or disaster.

e. On discovery of any problem within its span of control that may jeopardize or is jeopardizing the availability and performance of critical systems functions and information, as defined in this section of the contract, including any problems affecting scheduled exchanges of data between the DBPM and the State, the DBPM must notify MLTC within 60 minutes of such discovery. In its notification the DBPM must explain in detail the impact to critical path processes, such as enrollment management and encounter submission processes.

f. When the problem results in delays in report distribution or problems with online access to critical systems functions and information during a business day, the DBPM must notify MLTC within fifteen (15) minutes of discovery of the problem. This notification will allow the applicable work activities to be rescheduled or handled based on IS unavailability protocols.

g. The DBPM must provide a minimum of hourly updates to MLTC on IS unavailability events, including problem resolution. At a minimum these updates must be provided via email or telephone.

h. The DBPM must resolve unscheduled IS unavailability and restore services of CME and ECM functions, caused by a failure of systems and telecommunications technologies within the DBPM's span of control, within sixty (60) minutes of the official declaration of system unavailability. Unscheduled system unavailability to any other DBPM IS functions caused by system and telecommunications technologies within the DBPM's span of control must be resolved, and the restoration of services implemented, within eight (8) hours of the official declaration of IS unavailability.

i. Cumulative system unavailability caused by systems or infrastructure technologies within the DBPM's span of control must not exceed twelve (12) hours during any continuous twenty (20) business day period.

j. The DBPM is not responsible for the availability and performance of systems and infrastructure technologies outside of its span of control.

k. Within five (5) business days of the occurrence of a system availability problem, the DBPM must provide MLTC with full written documentation that includes a CAP describing how the DBPM will prevent the problem from occurring again.

11. Contingency Plan

a. The DBPM, regardless of the architecture of its systems, must develop and be continually ready to implement, a contingency plan to protect the availability, integrity, and security of data during unexpected failures or disasters (either natural or man-made), to continue essential application or IS functions during or immediately following the failure or disaster.

b. Contingency plans must include a disaster recovery plan (DRP) and a business continuity plan (BCP). A DRP is designed to recover systems, networks, workstations, applications, etc., in the event of a disaster. A BCP must focus on restoring the operational function of the organization in the event of a disaster and includes items related to IT, as well as operational items, such as employee notification processes and the procurement of office space, equipment, and supplies needed to do business in emergency mode.

c. The DBPM must submit a final contingency plan to MLTC for review and approval no later than forty-five (45) calendar days before the contract start date.

d. At a minimum, the contingency plan must address the following scenarios:

i. The central computer installation and resident software are destroyed or damaged.

ii. System interruption or failures that result from network, operating hardware, software, or operations errors that compromise the integrity of transactions that are active in a live system at the time of the outage.

iii. System interruption or failure that result from network, operating hardware, software, or operations errors that compromise the integrity of data maintained in a live or archival system.

iv. System interruption or failure that result from network, operating hardware, software, or operational errors that do not compromise the integrity of transactions or data maintained in a live or archival system, but prevents access to the system, such as causing unscheduled system unavailability.

v. The plan must specify projected recovery times and data loss for mission-critical systems in the event of a declared disaster.

vi. The DBPM must annually test its plan through simulated disasters and lower level failures in order to demonstrate to MLTC that it can restore systems functions on a timely basis. In the event the DBPM fails to demonstrate through these tests that it can restore systems functions, the DBPM must submit a CAP to MLTC describing how the failure will be resolved within ten (10) business days of the conclusion of the test.

12. Off-site Storage and Remote Back-up

a. The DBPM must provide for off-site storage and a remote back-up of operating instructions, procedures, reference files, system documentation, and operational files.

b. The data back-up policy and procedures must include, but not be limited to:

i. Descriptions of the controls for back-up processing, including how frequently back-ups occur.

ii. Documented back-up procedures.

iii. The location of data that has been backed up (off-site or on-site, as applicable).

iv. Identification and description of what is being backed up as part of the back-up plan.

v. Any change in back-up procedures in relation to the DBPM's technology changes.

c. MLTC must be provided with a list of all back-up files to be stored at remote locations and the frequency by which these files are updated.

13. Records Retention

a. The DBPM must have online retrieval and access to documents and files for six (6) years in live systems and ten (10) years in archival systems, for audit and reporting purposes. The claims for services that have a once-in-a-life-time indicator must remain in the current/active claims history for claims editing and are not to be archived or purged. Online access to claims processing data must be possible by Medicaid ID number, provider ID number, and/or internal control number). The DBPM must provide 48-hour turnaround or shorter for requests for access to information that is six (6) years old, and 72-hour turnaround or shorter for requests for access to information in machine readable form, that is between six (6) and ten (10) years old. If an audit or administrative, civil, or criminal investigation or prosecution is in progress; or audit findings or administrative, civil, or criminal investigations or prosecutions are unresolved; then, information must be kept in electronic form until all tasks or proceedings are completed.

b. The historical encounter data submission must be retained for a period not less than six (6) years, following generally accepted retention guidelines.

T. REPORTING AND DELIVERABLES

1. General Requirements

a. This section of the RFP describes in general terms the requirements placed on the DBPM regarding State and Federal reporting. Program and financial reporting requirements are discussed throughout the RFP and summarized in Attachment 5 – Reporting Requirements. The DBPM must comply with all reporting requirements, or to the extent it does not it may be subject to penalties, sanctions, or contract termination.

b. All deliverables are subject to review by the State and will not be considered complete until deemed complete by MLTC. The format and content of each deliverable must be defined and agreed upon prior to the onset of work. The State will not review a deliverable unless the format and content has been approved in advance.

c. MLTC may grant approval, reject all or some part of the deliverable, or request that revisions be made by the DBPM. Additional review periods are required whenever revisions are requested or a deliverable is rejected. Each deliverable must be consistent with previously approved deliverables. The State reserves the right to require the DBPM to revise deliverables previously approved or to reject current deliverables based on inconsistencies with previously approved deliverables.

d. DBPM policies are subject to approval by MLTC, and will be monitored through operational reviews.

2. Ownership Disclosure

Federal laws require full disclosure of ownership, management, and control of Medicaid DBPMs (42 CFR §§455.100-455.106). The DBPM must disclose to MLTC this information at contract award, annually thereafter for each contract year, and within thirty (30) calendar days of any change in the DBPM's management, ownership or control.

3. Information Related to Business Transactions

a. The DBPM must furnish, to MLTC and the federal DHHS, information related to significant business transactions as set forth in 42 CFR §455.105. Failure to comply with this requirement may result in termination of this contract.

b. The DBPM must submit, within 30 calendar days of a request made by MLTC, full and complete information regarding:

i. The ownership of any subcontractor with whom/which the DBPM has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request.

ii. Any significant business transactions between the DBPM and any wholly owned supplier, or between the DBPM and any subcontractor, during the five (5) year period ending on the date of the request.

4. Encounter Data

a. The DBPM must comply with the required format and timelines provided by MLTC for the submission of encounter data. Encounter data includes claims paid or denied by the DBPM or the DBPM's subcontractors for services delivered to members through the DBPM during a specified reporting period. MLTC collects and uses this data for many purposes such as federal reporting, rate setting, risk adjustment, service verification, managed care quality improvement, utilization patterns, access to care determinations, and various research studies.

b. MLTC may change the encounter data transaction requirements with ninety (90) calendar days advance written notice to the DBPM. The DBPM must, on notice from MLTC, make the necessary

changes to its systems to comply with MLTC requirements and provide notice of the changes to its contractors. It is the DBPM's responsibility to ensure that its contractors comply with MLTC requirements within the specified timeframes.

5. Financial Reporting

a. The DBPM must submit quarterly and annual financial reporting to MLTC. The details and timing of the reports will be developed with DBPM input. Examples of expected reports include, but are not limited to:

i. Certification statement.

ii. Balance sheet.

iii. Income statement.

iv. Lag (incurred but not reported) report.

v. Medical loss ratio calculation.

vi. Related-party statements.

vii. Run rate income statement.

viii. Auditor's report and report on internal controls.

ix. Performance measure calculation reports.

x. Annual disclosure report.

xi. Enrollment/revenue reconciliation.

b. MLTC also requires the DBPM to electronically provide detailed claims and membership data that tie to the run rate income statement. The DBPM's response to a MLTC data request must include, at a minimum, the following data fields:

i. Rating category.

ii. Category of service.

iii. Utilizers.

iv. Paid dollars.

v. Paid units.

vi. Units measure.

vii. Paid days.

viii. Cost per unit.

ix. Cost per day.

x. Per member per month (PMPM) cost.

xi. Member months.

xii. Month of service.

xiii. Month of payment.

c. The DBPM must obtain an annual financial audit acceptable to MLTC for any expenditure of State-awarded funds made by the DBPM. The audit must include management letters and audit recommendations.

d. State auditors must have access to all records and accounts for the contract year(s) in which the award was made. The DBPM must comply with Federal and State single audit standards, as applicable. MLTC reserves the right to audit or request an audit (at the DBPM's expense) of any data or report required under the contract.

e. Risk contracts must provide that MLTC and CMS may inspect and audit any financial records of the DBPM or its contractors. There must be no restrictions on the right of the State or Federal government to conduct whatever inspections and audits either of them deem necessary to ensure quality, appropriateness, or timeliness of services and reasonableness of their costs.

6. Information on Persons Convicted of Crimes

The DBPM must furnish to MLTC information about any person convicted of a criminal offense under a program relating to Medicare (Title XVIII) and Medicaid (Title XIX) as set forth in 42 CFR §455.106. Failure to comply with this requirement may lead to termination of this contract.

7. Submission Process and Timeframes

a. The DBPM must ensure that all required deliverables, which may include documents, manuals, files, plans, or reports, as stated in this RFP or required at a future date, are submitted to MLTC in a timely manner for review and approval. The DBPM's failure to submit the deliverables as specified may result in the assessment of liquidated damages, as stated in Section IV.U – Contract Monitoring of this RFP.

b. MLTC may, at its discretion, require the DBPM to submit additional deliverables both ad hoc and recurring. If MLTC requests any revisions to the deliverables already submitted, the DBPM must make the changes and re-submit the deliverables, according to the time period and format required by MLTC. A sixty- (60) calendar-day notice will be given on changes to any ongoing reports.

c. Unless otherwise specified in Attachment 5 – Reporting Requirements, deadlines for submitting deliverables are:

i. Monthly deliverables must be submitted no later than the 15th calendar day of the following month.

ii. Quarterly deliverables must be submitted within forty-five (45) calendar days of the last day of the calendar quarter immediately preceding the due date.

iii. Annual reports and files, and other deliverables due annually, must be submitted within thirty (30) calendar days following the 12th month of the contract year; except, those annual reports that are specifically exempted from this thirty- (30) calendar-day deadline by this RFP or by written agreement between MLTC and the DBPM.

iv. If a due date falls on a weekend or State-recognized holiday, deliverables are due the next business day.

8. Ad Hoc Reports

a. The DBPM must prepare and submit any other reports required and requested by MLTC, any of MLTC's designees, the State Legislature, or CMS that are related to the DBPM's duties and obligations under this contract. Information considered to be proprietary must be clearly identified by the DBPM at the time of submission.

b. Ad-hoc reports must be submitted within five (5) business days from the date of request, unless otherwise specified by MLTC.

9. Errors

a. The DBPM must prepare complete and accurate reports for submission to MLTC. If after preparation and submission, a DBPM error is discovered, either by the DBPM or MLTC, the DBPM must correct the error(s) and resubmit the report within the following timeframes:

i. For encounters, in accordance with the timeframes specified in the Section IV.R – Claims Management of this RFP.

ii. For all reports, fifteen (15) calendar days from the date of discovery by the DBPM or date of written notification by MLTC (whichever is earlier). MLTC may at its discretion extend the due date if an acceptable plan of correction has been submitted and the DBPM can demonstrate to MLTC's satisfaction that the problem cannot be corrected in fifteen (15) calendar days.

b. Failure of the DBPM to respond within these timeframes may result in penalties per Section IV.U – Contract Monitoring.

10. Reporting Dashboard

a. The DBPM must work with MLTC to develop a reporting dashboard. The purpose of this dashboard is to provide DBPM and MLTC leadership with easily accessible DBPM results related to access to and quality of care, as well as program cost-effectiveness. Access to this dashboard will be determined in consultation with MLTC. The dashboard must be operational within six (6) months after the contract start date. The dashboard will augment, but not replace, other reporting templates required by MLTC. At its sole discretion, MLTC may determine that reports generated by this dashboard are sufficient and may no longer require the DBPM to complete similar or other reports. Dashboards must be updated within the timelines specified by MLTC. The reporting dashboard must include, at a minimum, statistics related to:

i. Member enrollment.

ii. Call center statistics.

iii. Status of credentialing applications.

iv. Performance measures.

v. Care management.

vi. Pending grievances and appeals.

vii. Pending claims.

viii. Financial status.

ix. Any other issues as identified by MLTC.

b. MLTC reserves the right to require DBPM participation in an alternative reporting and dashboard system at its discretion.

U. CONTRACT MONITORING

1. DBPM Policies and Procedures

MLTC will provide the DBPM with updates to attachments; other information; interpretation of all pertinent State and/or Federal Medicaid regulations; and, DBPM policies, procedures, and guidelines affecting the provision of services under this contract. The DBPM will submit written requests to MLTC for additional clarification, interpretation, or other information, as appropriate. Provision of this information does not relieve the DBPM of its obligation to keep informed of applicable State and Federal laws related to its obligations under this contract.

2. Operational Reviews

a. In accordance with CMS requirements (42 CFR §438.66), MLTC, or its designee, will conduct periodic operational reviews to ensure program compliance and identify best practices. The reviews will identify and make recommendations for areas of improvement, monitor the DBPM's progress towards implementing mandated programs or operational enhancements, and provide the DBPM with technical assistance when necessary. The type and duration of the review will be solely at MLTC's discretion.

b. This monitoring by MLTC does not relieve the DBPM of its responsibility to continuously monitor its providers' and subcontractors' performance to ensure compliance with contract provisions.

c. Except in cases in which advance notice is not possible or advance notice may render the review less useful, MLTC will give the DBPM a minimum of three (3) weeks advance notice of the date of a review. MLTC reserves the right to conduct reviews without notice to monitor contractual requirements and performance.

d. MLTC, or its designee, will coordinate with the DBPM to establish the scope of any review, the review site (if on-site), relevant time frames for obtaining information, and the review criteria.

e. MLTC may request, at the expense of the DBPM, to conduct on-site reviews of functions performed at out-of-State locations and will coordinate travel arrangements and accommodations with the DBPM.

f. The review may include an inspection of the DBPM's facilities, as well as auditing or review of any records including, but not limited to, dental records, grievances, utilization and medical management, finance, management systems, policies and procedures, or any other areas or materials relevant to this contract.

g. In preparation for a review, the DBPM must cooperate with MLTC, by forwarding, in advance, policies, procedures, job descriptions, contracts, records, logs, and any other materials upon request. Documents not requested in advance must be made available during the course of a review. DBPM staff must be available at all times during a review. The DBPM must provide an appropriate private workspace and internet access to the review team.

h. The DBPM will be provided a copy of the draft review report and given the opportunity to comment on any review finding prior to MLTC issuing the final report, unless the review concerns potential fraudulent or criminal action. The DBPM must develop CAPs based on the recommendations, if necessary. However, once MLTC finalizes the findings, the DBPM must comply with all recommendations that result from the review. Failure to comply with recommendations for improvement may result in monetary penalties and/or sanctions.

i. CAPs and any modifications must meet the approval of MLTC. Unannounced follow-up reviews may be conducted at any time after the initial operational review, to determine the DBPM's progress in implementing the recommendations and achieving compliance.

3. Business Reviews

a. MLTC will schedule business reviews with each DBPM, which will be held on a quarterly basis or frequency as determined by MLTC. Business reviews are regular meetings with MLTC staff and MLTC leadership to review ongoing business operations of the DBPM, performance metrics, quality outcomes, and other topics as determined by MLTC.

b. The DBPM must participate in MLTC-organized business reviews.

c. The DBPM Executive Director will participate in, and ensure other key staff members as requested by MLTC to participate in the business reviews. The Executive Director must ensure the DBPM is prepared to participate pursuant to an MLTC-developed agenda and/or presentation template.

4. Contract Non-Compliance

a. Administrative Actions

i. In the event the DBPM fails to perform any obligation under the contract, at the discretion of MLTC, the DBPM may be subject to the administrative actions detailed below. MLTC will provide written notice to the DBPM of non-compliance or deficiency. Administrative actions exclude liquidated damages, intermediate sanctions, and termination, and include:

a) A warning through written notice (may include consultation).

b) Education about program policies and billing procedures. The DBPM may be required to participate in a provider education program as a condition of continued participation. DBPM education programs may include attendance at quarterly meetings, at which issues and topics may include, but not be limited to:

1). The use of procedure codes.

2). The review of key provisions of the DBP.

3). Instruction about reimbursement rates.

4). Instruction about how to inquire about coding problems.

5). Quality/medical issues.

c) Submission of a CAP. MLTC will approve and monitor implementation of the CAP through available reporting resources, on-site evaluations, and required status reports. The CAP must address:

1). The steps to be taken by the DBPM to comply with the terms of the contract.

2). A timeframe for anticipated compliance and a date certain for correction of the issue.

b. Liquidated Damages

MLTC may impose liquidated damages if the terms of the CAP are not met. Liquidated damages will continue until satisfactory correction of the issue has occurred, as determined by MLTC.

In the event the DBPM fails to comply with any term or condition of the RFP or specifically subparagraphs i – ix as listed below, the damages detailed in this section and Attachment 10 – Liquidated Damages may be assessed in the sole discretion of MLTC. If assessed, the damages will be used to reduce MLTC's payments to the DBPM. If the damages exceed amounts due from MLTC, the DBPM will be required to make cash payment to MLTC for the amount in excess.

i. Readiness Review

MLTC will conduct a formal review of the DBPM's readiness to implement all required services described in this RFP. Should the DBPM fail the review, MLTC may assess damages of $5,000.00 for each calendar day until such time as MLTC certifies that the DBPM has met all readiness requirements.

ii. Date of Implementation

Should the DBPM fail to begin full operations on the contract start date, and should MLTC determine that the DBPM is responsible for the delay, MLTC may assess damages of $10,000.00 per calendar day for each day beyond the contract start date that the DBPM fails to begin full operations.

iii. Timely Reports and Data Delivery Requirements

All reports and data (including encounters) required by the contract must be produced in the format and media approved by MLTC and submitted by the due dates required by MLTC. If the data is incomplete, incorrect, or untimely, MLTC may assess a penalty of

$1,000.00 for each calendar day that a report or data delivery is late, includes less than the required copies, or is not in the approved format.

iv. Network Performance Requirement

Between the date of award and the contract start date, the DBPM must have a contracted provider network in place, sufficient in size and composition to meet the service requirements of its members on the contract start date. The required attestation of network sufficiency must be submitted to MLTC a minimum of ninety (90) calendar days prior to the contract start date. MLTC may assess a penalty of $1,000.00, per calendar day, for each day that the provider network is not adequate to meet the service needs of its members.

v. Employment of Key Personnel

The DBPM must meet all key personnel requirements specified in Section IV.D – Staffing Requirements of this RFP. MLTC may assess a penalty of $1,000.00 per day, per position, for each day after the thirty (30) allowed calendar days that a key position remains unfilled by a qualified person approved by MLTC.

vi. Excessive Reversals on State Fair Hearings

If more than ten percent (10%) of the DBPM decisions on member appeal are overturned by the State Fair Hearing process the DBPM may be assessed a penalty of $25,000.00 per reversal exceeding ten percent (10%) in a contract year.

vii. Marketing and Member Education Violations

a) Whenever MLTC in its discretion determines the DBPM or any of its agents, subcontractors, volunteers, or providers has engaged in any unfair, deceptive, or prohibited marketing or member education practices in connection with proposing, offering, selling, soliciting, or providing any dental services, in the discretion of MLTC one or more of the remedial actions specified in this Section must apply.

b) Unfair, deceptive, or prohibited marketing practices must include, but are not limited to:

1). Failing to secure written approval before distributing marketing or member materials.

2). Engaging in, encouraging, or facilitating prohibited marketing by a provider.

3). Failing to meet time requirements for communication with new members (e.g., distribution of welcome packets or welcome calls).

4). Failing to provide interpretation services or make materials available in required languages.

5). Engaging in any of the prohibited marketing or member education practices detailed in this RFP.

6). Making false or misleading verbal or written statements, visual descriptions, advertisements, or other representations of any kind that have the capacity, tendency, or effect of deceiving or misleading DBPM members or potential members about any dental services, the DBPM, any dental provider, or the DBP.

7). Representing that a DBPM or network provider offers any service, benefit, access to care, or choice that it does not offer.

8). Representing that a DBPM or dental provider has any status, certification, qualification, sponsorship, affiliation, or licensure that it does not possess.

9). Failing to state a material fact, if the failure deceives or tends to deceive.

10). Offering any kickback, bribe, award, or benefit to any Medicaid enrollee as an inducement to select, or to refrain from selecting, any dental service DBPM or dental provider.

11). Using the Medicaid member's or another person's information that is confidential, privileged, or which cannot be disclosed to or obtained by the user without violating a State or Federal confidentiality law, including:

i) Medical record and/or dental record information.

ii) Information that identifies the member as a recipient of any government-sponsored or mandated health coverage program.

12). Using any device or artifice in advertising a DBPM or soliciting Medicaid enrollees that misrepresents the solicitor's profession, status, affiliation, or mission.

c) If MLTC determines that the DBPM has violated any of the marketing and/or outreach requirements outlined in the contract, the DBPM may be subject to damages up to $10,000.00 per violation. The amount of damages is at the discretion of MLTC.

viii. Other Liquidated Damages may be assessed as otherwise permitted in the RFP.

ix. MLTC will provide written notice and factual basis for the assessment of liquidated damages to the DBPM. Within ten (10) business days of receipt of the written notice, the DBPM may appeal the assessment of liquidated damages in writing to the Deputy Director of the Delivery Systems Section of MLTC. A written decision will be issued within ten (10) business days. Within five (5) business days of receipt of the written decision, the DBPM may request reconsideration of the decision in writing to the Director of MLTC. The Director must issue a written opinion within thirty (30) calendar days. No further appeals will be allowed.

c. Failure to Provide Benefits and Services

If MLTC determines that the DBPM has failed to provide one or more benefits or services, MLTC will direct the DBPM to provide the benefit(s) or service(s). If the DBPM continues to refuse to provide the benefit(s) or service(s), MLTC will authorize the member(s) to obtain the services from another source and will notify the DBPM in writing that the DBPM will be charged the actual cost of the services. In this event, funds equivalent to the expense(s) will be deducted from the next monthly capitation payment or a future payment as determined by MLTC. With the deductions, when made, MLTC will provide a list of the affected member(s) concerning which payments to the DBPM have been deducted, the nature of the benefit(s) or service(s) denied, and payments MLTC made or will make to provide the medically necessary covered benefit(s) or service(s).

5. Intermediate Sanctions

a. Acts or Failures to Act Subject to Intermediate Sanctions

The following violations are grounds for intermediate sanctions that may be imposed in the sole discretion of MLTC when the DBPM act or fails to act:

i. The DBPM fails substantially to provide medically necessary services that the DBPM is required to provide, under law or under its contract with MLTC, to a member covered under the contract.

ii. The DBPM imposes on members premiums or charges that are in excess of allowable charges permitted under the Medicaid program.

iii. The DBPM discriminates against members on the basis of their health status or need for health care services.

iv. The DBPM misrepresents or falsifies information that it furnishes to CMS or to the State.

v. The DBPM misrepresents or falsifies information that it furnishes to a member, enrollee, or dental provider.

vi. The DBPM fails to comply with the requirements for provider incentive plans, if applicable.

vii. The DBPM distributes, directly or indirectly through any agent, marketing materials that were not approved in advance by MLTC or that contain false or materially misleading information.

viii. The DBPM violates any of the other applicable requirements of sections 1903(m) or 1932 of the Social Security Act and any implementing regulations.

ix. Any other action or inaction that the State deems a violation and that merits a sanction consistent with this section.

b. Other Misconduct Subject to Intermediate Sanctions

MLTC in its sole discretion also may impose sanctions against a DBPM if it finds any of the following non-exclusive actions or occurrences:

i. The DBPM failed to correct deficiencies in its delivery of service after having received written notice of these deficiencies from MLTC.

ii. The DBPM was excluded from participation in Medicare because of fraudulent or abusive practices, pursuant to Public Law 95-142.

iii. The DBPM or any of its owners, officers, or directors was convicted of a criminal offense relating to performance of the contract with MLTC, of fraudulent billing practices, or of any negligent practice resulting in death or injury to a DBPM member.

iv. The DBPM presented, or caused to be presented, any false or fraudulent claim for services, or submitted or caused to be submitted false information to the State or CMS.

v. The DBPM engaged in a practice of charging and accepting payment (in whole or part) from members for services for which a PMPM payment was made to the DBPM by MLTC.

vi. The DBPM rebated or accepted a fee or portion of a fee or charge for a member referral.

vii. The DBPM failed to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments.

viii. The DBPM failed to keep, or make available for inspection, audit, or copying, the records regarding payments claimed for providing services.

ix. The DBPM failed to furnish any information requested by MLTC regarding payments for providing goods or services.

x. The DBPM furnished goods or services to a member, which at the sole discretion of MLTC, and based on competent medical judgment and evaluation, are determined to be insufficient for his/her needs, harmful to the member, or of grossly inferior quality.

c. Sanction Types

i. MLTC may impose the following intermediate sanctions at its sole discretion:

a) Civil monetary penalties as specified in Attachment 10 – Liquidated Damages.

b) Appointment of temporary management as described in this section.

c) Granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll.

d) Suspension of all new enrollments into the DBPM.

e) Suspension of payment for members enrolled after the effective date of the sanction, unless and until CMS or MLTC is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

f) Any other remedy, right, or sanction allowed under the contract or applicable law.

ii. Payments under the contract will be denied for new members when, and for as long as, payment for those members is denied by CMS in accordance with the requirements of 42 CFR §438.730.

d. Notice of Sanction to DBPM and CMS

i. Prior to imposing any intermediate sanction, the State will give the DBPM timely written notice that explains the following:

a) The basis and nature of the sanction.

b) The DBPM's right to an administrative hearing.

ii. MLTC will give the CMS Regional Office written notice whenever it imposes or lifts an intermediate sanction for one of the violations listed in 42 CFR §438.700, specifying the affected DBPM, the kind of sanction, and the reason for MLTC's decision to lift a sanction (if applicable). Notice will be given no later than thirty (30) calendar days after MLTC imposes or lifts the sanction.

e. Payment of Liquidated Damages and Sanctions

i. The purpose of establishing and imposing liquidated damages is to provide a means for MLTC to obtain the services and level of performance required for successful operation of the contract. MLTC's failure to assess liquidated damages in one or more of the particular instances described herein will in no event waive the right, power, or authority of MLTC to assess additional liquidated damages or actual damages at that time or in the future.

ii. The decision to impose liquidated damages (including intermediate sanctions) will include consideration of some or all of the following factors:

a) The duration of the violation.

b) Whether the violation (or one that is substantially similar) has previously occurred.

c) The DBPM's compliance history.

d) The severity of the violation and whether it imposes an immediate threat to the health or safety of the DBPM's members.

e) The good faith exercised by the DBPM in attempting to achieve or remain in compliance.

iii. The violations described in Attachment 10 – Liquidated Damages are examples of the grounds, but not an exclusive list of grounds, on which MLTC may impose liquidated damages.

iv. Any liquidated damages assessed by MLTC that cannot be collected through withholding from future capitation payments will be due and payable to MLTC within thirty (30) calendar days after the DBPM's receipt of the notice of liquidated damages. However, in the event an appeal by the DBPM results in a decision in favor of the DBPM, any funds withheld by MLTC will be returned to the DBPM as consistent with the appeal decision.

f. Special Rules for Temporary Management

i. MLTC may install temporary management if it finds that there is continued egregious behavior by the DBPM, including, but not limited to, behavior that is described in 42 CFR §438.706, or that is contrary to any requirements of Sections 1903(m) and 1932 of the Social Security Act.

ii. MLTC will impose temporary management if it finds that a DBPM has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act. In this circumstance, MLTC must also notify members of the DBPM of their right to select another DBPM, and allow them to do so. The State may not delay imposition of temporary management to provide a hearing regarding the sanction. In addition, MLTC will not terminate temporary management until it determines that the sanctioned behavior will not recur.

g. Payment of Outstanding Monies or Collections from DBPM

The DBPM will be paid for any outstanding monies due less any assessed liquidated damages or sanctions. If liquidated damages exceed monies due, collection will be made from the DBPM performance bond or any insurance policy or policies required under this contract, as appropriate. The rights and remedies provided in this clause must not be exclusive and are in addition to any other rights and remedies provided by law or under this contract.

h. Provider Sanctions

Nothing contained in this RFP must prohibit MLTC, pursuant to applicable law, from imposing sanctions, including civil liquidated damages, license revocation, and Medicaid termination, on a dental provider for its violations of applicable law.

V. TRANSITION AND IMPLEMENTATION

1. Preliminary Implementation Plan

a. The DBPM is responsible for submitting a preliminary implementation plan with its proposal. This plan must describe the DBPM's plan to comply with all the major areas of the contract including:

i. Member services.

ii. Network development and management.

iii. Provider education.

iv. Quality management, including credentialing.

v. Utilization management.

vi. Transition and care coordination.

vii. Information systems management.

viii. Claims management.

ix. Grievances and appeals.

b. The preliminary implementation plan must also address staffing, facilities, and other operational issues as identified in this RFP and the DBPM's proposal. The plan must include tasks, deliverables, and milestones necessary to implement the program.

2. Transition Period

a. The transition period for the contract begins on the date of award and ends ninety (90) calendar days after the contract start date. During the transition period the DBPM must implement the requirements of the contract and collaborate with MLTC to facilitate a seamless transition for providers and members in order to prevent an interruption of services and to ensure continuity of care for members.

b. On contract award, the DBPM must immediately begin collaborating with MLTC to review the contract, its proposal, and preliminary implementation plan. The DBPM must provide to MLTC implementation plan updates, weekly, and collaborate with MLTC to address the following:

i. Defining project management and reporting standards.

ii. Establishing communication protocols between the DBPM, MLTC, existing providers, Heritage Health MCOs, and other relevant MLTC contractors such as the non-emergency transportation coordinator.

iii. Defining expectations for the content and format of contract deliverables.

iv. Resolving transition and implementation issues to MLTC's satisfaction.

c. At minimum, the DBPM must have the following key staff in place to participate in the transition coordination/collaboration process:

i. Executive Director.

ii. Dental Director.

iii. Operations Manager.

iv. Provider Services Manager.

v. Member Services Manager.

vi. Claims Administrator.

vii. Information Management and Systems Director.

3. Comprehensive Implementation Plan

a. Within 15 calendar days of the date of award, the DBPM must develop a detailed and comprehensive implementation plan to monitor progress throughout the transition/implementation period.

b. The DBPM must include in its implementation plan a detailed description of its implementation tasks, methods, staff accountable for completing tasks, and timelines, at a minimum for the following areas/issues:

i. Staffing.

ii. Data systems including system readiness testing, acceptance testing, transfer of electronic data and records, and a data conversion plan to include, at a minimum, intake, closure, eligibility, demographics, encounters, and other file data.

iii. Network development.

iv. Clinical transition.

v. Utilization management.

vi. Care coordination.

vii. Quality management.

viii. Member services.

ix. Member outreach/communications.

x. Security, business continuity, disaster recovery, and contingency planning.

xi. Member Handbook and Provider Manual completion.

xii. Claims and eligibility interface development.

xiii. Compliance plan.

xiv. Financial reporting plan.

xv. Member and staff orientation and training plans.

xvi. Post-implementation deliverables.

4. Network Adequacy Requirement

The DBPM must have a contracted provider network in place, sufficient in size and composition, to meet MLTC's access standards and the requirements of the covered population ninety (90) calendar days prior to the contract's start date. The DBPM should submit to MLTC a network development plan with its proposal. This plan must be updated upon contract award and bi-weekly until the contract start date. The plan must detail the DBPM's network, including GeoAccess reports, and describe any provider network gaps and the DBPM's remediation plans. Additional requirements regarding network adequacy are included in Section IV.I – Provider Network Requirements of this RFP.

5. Personnel

The DBPM must submit key staff resumes with its proposal, as possible. All key staff, as detailed in Section IV.D – Staffing Requirements must be hired prior to the Readiness Review. A minimum of two (2) weeks prior to the readiness review, the DBPM must submit to MLTC the resumes of any key staff member (that was not submitted with the DBPM's proposal) for MLTC review and approval. At that time, the DBPM must submit updated organizational charts. The DBPM must have sufficient personnel working and operating in the State during the transition and implementation period in order to be fully compliant with the terms of the contract.

6. Readiness Review

a. Prior to the contract start date, MLTC will conduct an operational and financial readiness review of the DBPM, and will provide needed technical assistance. The DBPM must cooperate with MLTC's review process to assess the DBPM's operational readiness and ability to provide covered services to members as of the contract start date. The DBPM will be permitted to commence operations, and Medicaid enrollees will be enrolled with the DBPM, only if the readiness review factors are met to MLTC's satisfaction.

b. Based on the results of the review, MLTC will issue a letter of findings and, if necessary, request a CAP from the DBPM.

c. The readiness review will cover all provisions of the contract with a particular focus on assessing the following areas:

i. Network adequacy.

ii. Staffing adequacy.

iii. Subcontracts.

iv. Provider services.

v. Member services.

vi. Quality management.

vii. Care coordination.

viii. Utilization management.

ix. Financial management.

x. Information processing and system testing.

xi. Continuity of care.

xii. Grievance and appeal process.

d. During the readiness review, the DBPM must provide to MLTC staff access to DBPM staff, operational documentation (including a demonstration of computer systems), private workspace, and the internet.

e. If the DBPM is unable to demonstrate its ability to meet the requirements of this contract, as determined by MLTC, within the time frames specified by MLTC, MLTC may terminate this contract and have no liability for payment to the DBPM.

W. TERMINATION OR EXIPIRATION OF DBPM CONTRACT

The turnover requirements in this Section are applicable upon termination or expiration of the contract.

1. General Turnover Requirements

In the event the contract is terminated or expired for any reason, the DBPM must:

a. Comply with all terms and conditions stipulated in the contract, including continuation of core dental benefits and services under the contract, until the termination effective date.

b. Promptly supply all information necessary for the reimbursement of any outstanding claims.

c. Comply with direction provided by MLTC to assist in the orderly transition of equipment, services, software, leases, etc. to MLTC or a third party designated by MLTC.

2. Turnover Plan

a. In the event of written notification of termination of the contract by either party, the DBPM must submit a Turnover Plan within thirty (30) calendar days from the date of notification, or circumstances necessitate a shorter timeframe, unless other appropriate timeframes have been mutually agreed upon by both the DBPM and MLTC. The Plan must address the turnover of records and information maintained by the DBPM relative to core dental benefits and services provided to Medicaid members for the time form specified by MLTC. The Turnover Plan must be a comprehensive document detailing the proposed schedule, activities, and resource requirements associated with the turnover tasks. The Turnover Plan must be approved by MLTC.

b. If the contract is not terminated by written notification as provided in this Section, the DBPM must propose a Turnover Plan six (6) months prior to the end of the contract period, including any extensions to such period. The Plan must address the possible turnover of the records and information maintained to either MLTC or a third party designated by MLTC. The Turnover Plan must be a comprehensive document detailing the proposed schedule, activities, and resource requirements associated with the turnover tasks. The Turnover Plan must be approved by MLTC.

c. As part of the Turnover Plan, the DBPM must provide MLTC with copies of all relevant member and core dental benefits and services data, documentation, or other pertinent information necessary, as determined by MLTC, for MLTC or a subsequent DBPM to assume the operational activities successfully. This includes correspondence, documentation of ongoing outstanding

issues, and other operations support documentation. The Plan will describe the DBPM's approach and schedule for transfer of all data and operational support information, as applicable. The information must be supplied in media and format specified by MLTC and according to the schedule approved by MLTC.

3. Transfer of Data

a. The DBPM must transfer all data regarding the provision of member core dental benefits and services to MLTC or a third party, at the sole discretion of MLTC and as directed by MLTC. All transferred data must be compliant with HIPAA.

b. All relevant data must be received and verified by MLTC or the subsequent DBPM. If MLTC determines that not all of the data regarding the provision of member core dental benefits and services to members was transferred to MLTC or the subsequent DBPM, as required, or the data is not HIPAA compliant, MLTC reserves the right to hire an independent contractor to assist MLTC in obtaining and transferring all the required data and to ensure that all the data are HIPAA compliant. The reasonable cost of providing these services will be the responsibility of the DBPM.

4. Post-Turnover Services

a. Thirty (30) days following turnover of operations, the DBPM must provide MLTC with a Turnover Results report documenting the completion and results of each step of the Turnover Plan. Turnover will not be considered complete until this document is approved by MLTC.

b. If the DBPM does not provide the required relevant data and reference tables, documentation, or other pertinent information necessary for MLTC or the subsequent DBPM to assume the operational activities successfully, the DBPM agrees to reimburse MLTC for all reasonable costs, including, but not limited to, transportation, lodging, and subsistence for all state and federal representatives, or their agents, to carry out their inspection, audit, review, analysis, reproduction and transfer functions at the location(s) of such records.

c. The DBPM also must pay any and all additional costs incurred by MLTC that are the result of the DBPM's failure to provide the requested records, data or documentation within the time frames agreed to in the Turnover Plan.

d. The DBPM must maintain all files and records related to members and providers for five years after the date of final payment under the Contract or until the resolution of all litigation, claims, financial management review or audit pertaining to the Contract, whichever is longer. The DBPM agrees to repay any valid, undisputed audit exceptions taken by MLTC in any audit of the contract.

V. PROPOSAL INSTRUCTIONS

This section documents the mandatory requirements that must be met by bidders in preparing the Technical and Cost Proposal. Bidders should identify the subdivisions of "Project Description and Scope of Work" clearly in their proposals; failure to do so may result in disqualification. Failure to respond to a specific requirement may be the basis for elimination from consideration during the State's comparative evaluation.

Proposals are due by the date and time shown in the Schedule of Events. Content requirements for the Technical and Cost Proposal are presented separately in the following subdivisions; format and order:

A. PROPOSAL SUBMISSION

1. REQUEST FOR PROPOSAL FORM

By signing the "Request for Proposal for Contractual Services" form, the bidder guarantees compliance with the provisions stated in this Request for Proposal, agrees to the Terms and Conditions stated in this Request for Proposal unless otherwise agreed to, and certifies bidder maintains a drug free work place environment.

The Request for Proposal for Contractual Services form must be signed in ink and returned by the stated date and time in order to be considered for an award.

Further, Section III. Terms and Conditions must be returned with the proposal response.

2. CORPORATE OVERVIEW

The Corporate Overview section of the Technical Proposal should consist of the following subdivisions:

a. BIDDER IDENTIFICATION AND INFORMATION

The bidder must provide the full company or corporate name, address of the company's headquarters, entity organization (corporation, partnership, proprietorship), state in which the bidder is incorporated or otherwise organized to do business, year in which the bidder first organized to do business and whether the name and form of organization has changed since first organized.

b. FINANCIAL STATEMENTS

The bidder must provide financial statements applicable to the firm. If publicly held, the bidder must provide a copy of the corporation's most recent audited financial reports and statements, and the name, address, and telephone number of the fiscally responsible representative of the bidder's financial or banking organization.

If the bidder is not a publicly held corporation, either the reports and statements required of a publicly held corporation, or a description of the organization, including size, longevity, client base, areas of specialization and expertise, and any other pertinent information, must be submitted in such a manner that proposal evaluators may reasonably formulate a determination about the stability and financial strength of the organization. Additionally, a non-publicly held firm must provide a banking reference.

The bidder must disclose any and all judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization, or state that no such condition is known to exist.

The State may elect to use a third-party to conduct credit checks as part of the corporate overview evaluation.

c. CHANGE OF OWNERSHIP

If any change in ownership or control of the company is anticipated during the twelve (12) months following the proposal due date, the bidder must describe the circumstances of such change and indicate when the change will likely occur. Any change of ownership to an awarded vendor(s) will require notification to the State.

d. OFFICE LOCATION

The bidder's office location responsible for performance pursuant to an award of a contract with the State of Nebraska must be identified.

e. RELATIONSHIPS WITH THE STATE

The bidder shall describe any dealings with the State over the previous five (5) years. If the organization, its predecessor, or any party named in the bidder's proposal response has contracted

with the State, the bidder shall identify the contract number(s) and/or any other information available to identify such contract(s). If no such contracts exist, so declare.

f. BIDDER'S EMPLOYEE RELATIONS TO STATE

If any party named in the bidder's proposal response is or was an employee of the State within the past twelve (12) months, identify the individual(s) by name, State agency with whom employed, job title or position held with the State, and separation date. If no such relationship exists or has existed, so declare.

If any employee of any agency of the State of Nebraska is employed by the bidder or is a Subcontractor to the bidder, as of the due date for proposal submission, identify all such persons by name, position held with the bidder, and position held with the State (including job title and agency). Describe the responsibilities of such persons within the proposing organization. If, after review of this information by the State, it is determined that a conflict of interest exists or may exist, the bidder may be disqualified from further consideration in this proposal. If no such relationship exists, so declare.

g. CONTRACT PERFORMANCE

If the bidder or any proposed Subcontractor has had a contract terminated for default during the past five (5) years, all such instances must be described as required below. Termination for default is defined as a notice to stop performance delivery due to the bidder's non-performance or poor performance, and the issue was either not litigated due to inaction on the part of the bidder or litigated and such litigation determined the bidder to be in default.

It is mandatory that the bidder submit full details of all termination for default experienced during the past five (5) years, including the other party's name, address, and telephone number. The response to this section must present the bidder's position on the matter. The State will evaluate the facts and will score the bidder's proposal accordingly. If no such termination for default has been experienced by the bidder in the past five (5) years, so declare.

If at any time during the past five (5) years, the bidder has had a contract terminated for convenience, non-performance, non-allocation of funds, or any other reason, describe fully all circumstances surrounding such termination, including the name and address of the other contracting party.

h. SUMMARY OF BIDDER'S CORPORATE EXPERIENCE

The bidder shall provide a summary matrix listing the bidder's previous projects similar to this Request for Proposal in size, scope, and complexity. The State will use no more than three (3) narrative project descriptions submitted by the bidder during its evaluation of the proposal.

The bidder must address the following:

i. Provide narrative descriptions to highlight the similarities between the bidder's experience and this Request for Proposal. These descriptions must include:

- **a)** The time period of the project;
- **b)** The scheduled and actual completion dates;
- **c)** The Contractor's responsibilities;
- **d)** For reference purposes, a customer name (including the name of a contact person, a current telephone number, a facsimile number, and e-mail address); and
- **e)** Each project description shall identify whether the work was performed as the prime Contractor or as a Subcontractor. If a bidder performed as the prime Contractor, the description must provide the originally scheduled completion date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget.

ii. Contractor and Subcontractor(s) experience must be listed separately. Narrative descriptions submitted for Subcontractors must be specifically identified as Subcontractor projects.

iii. If the work was performed as a Subcontractor, the narrative description shall identify the same information as requested for the Contractors above. In addition, Subcontractors

shall identify what share of contract costs, project responsibilities, and time period were performed as a Subcontractor.

i. SUMMARY OF BIDDER'S PROPOSED PERSONNEL/MANAGEMENT APPROACH

The bidder must present a detailed description of its proposed approach to the management of the project.

The bidder must identify the specific professionals who will work on the State's project if their company is awarded the contract resulting from this Request for Proposal. The names and titles of the team proposed for assignment to the State project shall be identified in full, with a description of the team leadership, interface and support functions, and reporting relationships. The primary work assigned to each person should also be identified.

The bidder shall provide resumes for all personnel proposed by the bidder to work on the project. The State will consider the resumes as a key indicator of the bidder's understanding of the skill mixes required to carry out the requirements of the Request for Proposal in addition to assessing the experience of specific individuals.

Resumes must not be longer than three (3) pages. Resumes shall include, at a minimum, academic background and degrees, professional certifications, understanding of the process, and at least three (3) references (name, address, and telephone number) who can attest to the competence and skill level of the individual. Any changes in proposed personnel shall only be implemented after written approval from the State.

j. SUBCONTRACTORS

If the bidder intends to Subcontract any part of its performance hereunder, the bidder must provide:

i. name, address, and telephone number of the Subcontractor(s);
ii. specific tasks for each Subcontractor(s);
iii. percentage of performance hours intended for each Subcontract; and
iv. total percentage of Subcontractor(s) performance hours.

3. TECHNICAL APPROACH

The technical approach section of the Technical Proposal must consist of the following subsections:

a. Understanding of the project requirements (limited to three (3) pages;
b. Response to proposal statements and questions in Attachment 11 – Proposal Statements and Questions; and
c. Proposal deliverables as listed in Attachment 12 – Policies, Procedures, and Plans.

Form A
Bidder Contact Sheet
Request for Proposal Number 5427 Z1

Form A should be completed and submitted with each response to this Request for Proposal. This is intended to provide the State with information on the bidder's name and address, and the specific person(s) who are responsible for preparation of the bidder's response.

Preparation of Response Contact Information	
Bidder Name:	
Bidder Address:	
Contact Person & Title:	
E-mail Address:	
Telephone Number (Office):	
Telephone Number (Cellular):	
Fax Number:	

Each bidder shall also designate a specific contact person who will be responsible for responding to the State if any clarifications of the bidder's response should become necessary. This will also be the person who the State contacts to set up a presentation/demonstration, if required.

Communication with the State Contact Information	
Bidder Name:	
Bidder Address:	
Contact Person & Title:	
E-mail Address:	
Telephone Number (Office):	
Telephone Number (Cellular):	
Fax Number:	

Form B

Notification of Intent to Attend Pre-Proposal Conference

Request for Proposal Number 5427Z1

Bidder Name:	
Bidder Address:	
Contact Person:	
E-mail Address:	
Telephone Number:	
Fax Number:	
Number of Attendees:	

The "Notification of Intent to Attend Pre-Proposal Conference" form should be submitted to the State Purchasing Bureau via e-mail (as.materielpurchasing@nebraska.gov), facsimile (402-471-2089), hand delivered or US Mail by the date shown in the Schedule of Events.

Attachment 1

Medical Loss Ratio Requirements

DBPMs that receive capitation payments to provide covered services to Nebraska Medicaid members are required to rebate a portion of the capitation payments to MLTC in the event the DBPM does not meet the 85% MLR standard. This document describes the methodology for calculating the MLR and payment of any rebate due MLTC.

MLR Calculation

1. A DBPM's MLR is the ratio of net qualified medical expenses to qualifying revenue for the MLR calculation:

   MLR = net qualified medical expenses ÷ qualifying revenue for the MLR calculation

2. Net qualified medical expense, the numerator in the MLR calculation, is defined as the sum of:

   a. Claims incurred
   b. Claims incurred but not paid, plus provisions for adverse deviation and loss adjustment expense
   c. Medical incentive bonuses
   d. Reinsurance premiums less reinsurance recoveries
   e. Activities that improve health care quality, per 45 CFR 158.150
   f. Less related-party medical margin

3. The denominator for the MLR calculation is the aggregate of revenue earned by the DBPM and related parties, including parent and subsidy companies and risk bearing partners under this contract, including capitation payments and ignores federal and state premium taxes and non-operating income. Any earned holdback is not factored into the calculation.

4. An activity that improves health care quality can be included in the numerator as long as it meets one of three standards: 1) meets the definition in 45 CFR 158.150 of an activity that improves health care quality and is not excluded under 45 CFR 158.150; 2) is an activity specific to Medicaid managed care external quality review activities; or 3) is an activity related to health information technology and meaningful use, as defined in 45 CFR 158.151, and excludes any costs that are identified as excluded under 45 CFR 158.150 or other federal regulations.

5. The MLR will be calculated using the DBPM's "run rate" income statements (not "booked"). "Run rate" is incurred expenses and qualifying revenue for the MLR calculation attributable to activities in the specified contract year.

6. MLTC reserves the right to audit, request additional information, and revise the DBPM's estimates of its MLR calculation.

MLR Rebate

1. The DBPM must calculate the MLR and submit it to MLTC quarterly. MLTC will calculate the MLR settlement annually, between six and nine months after the end of the contract year.

2. For each reporting year in which the MLR is less than 85%, the DBPM must provide a rebate to MLTC per the following formula:

   MLR rebate = maximum of $0 and [(85% - MLR) x qualifying revenue for the MLR calculation]

471-000-39 Dental Periodicity Schedule for Children

The following schedule developed by the American Academy of Pediatric Dentistry (AAPD), provides a minimum basis for follow-up assessments after the initial examination to ensure continued health and well-being and to detect conditions requiring treatment. At six month intervals, dental screening is to be obtained from a dentist beginning at age one or earlier if medically necessary. Visual inspection of the mouth for very young children is recommended as part of each Health Screening.

AGE	6-12 Months	12-24 Months	2-6 Years	6-12 Years	12 Years and Older
Clinical oral examination[1,2]	•	•	•	•	•
Assess oral growth and development[3]	•	•	•	•	•
Caries-risk assessment[4]	•	•	•	•	•
Radiographic assessment[5]	•	•	•	•	•
Prophylaxis and topical fluoride[4,5]	•	•	•	•	•
Fluoride supplementation[6,7]	•	•	•	•	•
Anticipatory guidance/counseling[8]	•	•	•	•	•
Oral hygiene counseling[9]	Parent	Parent	Patient/parent	Patient/parent	Patient
Dietary counseling[10]	•	•	•	•	•
Injury prevention counseling[11]	•	•	•	•	•
Counseling for nonnutritive habits[12]	•	•	•	•	•
Counseling for speech/language development	•	•	•		
Substance abuse counseling				•	•
Counseling for intraoral/perioral piercing				•	•
Assessment and treatment of developing malocclusion			•	•	•
Assessment for pit and fissure sealants[13]			•	•	•
Assessment and/or removal of third molars					•
Transition to adult dental care					•

[1] First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by child's risk status/susceptibility to disease.

[2] Includes assessment of pathology and injuries.

[3] By clinical examination.

[4] Must be repeated regularly and frequently to maximize effectiveness.

[5] Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.

[6] Consider when systemic fluoride exposure is suboptimal.

[7] Up to at least 16 years.

[8] Appropriate discussion and counseling should be an integral part of each visit for care.

[9] Initially, responsibility of parent; as child develops, jointly with parent; then, when indicated, only child.

[10] At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.

[11] Initially play objects, pacifiers, car seats; then when learning to walk, sports and routine playing, including the importance of mouth guards.

[12] At first, discuss the need for additional sucking; digits vs pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clinching, or brusixm.

[13] For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

2700.4 Instructions for Completing Form CMS-416: Annual Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Participation Report

Effective for reporting period federal fiscal year 2014 (October 1, 2013 through September 30, 2014), with submission of Form CMS-416 by April 1, 2015.

A. Purpose -- The annual EPSDT report (form CMS-416) provides basic information on participation in the Medicaid child health program. The information is used to assess the effectiveness of state EPSDT programs in terms of the number of individuals under the age of 21 (by age group and basis of Medicaid eligibility) who are provided child health screening services, referred for corrective treatment, and receiving dental services. Child health screening services are defined for purposes of reporting on this form as initial or periodic screens required to be provided according to a state's screening periodicity schedule.

The completed report demonstrates the state's attainment of its participation and screening goals. Participation and screening goals are two different standards against which EPSDT performance (or penetration) is measured on the form CMS-416. From the completed reports, trend patterns and projections are developed for the nation and for individual states or geographic areas, from which decisions and recommendations can be made to ensure that eligible children are given the best possible health care. The information is also used to respond to congressional and public inquiries.

B. Reporting Requirement -- Each state that supervises or administers a medical assistance program under Title XIX of the Social Security Act must report annually on form CMS-416. These data must include services reimbursed directly by the state under fee-for-service, or through managed care, prospective payment, or other payment arrangement or through any other health or dental plans that contract with the state. Each state is required to collect encounter data (or other data as necessary) from managed care and prospective payment entities in sufficient detail to provide the information required by this report. You may contact your CMS regional office EPSDT specialist if you need technical assistance in completing this form.

C. Effective Date -- The form CMS-416's initial effective date was April 1, 1990. The first full fiscal year for which the form was effective began October 1, 1990. This version of the form is not changed from the previous version, but these associated revised instructions must be used for the reporting period federal fiscal year 2014, beginning October 1, 2013 through September 30, 2014, for data due to CMS on the form CMS-416 on or before April 1, 2015.

D. Submittal Procedure -- States should submit the annual form CMS-416 **and** your state medical **and** dental periodicity schedules electronically to the CMS central office via the EPSDT mailbox at **EPSDT@cms.hhs.gov** not later than April 1 of the year following the end of the federal fiscal year being reported. The **electronic form and instructions** are available on the CMS website at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html. States may **not** modify the electronic form. It must be submitted as downloaded. A "hard copy" submittal to CMS is no longer required.

States that have data limitations or that have made program changes during a reporting period that significantly impact data results, such as a change in the periodicity schedule to follow the most recent version of the American Academy of Pediatrics' Bright Futures™ guidelines, may include a note, not to exceed 50 words, with the cover correspondence accompanying their CMS-416 submissions. This information will be included in a separate footnotes page on the Medicaid.gov website, accompanying the national and state data reports.

E. Detailed Instructions -- **Enter your state name and the federal fiscal year as directed below.** For each of the following line items, report total counts by the age groups indicated and by whether categorically or medically needy (described below). In cases where calculations are necessary, perform separate calculations for the total column and for each age group. **You must enter a number in each line and column of data requested even if the number is "0."**

Important Reporting Requirements:

- Report age based upon the individual's age as of September 30 of the reporting year.
- Report all data in the age category reflecting the individual's age at the end of the federal fiscal year even if the individual received services in two age categories. For example, if a child turned age 3 on September 1st, but had a 30-month well-child visit in March, the 30-month visit would be counted in the age 3-5 category.
- Screening data on Line 3a through Line 14 should reflect unduplicated counts of individuals from **Line 1b** (individuals enrolled for at least 90 continuous days during the reporting period).
- The objective of CMS-416 reporting is to capture on each line all services that were provided, regardless of payment status and unduplicated by child. Report data based on visits during which a service was provided to an eligible individual during the reporting period, according to the instructions for each line, regardless of whether the unduplicated claim was paid, unpaid, or denied. States must be able to ensure that once a service is reported on the CMS-416, it is not reported again in any reporting period if payment status changes, for example, from unpaid to paid.

State -- Enter the name of your state using the two character state code in upper case format.

Fiscal Year -- Enter the federal fiscal year (FFY) being reported in YYYY format.
Note: The federal fiscal year is from October 1 through September 30. For example, FFY 2014 is October 1, 2013 through September 30, 2014.

Line 1a -- Total Individuals Eligible for EPSDT-- Enter the total unduplicated number of individuals under the age of 21 enrolled in Medicaid or a Children's Health Insurance Program (CHIP) Medicaid expansion program determined to be eligible for EPSDT services, distributed by age and by basis of eligibility as of September 30. "Unduplicated" means that an eligible person is reported only once, although he/she may have had more than one period of eligibility during the year, and that a claim for a service that was provided is only counted once, whether the claim was unpaid, paid, or denied. Include all individuals regardless of whether the services are provided under fee-for-service, prospective payment, managed care, or other payment arrangements. States should determine the basis of eligibility consistent with the instructions from the Transformed Medicaid Statistical Information System (T-MSIS) Data Dictionary, in consultation with state Medicaid eligibility officials, if needed. Medicaid-eligible individuals under age 21 are considered eligible for EPSDT services regardless of whether they have been informed about the availability of EPSDT services or whether they accept EPSDT services at the time of informing. Individuals for whom third-party liability is available should also be counted in the number.

Do not include in this count the following groups of individuals:

- Medically needy individuals under the age of 21 if your state does **not** provide EPSDT services for the medically needy group;

- Individuals eligible for Medicaid only under a Section 1115 waiver as part of an expanded population for which the full complement of EPSDT services is not available;
- Undocumented aliens who are eligible only for emergency Medicaid services;
- Children in separate state CHIP programs; or
- Other groups of individuals under age 21 who are eligible only for limited services as part of their Medicaid eligibility (for example, pregnancy-related services).

Line 1b -- Total Individuals Eligible for EPSDT for 90 Continuous Days -- Enter the total unduplicated number of individuals under the age of 21 from Line 1a who have been continuously enrolled in Medicaid or a CHIP Medicaid expansion program for at least 90 continuous days in the federal fiscal year and determined to be eligible for EPSDT services, distributed by age and by basis of eligibility. For example, if an individual was enrolled from October 1 to November 30 and again from August 1 to September 30, the individual would not be considered eligible for 90 continuous days in the federal fiscal year.

Line 1c -- Total Individuals Eligible for EPSDT under a CHIP Medicaid Expansion Program -- Enter the total unduplicated number of individuals **included in Line 1b** who are under the age of 21 and eligible for EPSDT services as part of a CHIP Medicaid expansion program. For children who have been eligible for EPSDT under both Medicaid and a CHIP Medicaid expansion program during the report year, include the child on this line if they are enrolled in a CHIP Medicaid expansion as of September 30.

Line 2a -- State Periodicity Schedule -- Enter the number of initial or periodic general health screenings required to be provided to individuals within the age group specified according to the state's medical periodicity schedule. (Example: If your state's periodicity schedule requires screening at 12, 15, 18 and 24 months, the number 4 should be entered in the 1-2 age group column.) **Make no entry in the total column.**

Note: As noted above, use the state's current medical periodicity schedule to complete Line 2a and submit a copy of the state's current medical and dental periodicity schedules to CMS with your CMS-416 submission.

Line 2b -- Number of Years in Age Group -- Make no entries on this line. This is a fixed number reflecting the number of years included in each age group.

Line 2c -- Annualized State Periodicity Schedule -- Divide Line 2a by the number in Line 2b. Enter the quotient. This is the number of screenings expected to be received by an individual in each age group in one year. **Make no entry in the total column.**

Line 3a -- Total Months of Eligibility -- Enter the total months of eligibility for the individuals in each age group in Line 1b during the reporting year. An individual child should only be counted once in the age group the individual is in as of September 30. **Include the total months of eligibility in the age category where the individual is reported, even if the individual had months of eligibility in two age categories during the reporting period. For example, if an individual was eligible for 12 months, from October 1st through September 30th, but turned age 3 on August 1st, all 12 months of eligibility would be counted in the age 3-5 category.**

Line 3b -- Average Period of Eligibility -- Divide Line 3a by the number in Line 1b. Divide that number by 12 and enter the quotient. This number represents the portion of the year that individuals remained eligible for EPSDT services during the reporting year.

Line 4 -- Expected Number of Screenings per Eligible -- Multiply Line 2c by Line 3b. Enter the product. This number reflects the expected number of initial or periodic screenings per individual under age 21 per year based on the number required by the state-specific periodicity schedule and the average period of eligibility. **Make no entries in the total column.**

Line 5 -- Expected Number of Screenings -- Multiply Line 4 by Line 1b. Enter the product. This reflects the total number of initial or periodic screenings expected to be provided to the eligible individuals in Line 1b.

Line 6 -- Total Screens Received -- Enter the total number of initial or periodic screens furnished to eligible individuals from Line 1b under fee-for-service, prospective payment, managed care or other payment arrangements, based on an unduplicated paid, unpaid, or denied claim.

Note: States may use the CPT codes listed below as a proxy for reporting these initial or periodic screens. Use of these proxy codes is for reporting purposes only. States must continue to ensure that all five age-appropriate elements of an EPSDT screen, as defined by law, are provided to EPSDT recipients. (See Appendix I for a list of ICD-10 codes relevant to reporting on line 6, pending ICD-10 implementation.)

This number should <u>not</u> reflect sick visits or episodic visits provided to the enrolled individual unless an initial or periodic screen was also performed during the visit. However, it may reflect a screen outside of the normal state periodicity schedule that is used as a "catch-up" EPSDT screening. (A catch-up EPSDT screening is defined as a complete screening that is provided to bring an individual child up-to-date with the state's screening periodicity schedule. For example, a child who did not receive a periodic screen at age five visits a provider at age 5 years and 4 months. The provider may use that visit to provide a complete age appropriate screening and the screening may be counted on the CMS-416.) **Report all screening data in the age category reflecting the individual's age at the end of the federal fiscal year even if the individual received services in two age categories. For example, if a child turned age 3 on September 1st, but had a 30-month well-child visit the previous March, the 30-month visit would be counted in the age 3-5 age category.** Use the codes below or other documentation of such services furnished under capitated or prospective payment arrangements. The codes to be used to document the receipt of an initial or periodic screen are as follows:

CPT-4 codes: Preventive Medicine Services *
99381 New Patient under one year
99382 New Patient (ages 1-4 years)
99383 New Patient (ages 5-11 years)
99384 New Patient (ages 12-17 years)
99385 New Patient (ages 18-39 years)
99391 Established patient under one year
99392 Established patient (ages 1-4 years)
99393 Established patient (ages 5-11years)
99394 Established patient (ages 12-17 years)
99395 Established patient (ages 18-39 years)
99460 Initial hospital or birthing center care for normal newborn infant
99461 Initial care in other than a hospital or birthing center for normal newborn infant

99463 Initial hospital or birthing center care of normal newborn infant (admitted/discharged same date)
***These CPT codes do not require use of a "V" code.**

OR

CPT-4 codes: Evaluation and Management Codes **
99202-99205 New Patient
99213-99215 Established Patient

**** These CPT-4 codes must be used in conjunction with codes V20-V20.2, V20.3, V20.31 and V20.32 and/or V70.0 and/or V70.3-V70.9.**

Line 7 -- Screening Ratio -- Divide the actual number of initial and periodic screening services received (Line 6) by the expected number of initial and periodic screening services (Line 5). This ratio indicates the extent to which EPSDT eligibles received the number of initial and periodic screening services required by the state's periodicity schedule, prorated by the proportion of the year for which they were EPSDT eligible.

Note: In calculating Line 7, if the number exceeds 100 percent, enter 1.0 in this field.

Line 8 -- Total Eligibles Who Should Receive at Least One Initial or Periodic Screen -- The number of individuals who should receive at least one initial or periodic screen is dependent on each state's periodicity schedule. Use the following calculations:

1. Look at the number entered in Line 4 of this form. If that number is greater than 1, use the number 1. If the number on Line 4 is less than or equal to 1, use the number in Line 4. (This procedure will eliminate situations where more than one visit is expected in any age group in a year.).

2. Multiply the number from calculation 1 above by the number on Line 1b of the form. Enter the product on Line 8.

Line 9 -- Total Eligibles Receiving at Least One Initial or Periodic Screen -- Enter the unduplicated number of individuals under age 21 with at least 90 days continuous enrollment within the federal fiscal year from Line 1b, including those in fee-for-service, prospective payment, managed care, and other payment arrangements, who received at least one documented initial or periodic screen during the year, based on an unduplicated paid, unpaid, or denied claim. **Refer to codes in Line 6.**

Line 10 -- Participant Ratio -- Divide Line 9 by Line 8. Enter the quotient. This ratio indicates the extent to which eligibles are receiving any initial and periodic screening services during the year.

Note: In calculating Line 10, if this number exceeds 100 percent, enter 1.0 in this field.

Line 11 -- Total Eligibles Referred for Corrective Treatment -- Enter the unduplicated number of individuals from Line 1b, including those in fee-for-service, prospective payment, managed care, and other payment arrangements, who had a paid, unpaid, or denied claim for a visit/service that occurred within 90 days from the date of an initial or periodic screening within the reporting period, where none of the following is included as part of the claim: capitation payments, administrative fees, transportation services, nursing home services, ICF-MR services, HIPP payments, inpatient services, dental care, home health services, long-term care services, or pharmacy services. Include only those instances where both the

screening and the visit/service for which the subsequent claim was processed occurred within the reporting period.

Dental Lines 12a – 12g

NOTE A: For purposes of reporting the information on dental and oral health services in Lines 12a – 12g, "unduplicated" means that an individual may be counted only once on each line. However, an individual may be counted on two or more lines. For example, individuals under the age of 21 may be counted once on Line 12a for receiving any dental service, counted again on Line 12c for receiving a dental treatment service and, if applicable, counted again on Line 12f for receiving an oral health service by a qualified health care practitioner or by a dental professional who is neither a dentist nor providing services under the supervision of a dentist. These numbers should be inclusive of services reimbursed directly by the state under fee-for-service, or under managed care, prospective payment, or any other payment arrangements, or through any other health or dental plans that contract with the state to provide services to Medicaid or CHIP Medicaid expansion enrollees, based on an unduplicated paid, unpaid, or denied claim.

NOTE B: "Dental services" refers to services provided by or under the supervision of a dentist. Supervision is a spectrum and includes, for example, direct, indirect, general, collaborative or public health supervision as provided in the state's dental practice act. "Oral health services" refers to services provided by any qualified health care practitioner or by a dental professional who is neither a dentist nor providing services under the supervision of a dentist. For each line, the universe of appropriate procedure codes to report is provided in the instructions below (HCPCS or equivalent CDT or CPT codes).

IMPORTANT: All codes must be reported appropriately with respect to whether they represent "dental" or "oral health" services, based on provider type.

Line 12a -- Total Eligibles Receiving Any Dental Services -- Enter the unduplicated number of individuals under the age of 21 with at least 90 continuous days of enrollment during the federal fiscal year from Line 1b who received at least one dental service by or under the supervision of a dentist as defined by HCPCS codes D0100 - D9999 (or equivalent CDT codes D0100 - D9999 or equivalent CPT codes), based on an unduplicated paid, unpaid, or denied claim. All individuals reported on Lines 12b through 12e should be reported on this line, though an individual should be counted only **once** on this line regardless of how many dental services he or she received during the reporting period. See Notes A and B, above.

Line 12b -- Total Eligibles Receiving Preventive Dental Services -- Enter the unduplicated number of individuals under the age of 21 with at least 90 continuous days of enrollment during the federal fiscal year from Line 1b who received at least one preventive dental service by or under the supervision of a dentist as defined by HCPCS codes D1000 - D1999 (or equivalent CDT codes D1000 - D1999 or equivalent CPT codes, that is, only those CPT codes that are for preventive dental services and only if provided by or under the supervision of a dentist), based on an unduplicated paid, unpaid, or denied claim. See Notes A and B, above.

Line 12c -- Total Eligibles Receiving Dental Treatment Services -- Enter the unduplicated number of individuals under the age of 21 with at least 90 continuous days of enrollment during the federal fiscal year from Line 1b who received at least one dental treatment service by or under the supervision of a dentist, as defined by HCPCS codes D2000 - D9999 (or equivalent CDT codes D2000 – D9999 or equivalent CPT codes listed in Table 1, that is, only those CPT codes that involve periodontics, maxillofacial prosthetics, implants, oral and maxillofacial surgery, orthodontics, adjunctive general services, and only if provided by

or under the supervision of a dentist, based on an unduplicated paid, unpaid, or denied claim. See Notes A and B, above.

Line 12d -- Total Eligibles Receiving a Sealant on a Permanent Molar Tooth -- Enter the unduplicated number of individuals with at least 90 continuous days of enrollment during the federal fiscal year from Line 1b, in the appropriate age categories of 6-9 and 10-14, who received a sealant on a permanent molar tooth, as defined by HCPCS code D1351 (or equivalent CDT code D1351), based on an unduplicated paid, unpaid, or denied claim. For this line, include sealants placed by any dental professional for whom placing a sealant is within his or her scope of practice. Permanent molars are teeth numbered 2, 3, 14, 15, 18, 19, 30, 31, and additionally, for those states that cover sealants on third molars, also known as wisdom teeth, the teeth numbered 1, 16, 17, 32. See Notes A and B, above.

Line 12e -- Total Eligibles Receiving Diagnostic Dental Services -- Enter the unduplicated number of individuals under the age of 21 with at least 90 continuous days of enrollment during the federal fiscal year from Line 1b who received at least one diagnostic dental service by or under the supervision of a dentist, as defined by HCPCS codes D0100-D0999 (or equivalent CDT codes D0100 –D0999 or equivalent CPT codes, that is, only those CPT codes that are for diagnostic dental services, and only if provided by or under the supervision of a dentist, based on an unduplicated paid, unpaid, or denied claim. See Notes A and B, above.

12f -- Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider -- Enter the unduplicated number of individuals under the age of 21 with at least 90 continuous days of enrollment during the federal fiscal year from Line 1b who received at least one oral health service, as defined by HCPCS or CDT codes, or equivalent CPT codes, that is, only those CPT codes that are for oral health services, and only if provided by a non-dentist provider, based on an unduplicated paid, unpaid, or denied claim. A "non-dentist provider" is any qualified health care practitioner who is neither a dentist nor providing services under the supervision of a dentist. NOTE: Due to the variance in state practice acts and reimbursement policies, some states may not have data to report on this line. See Notes A and B, above.

12g -- Total Eligibles Receiving any Dental or Oral Health Service -- Enter the unduplicated number of individuals under the age of 21 with at least 90 continuous days of enrollment during the federal fiscal year from Line 1b who received either a "dental service" by or under the supervision of a dentist <u>or</u> an "oral health service" by a qualified health care practitioner who is neither a dentist nor providing services under the supervision of a dentist, based on an unduplicated paid, unpaid, or denied claim. All individuals reported in Lines 12a through 12f should also be reported on this line, though an individual should be counted only **once** on this line regardless of how many dental services and oral health services he or she received during the reporting period, that is, no matter how many times they appear in lines 12a through 12f. See Notes A and B, above.

Line 13 -- Total Eligibles Enrolled in Managed Care -- This number is reported for informational purposes only. Enter the total unduplicated number of individuals **from Line 1b** who are enrolled in any type of managed care arrangement, whether medical or dental or both, at any time during the reporting year. This includes any capitated arrangements such as managed care entities or individuals assigned to a primary care provider or primary care case manager, regardless of whether reimbursement to the provider is fee-for-service or capitated.

Line 14 -- Total Number of Screening Blood Lead Tests -- Enter the total number of screening blood lead tests furnished to eligible individuals under the age of six **from Line 1b** (that is, with at least 90 continuous days of enrollment during the federal fiscal year) under fee-for-service, prospective payment, managed care, or any other payment arrangements, based on an unduplicated paid, unpaid, or denied claim. Follow-up blood tests performed on individuals who have been diagnosed with or are being treated for lead poisoning should not be counted. You may use one of two methods, or a combination of these methods, to calculate the number of blood lead screenings provided:

1) Count the number of times CPT code 83655 ("lead") for a blood lead test is reported within certain ICD-9 CM codes (see Note below); or
2) You may include data collected from use of the HEDIS®[1] measure developed by the National Committee for Quality Assurance to report blood lead screenings if your state has elected to use this performance measure**.**

NOTE: On a claim, CPT code 83655 is the procedure code used to identify that a blood lead test was performed. CPT code 83655, when accompanied on the claim by a diagnosis code of V15.86 (exposure to lead) or V82.5 (special screening for other conditions such as a screening for heavy metal poisoning) may be used to identify a person receiving a screening blood lead test. However, a claim in which the procedure code 83655 is accompanied by a diagnosis code of 984.0 through 984.9 (toxic effect of lead and its compounds), or e861.5 (accidental poisoning by lead paints) would generally indicate that the person receiving the blood lead test had already been diagnosed or was being treated for lead poisoning and should not be counted.

(See Appendix II for a crosswalk of ICD-9 codes to ICD-10 codes, pending implementation of ICD-10.)

F. Disclosure Statement - According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0354. The time required to complete this information collection is estimated to average 28 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop: C4-26-05, Baltimore, Maryland 21244-1850.

[1] Health Effectiveness Data and Information Set

APPENDIX I: Form CMS-416 EPSDT Reporting Instructions
ICD-10 Codes for Line 6
Total Screens Received
Pending Implementation of ICD-10

Line 6 -- Total Screens Received -- Enter the total number of initial or periodic screens furnished to eligible individuals from Line 1b under fee-for-service, prospective payment, or managed care arrangements.

Note: States may use the CPT codes listed below as a proxy for reporting these initial or periodic screens. Use of these proxy codes is for reporting purposes only. States must continue to ensure that all five age-appropriate elements of an EPSDT screen, as defined by law, are provided to EPSDT recipients.

This number should not reflect sick visits or episodic visits provided to the enrolled individual unless an initial or periodic screen was also performed during the visit. However, it may reflect a screen outside of the normal state periodicity schedule that is used as a "catch-up" EPSDT screening. (A catch-up EPSDT screening is defined as a complete screening that is provided to bring an individual child up-to-date with the state's screening periodicity schedule. For example, a child who did not receive a periodic screen at age five visits a provider at age 5 years and 4 months. The provider may use that visit to provide a complete age appropriate screening and the screening may be counted on the CMS-416.) **Report all screening data in the age category reflecting the individual's age at the end of the federal fiscal year even if the individual received services in two age categories. For example, if a child turned age 3 on September 1st, but had a 30-month well-child visit in March, the 30-month visit would be counted in the age 3-5 category.** Use the codes below or other documentation of such services furnished under capitated arrangements. The codes to be used to document the receipt of an initial or periodic screen are as follows:

CPT-4 codes: Preventive Medicine Services *
99381 New Patient under one year
99382 New Patient (ages 1-4 years)
99383 New Patient (ages 5-11 years)
99384 New Patient (ages 12-17 years)
99385 New Patient (ages 18-39 years)
99391 Established patient under one year
99392 Established patient (ages 1-4 years)
99393 Established patient (ages 5-11years)
99394 Established patient (ages 12-17 years)
99395 Established patient (ages 18-39 years)
99460 Initial hospital or birthing center care for normal newborn infant
99461 Initial care in other than a hospital or birthing center for normal newborn infant
99463 Initial hospital or birthing center care of normal newborn infant (admitted/ discharged same date)

***These CPT codes do not require use of a "Z" code.**

APPENDIX I: Form CMS-416 EPSDT Reporting Instructions
ICD-10 Codes for Line 6
Total Screens Received
<u>Pending</u> Implementation of ICD-10

<u>OR</u>

CPT-4 codes: Evaluation and Management Codes **
99202-99205 New Patient
99213-99215 Established Patient

**** These CPT-4 codes must be used in conjunction with the following Z codes:**

Z76.2 (Encounter for health supervision and care of other healthy infant and child),
Z00.121 (Encounter for routine child health examination with abnormal findings),
Z00.129 (Encounter for routine child health examination without abnormal findings),
Z00.110 (Health examination for newborn under 8 days old) and
Z00.111 (Health examination for newborn 8 to 28 days old)
and/or
Z00.00-01 (Encounter for general adult medical examination without/with abnormal findings),
and/or
Z02.0 (Encounter for examination for admission to educational institution),
Z02.1 (Encounter or pre-employment examination),
Z02.2 (Encounter for examination for admission to residential institution),
Z02.3 (Encounter for examination for recruitment to armed forces),
Z02.4 (Encounter for examination for driving license),
Z02.5 (Encounter for examination for participation in sport),
Z02.6 (Encounter for insurance purposes),
Z02.81 (Encounter for paternity testing),
Z02.82 (Encounter for adoption services),
Z02.83 (Encounter for blood-alcohol and blood-drug test),
Z02.89 (Encounter for other administrative examinations),
Z00.8 (Encounter for other general examination),
Z00.6 (Encounter for examination for normal comparison and control in clinical research program),
Z00.5 (Encounter for examination of potential donor of organ and tissue),
Z00.70 (Encounter for examination for period of delayed growth in childhood without abnormal findings),
Z00.71 Encounter for examination for period of delayed growth in childhood with abnormal findings).

Line 14 -- Total Number of Screening Blood Lead Tests -- Enter the total number of screening blood lead tests furnished to eligible individuals **from Line 1b** under fee-for-service, prospective payment, or managed care arrangements. Follow-up blood tests performed on individuals who have been diagnosed with or are being treated for lead poisoning should not be counted. You may use one of two methods, or a combination of these methods, to calculate the number of blood lead screenings provided:

1) Count the number of times CPT code 83655 ("lead") for a blood lead test is reported within certain ICD-10 CM codes (see Note below); or
2) You may include data collected from use of the HEDIS®[2] measure developed by the National Committee for Quality Assurance to report blood lead screenings if your state had elected to use this performance measure**.**

NOTE: On a claim, CPT code 83655 is the procedure code used to identify that a blood lead test was performed. CPT code 83655, when accompanied on the claim by a diagnosis code of Z77.011 (exposure to lead) or Z13.88 **(**Encounter for screening for disorder due to exposure to contaminants) may be used to identify a person receiving a screening blood lead test, or Z57.8 (occupational exposure to other risk factors). However, a claim in which the procedure code 83655 is accompanied by a diagnosis code of 984.0 through 984.9 (toxic effect of lead and its compounds), T56.0X1A–4A (Toxic effect of lead and its compounds, initial encounter); M1A.10X0-1, M1A.1110-11, M1A.1120-21, M1A1190-91, M1A.1210-11, M1A.1610-11, M1A.1621, M1A.1690-91, M1A.1710-11, M1A1720-21, M1A.1790-91, M1A.18X0-X1, M1A.19X1A-X4A (**See below for a description of these codes**) would generally indicate that the person receiving the blood lead test had already been diagnosed or was being treated for lead poisoning and should not be counted.

[2] Health Effectiveness Data and Information Set

ICD-9 Codes (Form CMS-416)	ICD-10 Codes and Description (for Form CMS-416) NOT EFFECTIVE UNTIL ICD-10 IMPLEMENTATION
984.0 Toxic effect of inorganic lead compounds	**T56.0X1A** Toxic effect of lead and its compounds, accidental (unintentional), initial encounter **T56.0X2A** Toxic effect of lead and its compounds, intentional self-harm, initial encounter **T56.0X3A** Toxic effect of lead and its compounds, assault, initial encounter **T56.0X4A** Toxic effect of lead and its compounds, undetermined, initial encounter
984.1 Toxic effect of organic lead compounds	**T56.0X1A** Toxic effect of lead and its compounds, accidental (unintentional), initial encounter **T56.0X2A** Toxic effect of lead and its compounds, intentional self-harm, initial encounter **T56.0X3A** Toxic effect of lead and its compounds, assault, initial encounter **T56.0X4A** Toxic effect of lead and its compounds, undetermined, initial encounter
984.8 Toxic effect of other lead compounds	**T56.0X1A** Toxic effect of lead and its compounds, accidental (unintentional), initial encounter **T56.0X2A** Toxic effect of lead and its compounds, intentional self-harm, initial encounter **T56.0X3A** Toxic effect of lead and its compounds, assault, initial encounter **T56.0X4A** Toxic effect of lead and its compounds, undetermined, initial encounter
984.9 Toxic effect of unspecified lead compound	**M1A.10X0** Lead-induced chronic gout, unspecified site, without tophus (tophi), **M1A.10X1** Lead-induced chronic gout, unspecified site, with tophus (tophi) **M1A.1110** Lead-induced chronic gout, right shoulder, without tophus (tophi) **M1A.1111** Lead-induced chronic gout, right shoulder, with tophus (tophi) **M1A.1120** Lead-induced chronic gout, left shoulder, without tophus (tophi) **M1A.1121** Lead-induced chronic gout, left shoulder, with tophus (tophi) **M1A.1190** Lead-induced chronic gout, unspecified shoulder, without tophus (tophi) **M1A.1191** Lead-induced chronic gout, unspecified shoulder, with tophus (tophi) **M1A.1210** Lead-induced chronic gout, right elbow, without tophus (tophi)

ICD-9 Codes (Form CMS-416)	ICD-10 Codes and Description (for Form CMS-416) NOT EFFECTIVE UNTIL ICD-10 IMPLEMENTATION
984.9 Toxic effect of unspecified lead compound (continued from prior page)	**M1A.1211** Lead-induced chronic gout, right elbow, with tophus (tophi) **M1A.1220** Lead-induced chronic gout, left elbow, without tophus (tophi) **M1A.1221** Lead-induced chronic gout, left elbow, with tophus (tophi) **M1A.1290** Lead-induced chronic gout, unspecified elbow, without tophus (tophi) **M1A.1291** Lead-induced chronic gout, unspecified elbow, with tophus (tophi) **M1A.1310** Lead-induced chronic gout, right wrist, without tophus (tophi) **M1A.1311** Lead-induced chronic gout, right wrist, with tophus (tophi) **M1A.1320** Lead-induced chronic gout, left wrist, without tophus (tophi) **M1A.1321** Lead-induced chronic gout, left wrist, with tophus (tophi) **M1A.1390** Lead-induced chronic gout, unspecified wrist, without tophus (tophi) **M1A.1391** Lead-induced chronic gout, unspecified wrist, with tophus (tophi) **M1A.1410** Lead-induced chronic gout, right hand, without tophus (tophi) **M1A.1411** Lead-induced chronic gout, right hand, with tophus (tophi) **M1A.1420** Lead-induced chronic gout, left hand, without tophus (tophi) **M1A.1421** Lead-induced chronic gout, left hand, with tophus (tophi) **M1A.1490** Lead-induced chronic gout, unspecified hand, without tophus (tophi) **M1A.1491** Lead-induced chronic gout, unspecified hand, with tophus (tophi) **M1A.1510** Lead-induced chronic gout, right hip, without tophus (tophi) **M1A.1511** Lead-induced chronic gout, right hip, with tophus (tophi) **M1A.1520** Lead-induced chronic gout, left hip, without tophus (tophi) **M1A.1521** Lead-induced chronic gout, left hip, with tophus **M1A.1590** Lead-induced chronic gout, unspecified hip, without tophus (tophi)

ICD-9 Codes (Form CMS-416)	ICD-10 Codes and Description (for Form CMS-416) NOT EFFECTIVE UNTIL ICD-10 IMPLEMENTATION
984.9 Toxic effect of unspecified lead compound (continued from prior page)	**M1A.1591** Lead-induced chronic gout, unspecified hip, with tophus (tophi) **M1A.1610** Lead-induced chronic gout, right knee, without tophus (tophi) **M1A.1611** Lead-induced chronic gout, right knee, with tophus (tophi) **M1A.1620** Lead-induced chronic gout, left knee, without tophus (tophi) **M1A.1621** Lead-induced chronic gout, left knee, with tophus (tophi) **M1A.1690** Lead-induced chronic gout, unspecified knee, without tophus (tophi) **M1A.1691** Lead-induced chronic gout, unspecified knee, with tophus (tophi) **M1A.1710** Lead-induced chronic gout, right ankle and foot, without tophus (tophi) **M1A.1711** Lead-induced chronic gout, right ankle and foot, with tophus (tophi) **M1A.1720** Lead-induced chronic gout, left ankle and foot, without tophus (tophi) **M1A.1721** Lead-induced chronic gout, left ankle and foot, with tophus (tophi) **M1A.1790** Lead-induced chronic gout, unspecified ankle and foot, without tophus (tophi) **M1A.1791** Lead-induced chronic gout, unspecified ankle and foot, with tophus (tophi) **M1A.18X0** Lead-induced chronic gout, vertebrae, without tophus (tophi) **M1A.18X1** Lead-induced chronic gout, vertebrae, with tophus (tophi) **M1A.19X0** Lead-induced chronic gout, multiple sites, without tophus (tophi) **M1A.19X1** Lead-induced chronic gout, multiple sites, with tophus (tophi) **T56.0X1A** Toxic effect of lead and its compounds, accidental (unintentional), initial encounter **T56.0X2A** Toxic effect of lead and its compounds, intentional self-harm, initial encounter **T56.0X3A** Toxic effect of lead and its compounds, assault, initial encounter **T56.0X4A** Toxic effect of lead and its compounds, undetermined, initial encounter

APPENDIX II: Form CMS-416 EPSDT Reporting Instructions
Crosswalk of ICD-9 Codes to ICD-10 Codes for Line 14
Total Number of Screening Blood Tests
Pending Implementation of ICD-10

ICD-9 Codes (Form CMS-416)	ICD-10 Codes and Description (for Form CMS-416) NOT EFFECTIVE UNTIL ICD-10 IMPLEMENTATION
V15.85 Personal history of contact with and (suspected) exposure to potentially hazardous body fluids	**Z57.8** Occupational exposure to other risk factors
V15.86 Personal history of contact with and (suspected) exposure to lead	**Z77.011** Contact with and (suspected) exposure to lead
V82.5 Screening for Chemical Poisoning and other contamination	**Z13.88** Encounter for screening for disorder due to exposure to contaminants

Attachment 4

Dental Access Standards

1. Waiting Times and Timely Access

a. The DBPM must ensure that its network providers have an appointment system for core dental benefits and services and/or expanded services which are in accordance with prevailing dental community standards.

b. Formal policies and procedures establishing appointment standards must be submitted for initial review and approval during the readiness review process. Revised versions of these policies and procedures should be submitted to MLTC for record keeping purposes as they become relevant. If changes to policies and procedures are expected to have a significant impact on the provider network or member services, MLTC staff must be notified in writing 30 calendar days prior to implementation. Methods for educating both the providers and the members about appointment standards must be addressed in these policies and procedures. The DBPM must disseminate these appointment standard policies and procedures to its in-network providers and to its members. The DBPM must monitor compliance with appointment standards and must have a corrective action plan when appointment standards are not met.

c. Urgent Care must be provided within twenty-four (24) hours [42 CFR §438.206(c)(1)(i)]; Urgent care may be provided directly by the primary care dentist or directed by the DBPM through other arrangements.

d. Routine or preventative dental services within six (6) weeks.

e. Wait times for scheduled appointments should not routinely exceed forty-five (45) minutes, including time spent in the waiting room and the examining room, unless the provider is unavailable or delayed because of an emergency. If a provider is delayed, the member should be notified immediately. If a wait of more than ninety (90) minutes is anticipated, the member should be offered a new appointment.

f. The DBPM must establish processes to monitor and reduce the appointment “no-show” rate for primary care dentists. As best practices are identified, MLTC may require implementation by the DBPM. This information must be provided to MLTC during the readiness review process.

g. The DBPM must have written policies and procedures about educating its provider network about appointment time requirements and provide these to MLTC for approval during the readiness review process. The DBPM must develop a corrective action plan when appointment standards are not met; if appropriate, the corrective action plan should be developed in conjunction with the provider [42 CFR §438.206(c)(1)(iv), (v) and (vi)]. Appointment standards must be included in the Provider Manual. The DBPM is encouraged to include the standards in the provider contracts.

2. Geographic Access Standards

a. Dentists

The DBPM must, at a minimum, contract with:

i. Two (2) Dentists within forty-five (45) miles of the personal residences of members in urban counties.

ii. One (1) Dentist within sixty (60) miles of the personal residences of members in rural counties.

iii. One (1) Dentist within one hundred (100) miles of the personal residences of members in frontier counties.

b. The DBPM must, at a minimum, contract with following dental specialists:

i. One (1) oral surgeons, One (1) orthodontist, One (1) periodontist and One (1) pediadontist within forty-five (45) miles of the personal residences of members in urban counties.

ii. One (1) oral surgeon, One (1) orthodontist , One (1) periodontist and One (1) pediadontist within sixty (60) miles of the personal residences of members in rural counties.

iii. One (1) oral surgeon, One (1) orthodontist, One (1) periodontist and One (1) pediadontist within one-hundred (100) miles of the personal residences of members in frontier counties.

c. Urban, rural, and frontier county designations are detailed in Attachment 13 – Nebraska Counties Classified by Urban/Rural/Frontier Status.

This attachment is intended as a summary of periodic reporting requirements included in the RFP. The RFP contains additional reporting requirements that may be triggered by specific events (e.g. instances of fraud discovery). The DBPM must comply with all reporting requirements found in the RFP, attachments, and addendums.	
Monthly Deliverables	Due on the 15th day of the following calendar month unless otherwise noted in the RFP or agreed to in writing by the DBPM and MLTC.
Quarterly Deliverables	Due 45 calendar days after the end of the most recent quarter unless otherwise noted in the RFP or agreed to in writing by the DBPM and MLTC.
Semi-Annual Deliverables	Due as specified in this attachment.
Annual Deliverables	Reports, files, and other deliverables due annually must be submitted within 30 calendar days following the 12th month of the contract year, except those reports that are specifically exempted from the 30-calendar day deadline by this RFP or by written agreement between MLTC and the DBPM.
Ad Hoc Deliverables	Ad hoc reports must be submitted within five business days from the date of request, unless otherwise specified by MLTC.

If a due date falls on a weekend or State-recognized holiday, the deliverable is due the next business day. All reports must be submitted in an MLTC provided template or in a format approved by MLTC.

Monthly Deliverables	Description	Due Date
Claims Processing and Timely Payment of Claims	Summary data on claims payment activity and reasons for claims denials, per reporting requirements provided by MLTC. Include the disposition of every adjudicated and adjusted claim for each claim type.	15th day of the following calendar month
Provider Termination	All provider terminations by category and termination cause.	15th day of the following calendar month
Third-Party Liability	All instances in which a TPL is identified for a member as described in Section IV.R – Claims Management.	15th day of the following calendar month
Claims Payment Accuracy	Claims payment accuracy percentages as described in Section IV.R - Claims Management.	15th day of the following calendar month

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Member Grievance System (Grievance)	Summary of new grievances, resolved grievances, and status of unresolved grievances. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter
Member Grievance System (Appeals)	Summary of new appeals, completed appeals, and status of each ongoing appeal. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter
Member Grievance System (Expedited Appeals)	Summary of new expedited appeals, completed expedited appeals, and status of each ongoing expedited appeal. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter
Member Grievance System (State Fair Hearings)	Summary of new state fair hearings, concluded state fair hearings, and status of each ongoing state fair hearing. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter
Provider Grievance System (Grievances)	Summary of new grievances, resolved grievances, and status of unresolved grievances. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter
Provider Grievance System (Appeals)	Summary of new appeals, completed appeals, and status of each ongoing appeal. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter
Provider Grievance System (State Fair Hearings)	Summary of new state fair hearings, concluded state fair hearings, and status of each ongoing state fair hearing. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	15th day of the following calendar month for the first six months, then 45 calendar days following the most recent quarter

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New Referrals of Potential Fraud, Waste, Abuse and Erroneous Payments	Summary of new referrals as described in Section IV.O - Program Integrity.	Second Friday of the following calendar month
All Referrals of Fraud, Waste, Abuse, and Erroneous Payments Under Review by the ~~MCO~~DBPM	Summary of all referrals as described in Section IV.O - Program Integrity.	Second Friday of the following calendar month
Overpayments Identified and Collected	Summary of overpayments as described in Section IV.O - Program Integrity.	Second Friday of the following calendar month
Provider Who Have Left the ~~MCO~~DBPM Network	Summary of provider network departures as described in Section IV.O - Program Integrity.	Second Friday of the following calendar month
Miscellaneous Fraud Prevention Efforts	Summary of the ~~MCO~~DBPM's fraud prevention efforts as described in Section IV.O - Program Integrity.	Second Friday of the following calendar month
Claims Adjudicated	Data summarizing claims adjudicated to finalization in the previous calendar month as described in Section IV.O - Program Integrity.	Second Friday of the following calendar month
Member/Provider Call Center	Data summarizing DBPM member/provider call center performance, including call abandonment rate and average speed to answer.	15th day of the following calendar month
Service Authorizations	Data summarizing DBPM compliance with timely service authorization requirements as detailed in Section IV.N. – Utilization Management.	15th day of the following calendar month
Enrollment and Disenrollment Report	Summary of disenrollments as described in Section IV.B - Eligibility and Enrollment.	15th day of the following calendar month
Quarterly Deliverables	**Description**	**Due Date**
Member Grievance System (Grievance)	Summary of new grievances, resolved grievances, and status of unresolved grievances. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Member Grievance System (Appeals)	Summary of new appeals, completed appeals, and status of each ongoing appeal. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter

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Member Grievance System (Expedited Appeals)	Summary of new expedited appeals, completed expedited appeals, and status of each ongoing expedited appeal. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Member Grievance System (State Fair Hearings)	Summary of new state fair hearings, concluded state fair hearings, and status of each ongoing state fair hearing. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Provider Grievance System (Grievances)	Summary of new grievances, resolved grievances, and status of unresolved grievances. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Provider Grievance System (Appeals)	Summary of new appeals, completed appeals, and status of each ongoing appeal. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Provider Grievance System (State Fair Hearings)	Summary of new state fair hearings, concluded state fair hearings, and status of each ongoing state fair hearing. This report is required monthly for the first six months after the contract start date and will then be required quarterly.	45 calendar days following the most recent quarter
Care Coordination Report	Summary data and metric results as determined by MLTC.	45 calendar days following the most recent quarter
Out of Network Referrals	Data and analysis summarizing out of network provider authorizations.	45 calendar days following the most recent quarter
Provider Network Access	Summary data and metrics on network access as determined by MLTC and described in Attachment 4 – Dental Access Standards.	45 calendar days following the most recent quarter
Provider Network Adequacy	Summary data and metrics demonstrating network adequacy as determined by MLTC and described in Attachment 4 – Dental Access Standards.	45 calendar days following the most recent quarter

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Provider Network Cultural Competency Access	Summary data and metrics on cultural competency access as determined by MLTC.	45 calendar days following the most recent quarter
Provider Credentialing	Data and metrics summarizing the number of providers credentialed by licensure type, their location, and the status of pending credentials.	45 calendar days following the most recent quarter
Service Verification Detail	Data detailing service verifications as described in Section IV.S - Claims Management and Section IV.O - Program Integrity.	45 calendar days following the most recent quarter
Service Verification Summary	Service verification summary as described in Section X - Claims Management and Section IV.O - Program Integrity.	45 calendar days following the most recent quarter
Utilization Management Reviews	Summary data and analysis as detailed in Section IV.N – Utilization Management and as determined by MLTC.	45 calendar days following the most recent quarter
Utilization Management Committee	Summary and meeting minutes for UM Committee meetings as described in Section IV.N – Utilization Management.	45 calendar days following the most recent quarter
Quality Performance	Summary data and metric results as determined by MLTC.	45 calendar days following the most recent quarter
Quarterly Financial Reporting	Data and analysis summarizing financial results as determined by MLTC and as described in Section IV.T - Reporting and Deliverables.	45 calendar days following the most recent quarter
Value-Added Services	Summary of value added services as agreed upon by the ~~MCO~~DBPM and MLTC.	45 calendar days following the most recent quarter
Indian Health Services	Data and metrics summarizing Indian Health Service delivery.	45 calendar days following the most recent quarter
Subrogation	Data summarizing new and ongoing instances of subrogation.	45 calendar days following the most recent quarter

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Administrative Performance Measures	Data and analysis summarizing results of Administrative Performance Measures as identified by MLTC.	45 calendar days following the most recent quarter
Semi-Annual Deliverables	**Description**	**Due Date**
Paid Claims Audit	Results of error rate measurement data processing, medical necessity, and provider documentation audit of a statistically valid random sample of paid claims as described in Section IV.O - Program Integrity.	June 30 and December 31
Annual Deliverables	**Description**	**Due Date**
Quality Management Program Description and Work Plan	Discussion of the ~~MCO~~DBPM's quality goals, initiatives and work plan as described in Section IV.M – Quality Management.	30 calendar days following the 12th month of the contract year
Quality Management Program Evaluation	Data and analysis summarizing the results of the annual quality work plan as described in Section IV.M - Quality.	30 calendar days following the 12th month of the contract year
Member Satisfaction Survey	Data and analysis summarizing results of the annual member satisfaction survey.	120 calendar days following the 12th month of the contract year
Deficiency CAP Reports (All Provider Types)	Results and status of all corrective action plans by provider type.	30 calendar days following the 12th month of the contract year
Direct Medical Education/Indirect Medical Education Verification	For the state fiscal year, financial information on direct and indirect medical costs as required by MLTC in accordance with 471 NAC.	Due date to be provided prior to contract start
Performance Improvement Projects	Data summarizing annual results of each new and ongoing PIP.	30 calendar days following the 12th month of the contract year
Quality Performance Measures	Quality performance results as listed in Attachment 6 – Performance Measures.	Due dates to be provided prior to contract start and in accordance with reporting schedules for the governing entities.

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Provider Survey	Data and analysis summarizing results of the annual provider satisfaction survey. The provider satisfaction survey tool and methodology must be submitted to MLTC for approval at least 90 calendar days prior to its administration.	120 calendar days following the 12th month of the contract year
Annual Financial Reporting	Data and analysis summarizing financial results as determined by MLTC and as described in Section IV.T - Reporting and Deliverables.	30 calendar days following the 12th month of the contract year
Fraud, Waste, Abuse, and Erroneous Payments Annual Plan	Compliance plan addressing requirements outlined in Section IV.O - Program Integrity.	Last day of the contract year
Annual Program Integrity Confirmation	Signed form acknowledging responsibilities related to the receipt of State and federal funds as described in Section IV.O - Program Integrity.	December 31
Department of Insurance Financial Report	Copy of annual audited financial statement submitted to the Nebraska Department of Insurance.	June 1
Network Development and Management Plan	Details of the ~~MCO~~DBPM's network, including GeoAccess reports, and a discussion of any provider network gaps and the ~~MCO~~DBPM's remediation plans, as described in Section IV.I – Provider Network Requirements.	30 calendar days following the 12th month of the contract year
Utilization Management Program Review	Data and analysis summarizing the ~~MCO~~DBPM's annual evaluation of its UM program.	30 calendar days following the 12th month of the contract year
Annual Staffing Report	Organization charts and staffing lists as detailed in Section IV.D – Staffing Requirements.	30 calendar days following the 12th month of the contract year
QAPI Committee	Data and analysis addressing requirements detailed in Section IV.M – Quality Management.	30 calendar days following the 12th month of the contract year

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Attachment 6

Performance Measures

Child Core Measures
Percentage of Eligibles Who Received Preventive Dental Services (PDENT)
HEDIS Measures
Annual Dental Visit
Dental Quality Alliance
Percentage of enrolled children who received at least one dental service within the reporting year. https://www.qualitymeasures.ahrq.gov/content.aspx?id=47295
Percentage of enrolled children who received a treatment service as a dental service within the reporting year. https://www.qualitymeasures.ahrq.gov/content.aspx?id=47306
Percentage of enrolled children who received a comprehensive or periodic oral evaluation as a dental service within the reporting year. https://www.qualitymeasures.ahrq.gov/content.aspx?id=47296
Percentage of children enrolled in two consecutive years who received a comprehensive or periodic oral evaluation as a dental service in both years. https://www.qualitymeasures.ahrq.gov/content.aspx?id=47310

		FY2014						FY2015					
Age Band	COS	MMs	Dollars	Units	Util/1000	Unit Cost	PMPM	MMs	Dollars	Units	Util/1000	Unit Cost	PMPM
0-1	Adjunctive General Services	291,732	$ 8,587	119	5	$ 72.16	$ 0.03	295,534	$ 8,266	108	4	$ 76.54	$ 0.03
0-1	Endodontics	291,732	$ 7,625	89	4	$ 85.67	$ 0.03	295,534	$ 6,430	80	3	$ 80.38	$ 0.02
0-1	Oral and Maxillofacial Surgery	291,732	$ 9,392	150	6	$ 62.61	$ 0.03	295,534	$ 11,892	194	8	$ 61.30	$ 0.04
0-1	Orthodontics	291,732	$ -	-	-	$ -	$ -	295,534	$ -	-	-	$ -	$ -
0-1	Partial Dentures	291,732	$ -	-	-	$ -	$ -	295,534	$ 377	1	0	$ 377.00	$ 0.00
0-1	Periodontics	291,732	$ 88	2	0	$ 44.00	$ 0.00	295,534	$ 56	1	0	$ 56.00	$ 0.00
0-1	Preventative	291,732	$ 269,139	13,374	550	$ 20.12	$ 0.92	295,534	$ 310,698	13,564	551	$ 22.91	$ 1.05
0-1	Prosthodontics	291,732	$ -	-	-	$ -	$ -	295,534	$ -	-	-	$ -	$ -
0-1	Restorative	291,732	$ 76,476	719	30	$ 106.36	$ 0.26	295,534	$ 74,488	700	28	$ 106.41	$ 0.25
2-5	Adjunctive General Services	485,415	$ 268,752	6,497	161	$ 41.37	$ 0.55	467,090	$ 263,823	6,417	165	$ 41.11	$ 0.56
2-5	Endodontics	485,415	$ 248,027	3,226	80	$ 76.88	$ 0.51	467,090	$ 251,443	3,292	85	$ 76.38	$ 0.54
2-5	Oral and Maxillofacial Surgery	485,415	$ 201,754	3,378	84	$ 59.73	$ 0.42	467,090	$ 194,797	3,261	84	$ 59.74	$ 0.42
2-5	Orthodontics	485,415	$ 7,625	28	1	$ 272.32	$ 0.02	467,090	$ 5,230	23	1	$ 227.39	$ 0.01
2-5	Partial Dentures	485,415	$ 472	1	0	$ 472.00	$ 0.00	467,090	$ -	-	-	$ -	$ -
2-5	Periodontics	485,415	$ 2,076	34	1	$ 61.06	$ 0.00	467,090	$ 1,684	29	1	$ 58.07	$ 0.00
2-5	Preventative	485,415	$ 2,686,817	167,803	4,148	$ 16.01	$ 5.54	467,090	$ 2,850,492	162,280	4,169	$ 17.57	$ 6.10
2-5	Prosthodontics	485,415	$ -	-	-	$ -	$ -	467,090	$ -	-	-	$ -	$ -
2-5	Restorative	485,415	$ 3,067,124	33,107	818	$ 92.64	$ 6.32	467,090	$ 3,041,307	32,437	833	$ 93.76	$ 6.51
6-18	Adjunctive General Services	1,162,507	$ 655,736	15,466	160	$ 42.40	$ 0.56	1,191,822	$ 710,504	16,605	167	$ 42.79	$ 0.60
6-18	Endodontics	1,162,507	$ 393,941	2,870	30	$ 137.26	$ 0.34	1,191,822	$ 378,095	2,830	28	$ 133.60	$ 0.32
6-18	Oral and Maxillofacial Surgery	1,162,507	$ 2,026,968	22,703	234	$ 89.28	$ 1.74	1,191,822	$ 2,048,985	22,919	231	$ 89.40	$ 1.72
6-18	Orthodontics	1,162,507	$ 4,795,744	2,576	27	$ 1,861.70	$ 4.13	1,191,822	$ 6,289,046	3,257	33	$ 1,930.93	$ 5.28
6-18	Partial Dentures	1,162,507	$ 9,186	46	0	$ 199.70	$ 0.01	1,191,822	$ 10,914	48	0	$ 227.38	$ 0.01
6-18	Periodontics	1,162,507	$ 58,058	1,004	10	$ 57.83	$ 0.05	1,191,822	$ 67,215	1,168	12	$ 57.55	$ 0.06
6-18	Preventative	1,162,507	$ 9,415,441	496,995	5,130	$ 18.94	$ 8.10	1,191,822	$ 10,546,752	523,584	5,272	$ 20.14	$ 8.85
6-18	Prosthodontics	1,162,507	$ 4,304	8	0	$ 538.00	$ 0.00	1,191,822	$ 1,076	2	0	$ 538.00	$ 0.00
6-18	Restorative	1,162,507	$ 4,871,892	67,326	695	$ 72.36	$ 4.19	1,191,822	$ 5,137,335	70,577	711	$ 72.79	$ 4.31
19-24	Adjunctive General Services	127,623	$ 78,296	1,000	94	$ 78.30	$ 0.61	123,094	$ 61,195	791	77	$ 77.36	$ 0.50
19-24	Endodontics	127,623	$ 98,692	373	35	$ 264.59	$ 0.77	123,094	$ 91,691	344	34	$ 266.54	$ 0.74
19-24	Oral and Maxillofacial Surgery	127,623	$ 284,277	2,658	250	$ 106.95	$ 2.23	123,094	$ 239,845	2,300	224	$ 104.28	$ 1.95
19-24	Orthodontics	127,623	$ 8,542	6	1	$ 1,423.67	$ 0.07	123,094	$ 23,823	12	1	$ 1,985.25	$ 0.19
19-24	Partial Dentures	127,623	$ 8,148	45	4	$ 181.07	$ 0.06	123,094	$ 8,390	45	4	$ 186.45	$ 0.07
19-24	Periodontics	127,623	$ 36,557	656	62	$ 55.73	$ 0.29	123,094	$ 38,178	680	66	$ 56.14	$ 0.31
19-24	Preventative	127,623	$ 378,558	20,057	1,886	$ 18.87	$ 2.97	123,094	$ 378,165	18,782	1,831	$ 20.13	$ 3.07
19-24	Prosthodontics	127,623	$ 5,903	13	1	$ 454.04	$ 0.05	123,094	$ 7,256	16	2	$ 453.51	$ 0.06
19-24	Restorative	127,623	$ 508,914	7,252	682	$ 70.18	$ 3.99	123,094	$ 497,226	6,971	680	$ 71.33	$ 4.04
25-54	Adjunctive General Services	507,171	$ 233,192	3,574	85	$ 65.25	$ 0.46	494,494	$ 240,040	2,894	70	$ 82.94	$ 0.49
25-54	Endodontics	507,171	$ 541,473	2,125	50	$ 254.81	$ 1.07	494,494	$ 520,138	2,024	49	$ 256.99	$ 1.05
25-54	Oral and Maxillofacial Surgery	507,171	$ 1,052,729	14,354	340	$ 73.34	$ 2.08	494,494	$ 972,849	13,376	325	$ 72.73	$ 1.97
25-54	Orthodontics	507,171	$ 211	1	0	$ 211.00	$ 0.00	494,494	$ -	-	-	$ -	$ -
25-54	Partial Dentures	507,171	$ 354,058	2,120	50	$ 167.01	$ 0.70	494,494	$ 377,094	2,166	53	$ 174.10	$ 0.76
25-54	Periodontics	507,171	$ 208,101	3,595	85	$ 57.89	$ 0.41	494,494	$ 210,628	3,662	89	$ 57.52	$ 0.43
25-54	Preventative	507,171	$ 1,649,794	90,472	2,141	$ 18.24	$ 3.25	494,494	$ 1,705,914	88,268	2,142	$ 19.33	$ 3.45
25-54	Prosthodontics	507,171	$ 362,068	710	17	$ 509.95	$ 0.71	494,494	$ 332,161	667	16	$ 497.99	$ 0.67
25-54	Restorative	507,171	$ 2,519,151	34,194	809	$ 73.67	$ 4.97	494,494	$ 2,517,369	33,510	813	$ 75.12	$ 5.09
55-64	Adjunctive General Services	121,345	$ 28,705	541	54	$ 53.06	$ 0.24	123,876	$ 32,838	590	57	$ 55.66	$ 0.27
55-64	Endodontics	121,345	$ 53,909	216	21	$ 249.58	$ 0.44	123,876	$ 59,361	239	23	$ 248.37	$ 0.48
55-64	Oral and Maxillofacial Surgery	121,345	$ 247,515	3,742	370	$ 66.15	$ 2.04	123,876	$ 243,087	3,713	360	$ 65.47	$ 1.96
55-64	Orthodontics	121,345	$ -	-	-	$ -	$ -	123,876	$ -	-	-	$ -	$ -
55-64	Partial Dentures	121,345	$ 172,666	1,351	134	$ 127.81	$ 1.42	123,876	$ 204,386	1,541	149	$ 132.63	$ 1.65
55-64	Periodontics	121,345	$ 33,694	570	56	$ 59.11	$ 0.28	123,876	$ 32,858	565	55	$ 58.16	$ 0.27
55-64	Preventative	121,345	$ 310,222	16,941	1,675	$ 18.31	$ 2.56	123,876	$ 330,368	17,116	1,658	$ 19.30	$ 2.67
55-64	Prosthodontics	121,345	$ 258,176	503	50	$ 513.27	$ 2.13	123,876	$ 272,998	541	52	$ 504.62	$ 2.20
55-64	Restorative	121,345	$ 366,299	4,863	481	$ 75.32	$ 3.02	123,876	$ 406,115	5,285	512	$ 76.84	$ 3.28
65+	Adjunctive General Services	218,891	$ 38,209	940	52	$ 40.65	$ 0.17	218,284	$ 37,410	952	52	$ 39.30	$ 0.17
65+	Endodontics	218,891	$ 36,021	156	9	$ 230.90	$ 0.16	218,284	$ 39,458	167	9	$ 236.28	$ 0.18
65+	Oral and Maxillofacial Surgery	218,891	$ 257,690	3,783	207	$ 68.12	$ 1.18	218,284	$ 257,095	3,880	213	$ 66.26	$ 1.18
65+	Orthodontics	218,891	$ -	-	-	$ -	$ -	218,284	$ -	-	-	$ -	$ -
65+	Partial Dentures	218,891	$ 281,598	2,825	155	$ 99.68	$ 1.29	218,284	$ 306,002	3,060	168	$ 100.00	$ 1.40
65+	Periodontics	218,891	$ 29,050	505	28	$ 57.52	$ 0.13	218,284	$ 31,837	568	31	$ 56.05	$ 0.15
65+	Preventative	218,891	$ 410,298	22,164	1,215	$ 18.51	$ 1.87	218,284	$ 421,549	21,737	1,195	$ 19.39	$ 1.93
65+	Prosthodontics	218,891	$ 404,873	773	42	$ 523.77	$ 1.85	218,284	$ 378,131	767	42	$ 493.00	$ 1.73
65+	Restorative	218,891	$ 403,364	5,552	304	$ 72.65	$ 1.84	218,284	$ 414,976	5,616	309	$ 73.89	$ 1.90

	FY2014						FY2015					
Age Band	**MMs**	**Dollars**	**Units**	**Util/1000**	**Unit Cost**	**PMPM**	**MMs**	**Dollars**	**Units**	**Util/1000**	**Unit Cost**	**PMPM**
0-1	291,732	$ 371,307	14,453	595	$ 25.69	$ 1.27	295,534	$ 412,207	14,648	595	$ 28.14	$ 1.39
2-5	485,415	$ 6,482,648	214,074	5,292	$ 30.28	$ 13.35	467,090	$ 6,608,776	207,739	5,337	$ 31.81	$ 14.15
6-18	1,162,507	$ 22,231,271	608,994	6,286	$ 36.50	$ 19.12	1,191,822	$ 25,189,922	640,990	6,454	$ 39.30	$ 21.14
19-24	127,623	$ 1,407,887	32,060	3,015	$ 43.91	$ 11.03	123,094	$ 1,345,770	29,941	2,919	$ 44.95	$ 10.93
25-54	507,171	$ 6,920,777	151,145	3,576	$ 45.79	$ 13.65	494,494	$ 6,876,193	146,567	3,557	$ 46.92	$ 13.91
55-64	121,345	$ 1,471,187	28,727	2,841	$ 51.21	$ 12.12	123,876	$ 1,582,010	29,590	2,866	$ 53.46	$ 12.77
65+	218,891	$ 1,861,102	36,698	2,012	$ 50.71	$ 8.50	218,284	$ 1,886,458	36,747	2,020	$ 51.34	$ 8.64
Total	**2,914,684**	**$ 40,746,179**	**1,086,151**	**4,472**	**$ 37.51**	**$ 13.98**	**2,914,194**	**$ 43,901,337**	**1,106,222**	**4,555**	**$ 39.69**	**$ 15.06**

	FY2014						FY2015					
COS	**MMs**	**Dollars**	**Units**	**Util/1000**	**Unit Cost**	**PMPM**	**MMs**	**Dollars**	**Units**	**Util/1000**	**Unit Cost**	**PMPM**
Adjunctive General Services	2,914,684	$ 1,311,478	28,137	116	$ 46.61	$ 0.45	2,914,194	$ 1,354,077	28,357	117	$ 47.75	$ 0.46
Endodontics	2,914,684	$ 1,379,689	9,055	37	$ 152.37	$ 0.47	2,914,194	$ 1,346,616	8,976	37	$ 150.02	$ 0.46
Oral and Maxillofacial Surgery	2,914,684	$ 4,080,325	50,768	209	$ 80.37	$ 1.40	2,914,194	$ 3,968,549	49,643	204	$ 79.94	$ 1.36
Orthodontics	2,914,684	$ 4,812,122	2,611	11	$ 1,843.02	$ 1.65	2,914,194	$ 6,318,099	3,292	14	$ 1,919.23	$ 2.17
Partial Dentures	2,914,684	$ 826,129	6,388	26	$ 129.33	$ 0.28	2,914,194	$ 907,164	6,861	28	$ 132.22	$ 0.31
Periodontics	2,914,684	$ 367,625	6,366	26	$ 57.75	$ 0.13	2,914,194	$ 382,455	6,673	27	$ 57.31	$ 0.13
Preventative	2,914,684	$ 15,120,270	827,806	3,408	$ 18.27	$ 5.19	2,914,194	$ 16,543,939	845,331	3,481	$ 19.57	$ 5.68
Prosthodontics	2,914,684	$ 1,035,323	2,007	8	$ 515.86	$ 0.36	2,914,194	$ 991,623	1,993	8	$ 497.55	$ 0.34
Restorative	2,914,684	$ 11,813,219	153,013	630	$ 77.20	$ 4.05	2,914,194	$ 12,088,815	155,096	639	$ 77.94	$ 4.15
Total	**2,914,684**	**$ 40,746,179**	**1,086,151**	**4,472**	**$ 37.51**	**$ 13.98**	**2,914,194**	**$ 43,901,337**	**1,106,222**	**4,555**	**$ 39.69**	**$ 15.06**

Attachment 8 - Dental Rates

FY2018 Rate Summary				
Age Band	**FY15 MMs**	**Net Medical Rate**	**NML**	**Loaded Rate**
0-1	295,534	$ 1.63	9.0%	$ 1.80
2-5	467,090	$ 16.71	9.0%	$ 18.36
6-18	1,191,822	$ 25.61	9.0%	$ 28.13
19-24	123,094	$ 13.20	9.0%	$ 14.51
25-54	494,494	$ 16.75	9.0%	$ 18.40
55-64	123,876	$ 15.45	9.0%	$ 16.97
65+	218,284	$ 10.40	9.0%	$ 11.43
Total	**2,914,194**	**$ 18.15**	**9.0%**	**$ 19.94**

Attachment 9

Quality Performance Program (QPP) Measures – Contract Year One

Base Performance Requirement	QPP Payment Threshold	% of QPP Pool
Claims Processing Timeliness - 15 Days: Process and pay or deny, as appropriate, at least 90% of all clean claims for dental services provided to members within fifteen (15) days of the date of receipt. The date of receipt is the date the DBPM receives the claim.	≥ 95% within 15 days	20%
Standard Service Authorizations: Process 80% of standard service authorization determinations within two (2) business days of obtaining appropriate dental information that may be required regarding a proposed admission, procedure, or service requiring a review determination.	≥ 85% within 2 business days	20%
Encounter Acceptance Rate: 95% of encounters submitted must be accepted by MLTC's Medicaid Management Information System pursuant to MLTC specifications.	≥ 98%	20%
Call Abandonment Rate: Less than 5% of calls that reach the Member/Provider 800 lines and are placed in queue but are not answered because the caller hangs up before a representative answers the call. Measured using annual system-generated reports.	<3%	10%
Average Speed to Answer: Calls to Member/Provider lines must be answered on average within 30 seconds. Measured using annual system-generated reports.	30 seconds	10%
Appeal Resolution Timeliness: The DBPM must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within forty-five (45) calendar days from the day the DBPM receives the	≥ 95% within 30 days	10%
Grievance Resolution Timeliness: The DBPM must dispose of each grievance and provide notice, as expeditiously as the member's health condition requires, within State-established timeframes not to Exceed ninety (90) calendar days from the day the DBPM receives the grievance.	≥ 95% within 60 days	10%

Attachment 10 – Liquidated Damages

Failed Deliverable	Penalty
Readiness Review	MLTC will conduct a formal review of the DBPM's readiness to implement all required services described in this RFP. Should the DBPM fail the review, MLTC may assess damages of $5,000.00 for each calendar day until such time as MLTC certifies that the DBPM has met all readiness requirements.
Date of Implementation	Should the DBPM fail to begin full operations on the contract start date, and should MLTC determine that the DBPM is responsible for the delay, MLTC may assess damages of $10,000.00 per calendar day for each day beyond the contract start date that the DBPM fails to begin full operations.
Network Performance Requirement	The DBPM must have a contracted provider network in place and submit the required attestation of network sufficiency ninety (90) calendar days prior to the contract start date. A penalty of $1,000.00 shall be assessed, at MLTC' discretion, per calendar day for each day that the provider network is not adequate to meet the service needs of the covered populations as described in Section IV.D – Provider Network Requirements and the attestation of network sufficiency has not been received.
Employment of Key Personnel	The DBPM must meet all key personnel requirements specified in Section IV.D – Staffing Requirements. MLTC may assess a penalty of $1,000.00 per calendar day, per position, for each day after the thirty (30) allowed calendar days that a key position remains unfilled by a qualified person approved by MLTC.
Excessive Reversals on Appeal	If the DBPM exceeds ten percent (10%) of member appeals overturned upon final appeal over a 12-month period (January – December or the first twelve months that the contract is in effect), a penalty of $25,000.00 may be imposed for every additional overturned appeal. This penalty may also be assessed for each occurrence in which the DBPM does not provide the medical services or requirements set forth in an administrative decision by MLTC or a state fair hearing.
Ongoing and Ad Hoc Reporting	As detailed in Attachment 5 – Reporting Requirements, MLTC may assess a penalty of $1,000.00 for each calendar day that a report is late, inaccurate, includes less than the required copies, or is not in the approved format.

Attachment 10 – Liquidated Damages

Encounter Data	$5,000.00 per calendar day for each day after the due date that the monthly encounter data has not been received in the format and per specifications required by MLTC. $5,000.00 per calendar day for each day encounter data is received after the due date, for failure to correct and resubmit encounter data that was originally returned to the DBPM for correction because submission data was in excess of the 5% error rate threshold, until acceptance of the data. $5,000.00 per return of re-submission of encounter data that was returned to the DBPM, as submission data was in excess of the 5% error rate threshold, for correction and was rejected for the second time. $5,000.00 per calendar day for inability to reconcile financial statement of medical expenses paid with the total dollars submitted through encounter data for that quarter within ten percent (10%) for 2017 and five percent (5%) for 2018. $5,000.00 per occurrence of medical record review by MLTC or its designee where the DBPM or its provider(s) denotes provision of services which were not submitted in the encounter data regardless of whether or not the provider was paid for the service that was documented.
Claims Processing	Ninety percent (90%) of all clean claims must be paid within fifteen (15) business days of the date of receipt. If not met, subject to $5,000.00 for the each month that a DBPM's claims performance percentages by claim type fall below the performance standard. Ninety-nine percent (99%) of all clean claims must be paid within sixty (60) calendar days of the date of receipt. If not met, subject to $5,000.00 for the each month that a DBPM's claims performance percentages by claim type fall below the performance standard.
PCD Assignment	$2,500.00 per calendar day for failure to assign a PCD within one month of the effective date of enrollment until the assignment is made.
Member Services	$2,500.00 per calendar day for failure to provide member services functions from 7:00 a.m. to 7:00 p.m. central time, Monday through Friday, to address nonemergency issues encountered by members, and 24 hours a day, 7 days a week to address emergency issues encountered by members.
Provider Services	$2,500.00 per calendar day for failure to furnish provider services functions from 7:00 a.m. to 7:00 p.m. central time, Monday through Friday, to address nonemergency issues encountered by members, and 24 hours a day, 7 days a week to address emergency issues encountered by members and for failure to handle emergent provider issues on a 24 hours a day, 7 days a week basis.

Intermediate Sanctions
Per 42 CFR 438.704(b)(1): A maximum of $25,000.00 for each determination of failure to provide services; misrepresentation or false statements to enrollees, potential enrollees or health care providers; failure to comply with provider incentive plan requirements; marketing violations.
Per 42 CFR 438.704(b)(2): A maximum of $100,000.00 for each determination of discrimination; misrepresentation or false statements to CMS or the State or any such action or inaction that the State deems a violation that merits a fine consistent with this section.
Per 42 CFR 438.704(b)(3): A maximum of $15,000.00 for each member the State determines was not enrolled because of a discriminatory practice (subject to the $100,000.00 overall limit above) or any such action or inaction that the State deems a violation that merits a fine consistent with this section.
Per 42 CFR 438.704(c): A maximum of $25,000.00 or double the amount of the excess charges, (whichever is greater) for charging premiums or charges in excess of the amounts permitted under the Medicaid program; or any such action or inaction that the State deems a violation that merits a fine consistent with this section. The State must deduct from the penalty the amount of overcharge and return it to the affected enrollee(s).

Attachment 11
Proposal Statements and Questions

No.	RFP Section	Statement/Question	Page Limit
1	Not applicable	Identify and describe any regulatory action or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against the DBPM's organization within the last five years. In addition, identify and describe any letter of deficiency issued, as well as any corrective actions required by any federal or state regulatory entity within the last five years that relate to Medicaid and CHIP contracts. Include the organization's parent company, affiliates, and subsidiaries in the response to this question.	Not applicable
2	IV.B Eligibility and Enrollment	Describe the DBPM's anticipated process to utilize the eligibility and enrollment files from MLTC or its designee to manage membership. Include the process for resolving discrepancies between these files and internal membership records.	1 page
3	IV.C Business Requirements	Describe the approach the DBPM will take to ensure compliance with all relevant provisions of Part 438 of Chapter 42 of the CFR, Title 471, 477, and 482 NAC.	Not applicable
4	IV.C Business Requirements	Include a copy of the COA from the Department of Insurance.	Not applicable
5	IV.C Business Requirements	Describe the DBPM's proposed approach for collaboration with other entities and programs, as required in Section IV.C.	3 pages
6	IV.C Business Requirements	Describe if any of the DBPM's Medicaid DBPMs are accredited by NCQA and, if not currently accredited in Nebraska, how it will attain accreditation for its Nebraska DBPM. Please describe any unsuccessful accreditation attempts in other states.	1 page
7	IV.C Business Requirements	If applicable, describe any restriction of coverage for counseling or referral services the DBPM is required to provide because of moral or religious obligation. Describe how the DBPM will provide members with access to those services.	1 page
8	IV.D Staffing Requirements	Describe the organization's number of employees, lines of business, and office locations. Submit an organizational chart showing the structure and lines of responsibility and authority in the company. Include the organization's parent organization, affiliates, and subsidiaries that will support this contract.	3 pages, excluding organizational chart

No.	RFP Section	Statement/Question	Page Limit
9	IV.D Staffing Requirements	Provide an organizational chart for this contract, including but not limited to key staff and additional required staff. Label this "Nebraska Organizational Chart"	Not applicable
10	IV.D Staffing Requirements	In table format, indicate the proposed number of FTEs for each key staff and additional required staff for discrete time periods (no longer than 3 month intervals) from contract award through 6 months after the start date of operations and whether or not positions are located in Nebraska. Label this table "Proposed FTEs by Time Period."	Not applicable
11	IV.D Staffing Requirements	Provide job descriptions (including education and experience qualifications) of employees in key staff positions.	1 page per job description
12	IV.E. Covered Benefits and Services	Provide the DBPM's definition of medical necessity. Describe the process for developing and periodically reviewing and revising the definition. Describe the degree to which the definition is consistent with or differs from MLTC's definition of medically necessity per 471 NAC 1-002.02A.	3 pages
13	IV.E Covered Benefits and Services	Provide a description of the value-added services the DBPM proposes to offer to members. For each service: • Define and describe the service. • Note any limitations or restrictions that apply to the service. • Propose how and when members and providers will be notified of the service's availability. • Describe how a member may obtain/access the service. • Describe how the DBPM will identify the expanded benefit in administrative or encounter data.	Not applicable
14	IV.E Covered Benefits and Services	Describe the DBPM's approach to member education and outreach regarding EPSDT, including any innovative mechanisms. Address the use of the DBPM's system for tracking each member's screening, diagnosis and treatment to ensure services are delivered within the established timeframes.	4 pages

No.	RFP Section	Statement/Question	Page Limit
15	IV.G Member Services and Education	Describe member services processes including: • Training of customer service staff (both initial and ongoing). • Routing calls to appropriate persons, including escalation. • Making information available to customer service staff (the type of information and how it is provided, e.g. hard copy or on-line search capacity). • Handling calls from members with limited English proficiency and persons who are hearing impaired. • Monitoring and ensuring the quality and accuracy of information provided to members. • Monitoring and ensuring adherence to performance standards. • How MSRs will interact with other organizations including MLTC and other programs/social service entities (e.g., WIC, housing assistance, and homeless shelters). • After hours procedures.	6 pages
16	IV.G Member Services and Education	Describe the informational materials the DBPM proposes to send to new members.	2 pages
17	IV.G Member Services and Education	Describe the approach the DBPM will take to provide members with written material that is easily understood, including alternate formats and other languages. Address how the DBPM will ensure that materials are at the appropriate reading level.	2 pages
18	IV.G Member Services and Education	Provide an overview of the DBPM's proposed member website, including how it will satisfy requirements in this RFP. Provide examples of information that will be available on the website and on portals for members.	6 pages
19	IV.G Member Services and Education	Discuss the DBPM's approach to welcoming new members, addressing requirements listed in the RFP. Discuss any proposed alternate methods or plans the DBPM would use to effectively welcome members.	3 pages
20	IV.G Member Services and Education	Detail the strategies the DBPM will use to influence member behavior to access health care resources appropriately and adopt healthier lifestyles.	5 pages

No.	RFP Section	Statement/Question	Page Limit
21	IV.G Member Services and Education	Describe proposed member education content and materials and attach examples used with Medicaid or CHIP populations in other states. Describe innovative methods the DBPM has used for member education. Describe how the DBPM will provide equitable member education throughout the State. Provide examples and descriptions of how member education will be used to improve service coordination including: • The use of technological tools, including social media and mobile technology. • Partnership with community-based organizations for education and outreach.	10 pages
22	IV.H Grievances and Appeals	Provide a flowchart and comprehensive written description of the DBPM's member grievance and appeals process, including the approach for meeting the general requirements and plan to: • Ensure individuals who make decisions about grievances and appeals have the appropriate expertise and were not involved in any previous level of review. • Ensure an expedited process exists when taking the standard time could seriously jeopardize the member's health. As part of this process, explain how the DBPM will determine when the expedited process is necessary. • Use data from the grievance and appeals system to improve the DBPM's operational performance.	3 pages
23	IV.H Grievances and Appeals	Describe the approach the DBPM will take to provide members with grievance, appeal, and State fair hearing information. Address how the DBPM will ensure 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.	2 pages

No.	RFP Section	Statement/Question	Page Limit
24	IV.I Provider Network Requirements	Describe the DBPM's proposed provider network outreach approach and recruitment strategy. Provide a detailed work plan for developing an adequate network within the timeframe described in Section IV.I. Describe the method the DBPM plans to use on an ongoing basis to assess and ensure that MLTC's network standards are maintained, including standards related to: • Distance. • Appointment access. • Cultural competency.	6 pages, excluding plan for developing an adequate network
25	IV.I Provider Network Requirements	Provide a comprehensive discussion of the DBPM's approach to maximizing the number of members participating in a Dental Home, including: • The strategy the DBPM will use initially, and on an ongoing basis, to ensure Dental Home participation. • Examples of successful strategies and lessons learned in encouraging Dental Home participation.	
26	IV.I Provider Network Requirements	Describe the DBPM's required Dental Home responsibilities and how the DBPM will verify Dental Home providers are performing them.	2 pages
27	IV.I Provider Network Requirements	Describe innovative strategies the DBPM's intends to use to identify specialty types for which member access is limited. Describe the DBPM's intended initiatives for increasing the number of specialists within those specialty types that participate in the DBPM's network. Identify potential challenges the DBPM anticipates in ensuring members receive appropriate care for specialties where access concerns exist, and explain how the DBPM will mitigate those challenges.	3 pages
28	IV.I Provider Network Requirements	Describe the DBPM's process for monitoring and ensuring adherence to MLTC's requirements regarding appointment availability and wait times.	2 pages

No.	RFP Section	Statement/Question	Page Limit
29	IV.I Provider Network Requirements	Describe the DBPM's approach to promoting and facilitating the capacity of its providers to provide: • Patient-centered care. • Improved health outcomes. • Member compliance. • Member satisfaction. Discuss the DBPM's successes with patient- centeredness in other Medicaid programs, what lessons have been learned, and the DBPM's planned approach in Nebraska.	3 pages
30	IV.I Provider Network Requirements	Describe how the DBPM would respond to the network termination or loss of a large-scale provider group. Take the following areas into consideration in the response: • Notification to MLTC. • The automated systems and membership supports used to assist affected members with provider transitions. • Systems and policies used for continuity of care of members experiencing provider transitions. • Impact if the loss is in a geographic area where other providers of the same provider type are not available and the DBPM's response to that impact.	3 pages
31	IV.I Provider Network Requirements	Describe the DBPM's credentialing and re-credentialing process including: • Ensuring that providers are enrolled in Medicaid and have a valid identification number. • Obtaining information on ownership and control. • Identifying excluded providers and persons convicted of crimes searches. • Using quality and utilization measures in the recredentialing process.	3 pages

No.	RFP Section	Statement/Question	Page Limit
32	IV.I Provider Network Requirements	Explain the process the DBPM will put in place to maintain the provider file with detailed information on each provider sufficient to support provider payment, including issuance of IRS 1099 forms, meeting all federal and MLTC reporting requirements, and cross referencing State and Federal identification numbers to ensure excluded providers are identified.	2 pages
33	IV.J Provider Services	Describe the DBPM's Provider Services toll-free telephone line, including: • How the DBPM will provide a fully-staffed line between the hours of 7:00 a.m. and 7:00 p.m. CST. Monday through Friday, to address non-emergency issues. • How the DBPM will ensure that provider calls are acknowledged and resolved within three business days of receipt. • The location of operations, and if out of state, describe how the DBPM will accommodate services for Nebraska. • How the DBPM will measure and monitor the accuracy of responses provided by call center staff, as well as caller satisfaction.	3 pages
34	IV.J Provider Services	Provide an overview of the DBPM's proposed provider website, including examples of information that will be available on the website and on portals for providers. Include proposed resources and tools that will be of use to providers. Please provide a description of technology that will be used to enhance the provider website.	5 pages excluding sample resources, tools and materials

No.	RFP Section	Statement/Question	Page Limit
35	IV.J Provider Services	Describe the DBPM's proposed provider education and training program, including • A description of the training program. • A work plan that outlines education and training activities, including frequency of office visits to conduct activities. • A listing of the types of materials and content the DBPM will distribute (include three samples of materials). • How the DBPM will evaluate usefulness of educational sessions and utilize feedback to influence future training sessions.	5 pages, excluding sample materials
36	IV.J Provider Services	Provide a description of the DBPM's proposed approach to handling provider complaints. Include intended interaction and correspondence, as well as timeframes in which the DBPM will acknowledge and resolve inquiries and grievances. Explain how the DBPM will track provider complaints and how the DBPM will use this type of information to improve provider services. Include a description of any type of internal reporting the DBPM will perform, and how the DBPM will use reporting information to influence the activities of the DBPM's provider services representatives.	3 pages
37	IV.J Provider Services	Describe the approach the DBPM will take to assess provider satisfaction, including tools the DBPM plans to use, frequency of assessment, and responsible parties. Provide relevant examples of how the DBPM has utilized survey results to implement quality improvements in similar programs and how these changes have improved outcomes.	5 pages

No.	RFP Section	Statement/Question	Page Limit
38	IV.K Subcontracting Requirements	For each subcontractor included in the proposal, provide the organization's role in this project, corporate background, size, resources and details addressing the following: • The date the company was formed, established or created. • Ownership structure (whether public, partnership, subsidiary, or specified other). • Organizational chart. • Total number of employees. • Whether the subcontractor is currently providing services for the DBPM in other states and the subcontractor's location.	1 page per subcontracting organization
39	IV.K Subcontracting Requirements	For subcontracted roles included in the proposal, describe the DBPM's process for monitoring and evaluating performance and compliance, including but not limited to how the DBPM will: • Ensure receipt of all required data including encounter data. • Ensure that utilization of health care services is at an appropriate level. • Ensure delivery of administrative and health care services at an acceptable or higher level of care to meet all standards required by this RFP. • Ensure adherence to required grievance policies and procedures.	8 pages
40	IV.L Care Coordination	Describe how the DBPM will assist members to identify and gain access to community resources that provide services the Medicaid program does not cover.	2 pages

No.	RFP Section	Statement/Question	Page Limit
41	IV.M Quality Management	Provide a description of the DBPM's proposed QAPI program. Include the following in the description: • The proposed structure, and policies and procedures that explain the accountability of each organizational unit. • The program's infrastructure, including coordination with subcontractors and corporate entities, if applicable. • Proposed QAPI committee membership and committee responsibilities. • How focus areas will be selected, including how data will be used in the selection process. • The proposed QAPI work plan, including planned initiatives.	10 pages
42	IV.M Quality Management	Describe experience in using results of performance measures, member satisfaction surveys, and other data to drive improvements and positive affect the health care status of members. Provide examples of changes implemented to improve the program and members' health outcomes.	5 pages
43	IV.M Quality Management	Describe the DBPM's process for soliciting feedback and recommendations from key stakeholders, members, and families/caregivers, and using the feedback to improve the DBPM's quality of care.	2 pages
44	IV.M Quality Management	Describe the DBPM's proposed methodology to identify, design, implement, and evaluate PIPs. Provide examples of PIPs conducted by the DBPM, and how operations improved because of their results.	3 pages
45	IV.M Quality Management	Discuss the DBPM's approaches to annual member satisfaction surveys. Provide relevant examples of how the DBPM has utilized survey results to implement quality improvements in similar programs and how these changes have improved outcomes.	1 page

No.	RFP Section	Statement/Question	Page Limit
46	IV.M Quality Management	Describe the DBPM's practice of profiling the quality of care delivered by dental providers, including the methodology for determining which and how many providers will be profiled. • Submit sample quality reports. • Describe the rationale for selected the measures that are gathered/reported. • Describe the proposed frequency of profiling activities.	3 pages, excluding sample quality reports
47	IV.M Quality Management	Describe the information the DBPM will provide to members and providers about the QAPI program.	2 pages
48	IV.N Utilization Management	Describe the DBPM's approach to utilization management, including: • Innovations and automation the DBPM will use for its UM program. • Accountability for developing, implementing, and monitoring compliance with utilization policies and procedures, and consistent application of criteria by individual clinical reviewers. • Mechanisms to detect and document over- and under-utilization of dental services. • Processes and resources used to develop and regularly review utilization review criteria. • How the DBPM will use its UM Committee to support UM activities.	5 pages
49	IV.N Utilization Management	Describe the process the DBPM will have in place to determine appropriate practice guidelines notify providers of new practice guidelines, and monitor implementation of those guidelines.	2 pages

No.	RFP Section	Statement/Question	Page Limit
50	IV.N Utilization Management	Describe the DBPM's proposed approach to prior authorization, including: • The data sources and processes to determine which services require prior authorization, and how often these requirements will be reevaluated. Describe what will be considered in the reevaluation of need for current prior authorization requirements. • The proposed prior authorization processes for members requiring services from non-participating providers and expedited prior authorization. • The DBPM's process for notifying providers either verbally or in writing, and the member in writing, of denials or decisions to authorize services in amount duration or scope that is less than requested.	4 pages
51	IV.N Utilization Management	Provide a listing of services for which the DBPM will require prior authorization and describe how the DBPM will communicate this information, as well as the results of authorization decisions, to providers and members.	2 pages excluding the listing of services
52	IV.N Utilization Management	Describe how the DBPM will ensure members receive written and timely notice of action relating to adverse actions taken by the DBPM.	1 page
53	IV.N Utilization Management	Describe the DBPM's process for conducting retrospective reviews to examine trends, issues, and problems in utilization.	2 pages
54	IV.N Utilization Management	Describe the DBPM's methodology to assess disparities in treatment among races and ethnic groups and correct those disparities.	2 pages
55	IV.O Program Integrity	Describe the DBPM's approach for meeting the Program Integrity requirements described in the RFP, including but not limited to a compliance plan for the prevention, detection, reporting, and implementation of corrective actions for suspected cases of FWA and erroneous payments. Include best practices the DBPM has utilized in other states.	4 pages
56	IV.O Program Integrity	Describe how the DBPM currently works with other entities that investigate and prosecute provider and member fraud, waste, and abuse. How will the DBPM apply methods in Nebraska?	2 pages

No.	RFP Section	Statement/Question	Page Limit
57	IV.O Program Integrity	Currently, how does the DBPM educate members and providers to prevent fraud, waste, abuse, and erroneous payments? How will the DBPM apply methods in Nebraska?	3 pages
58	IV.O Program Integrity	Describe the DBPM's method and process for capturing TPL and payment information from its claims system. Explain how the DBPM will use this information.	3 pages
59	IV.Q Provider Reimbursement	Describe the DBPM's approach to ensuring that out of network prior authorization and payment issues are resolved expeditiously in instances when the DBPM is unable to provide necessary services to a member within its network.	2 pages
60	IV.S Systems and Technical Requirements	Provide a general system description that details how each component of the DBPM's health information system will support the major functional areas of the DBP. Include a systems diagram that highlights each system component, including subcontractor components, and the interfacing or supporting systems used to ensure compliance with RFP requirements. Describe how the DBPM's system will share information between Nebraska's systems and its own system to avoid duplication of effort. Identify any requirements that cannot be met without custom modifications or updates to the DBPM's systems. If modifications or updates or updates are required, describe them and the DBPM's plan for completion prior to program operations.	12 pages, not including the systems diagram
61	IV.S Systems and Technical Requirements	Provide a description of how the DBPM will comply with applicable Federal (including but not limited to HIPAA) standards for information exchange, and ensure adequate system access management and information accessibility. Affirm the DBPM's use of HIPAA-compliant files and transaction standards. Include the process for resolving discrepancies between member eligibility files and the DBPM's internal membership records, including differences in members' addresses.	3 pages

No.	RFP Section	Statement/Question	Page Limit
62	IV.S Systems and Technical Requirements	Describe the DBPM's approach to monitoring system availability issues and the resolution process. Provide a description of the DBPM's system help desk. Include the DBPM's process for ensuring that recurring problems, not specific to system unavailability, are identified and reported to DBPM management within one business day of recognition and are promptly corrected.	2 pages
63	IV.S Systems and Technical Requirements	Provide a description of the DBPM's eligibility and enrollment database. Include a description of how the DBPM will: • Complete updates within the timeframes specified in the contract. • Identify members across multiple populations and systems. • Monitor, track, and resolve any discrepancies between the enrollment files and the DBPM's system (e.g., duplication of records and information mismatches).	2 pages
64	IV.S Systems and Technical Requirements	Provide a description of the DBPM's information security management functions. Include a description of proposed access restrictions for various hierarchical levels, controls for managing information integrity, audit trails, and physical safeguards of data processing facilities.	3 pages

No.	RFP Section	Statement/Question	Page Limit
65	IV.S Systems and Technical Requirements	Describe the DBPM's business continuity, contingency, and recovery planning. Attach a copy of the DBPM's plan, or summarize how the plan addresses the following aspects of emergency preparedness and disaster recovery: • Operational and system redundancy in place to reduce the risk of down-time. • System and operational back-up sites. • Contingency and recovery planning including resumption of operations. • Prioritized business functions for resumption of operations and responsible key personnel. • Employee and supplier preparedness, including a plan for training and communication to employees and suppliers and identified responsibilities of key personnel, in the event communications are unavailable. • Approach to provider preparedness for continuity of member care and assurance of payment for services rendered in good faith. • Testing approach and regular schedule to improve and update the plan over time.	3 pages, excluding sample plan
66	IV.R Claims Management	Describe the DBPM's strategies for ensuring its claim processing is ready at the time of contract implementation, to ensure timely accurate claims processing. Include the DBPM's strategy for identifying problem areas, and how the DBPM will ensure rapid response.	2 pages
67	IV.R Claims Management	Describe the DBPM's methodology for ensuring that claims payment accuracy standards will be achieved. At a minimum, address: • The process for auditing claims samples. • Documentation of the results of these audits. • The processes for implementing any necessary corrective actions resulting from the audit.	3 pages
68	IV.R Claims Management	Describe in detail how the DBPM will verify that services were actually provided including: • Minimum sampling criteria to ensure a representative sample. • How results of monitoring will be reported to the State quarterly.	3 pages

No.	RFP Section	Statement/Question	Page Limit
69	IV.R Claims Management	Describe the DBPM's approach for ensuring encounter data is submitted accurately and timely to MLTC, consistent with required formats. Include in the response how the DBPM proposes to monitor data completeness and manage the non-submission of encounter data by a provider or subcontractor.	5 pages
70	IV.T Reporting and Deliverables	Provide an example of dashboards that the DBPM will use to track DBPM performance for DBPM leadership and the QAPI Committee.	Not applicable
71	IV.T Reporting and Deliverables	Provide examples of the following reports: • Member Grievance System • Performance Improvement Projects How will the DBPM use required reports in its day to day management and operations?	Not applicable
72	IV.F FFS Claims Management and Processing	Provide a detailed description of the DBPM's approach to implementing the necessary functionality to support FFS claims processing.	Not applicable
73	IV.F FFS Claims Management and Processing	Describe the level of effort necessary to support Nebraska program and policy changes, including but not limited to new covered services, prior authorization requirements, or additional populations.	Not applicable
74	IV.F FFS Claims Management and Processing	Describe how the DBPM will maintain a distinction between FFS and managed care processing rules, claims transactions, providers, members and prior authorizations within the system.	Not applicable
75	IV.F FFS Claims Management and Processing	Provide an explanation of the DBPM's plan and approach for business operations to support the FFS volume vs. the risk-based volume. Will the plan have separate or joint business operations units for some or all processes?	Not applicable
76	IV.F FFS Claims Management and Processing	Provide an explanation of the significant risks associated with the implementation and ongoing operation of claims broker services, and provide mitigation strategies for those risks.	Not applicable
77	IV.F FFS Claims Management and Processing	Provide a timeline for implementation of claims broker functionality, including the number of months that it will take to pay FFS claims.	Not applicable

No.	RFP Section	Statement/Question	Page Limit
78	IV.V Transition and Implementation	Provide a preliminary implementation plan that describes the DBPM's plan to comply with all the major areas of the contract including: • Member services • Network development and management • Provider education • Quality management, including credentialing • Utilization management • Transition and care coordination • Information systems management • Claims management • Grievances and appeals	Not applicable

This attachment is intended as a summary of the policies, procedures and plan requirements included in the RFP. The RFP may contains additional requirements not included in this attachment. The DBPM must comply with all reporting requirements found in the RFP, attachments, and addendums.		
Required with Proposal	**Description**	**Due Date**
Provider Contract Template	Submit provider contract template as described in Section IV.I - Provider Network.	Required with proposal
Network Development Plan	Submit plan for developing an adequate provider network within the timeframe described in Section IV.I - Provider Network.	Required with proposal
Key Staff Resumes	As possible, submit resumes of proposed key staff as described in Section IV.V - Transition and Implementation.	Required with proposal
Preliminary Implementation Plan	Submit preliminary implementation plan as described in Section IV.V - Transition and Implementation.	Required with proposal
Draft Member Handbook	Submit a draft copy of the member handbook as described in Section IV.G – Member Services and Education.	Required with proposal
Contract Award Period	**Description**	**Due Date**
Implementation Plan	Submit contract implementation plan as described in Section IV.V - Transition and Implementation.	15 calendar days after date of award
30 Calendar Days After Date of Award	**Description**	**Due Date**
Marketing and Member Education Plan	Submit plan detailing proposed marketing activities and materials as described in Section IV.G - Member Services and Education.	30 calendar days after date of award
Welcome Packet Contents	Submit welcome packet materials including the member handbook.	30 calendar days after date of award

DBPM Provider Website	As detailed in Section IV.J - Provider Services, the DBPM's provider website is considered marketing material and must be submitted for review and approval.	30 calendar days after date of award
Provider Training Handbook and Training Schedule	Submit a copy of the provider training handbook and training schedule as described in Section IV.J - Provider Services	30 calendar days after date of award
Provider Handbook	Submit provider handbook for approval as described in Section IV.J - Provider Services	30 calendar days after date of award
Utilization Management Policies and Procedures	Submit UM program description as described in Section IV.N - Utilization Management.	30 calendar days after date of award
Provider Complaint System	Submit policies and procedures detailing the ~~MCO~~DBPM's provider complaint system as described in Section IV.J - Provider Services.	30 calendar days after date of award
Provider Directory Template	Submit templates for the provider directory as described in Section IV.E - Members Services and Education.	30 calendar days after date of award
Human Resources and Staffing Plan	Submit a plan detailing how the ~~MCO~~DBPM will obtain and maintain appropriate staffing levels as described in Section IV.D – Staffing Requirements.	30 calendar days after date of award
90 Days Prior to Contract Start Date	**Description**	**Due Date**
Provider Network List	Submit list of all network providers via the provider enrollment file as described in Section IV.I - Provider Network.	90 days prior to contract start date
Provider Network Sufficiency Attestation	Submit data and analysis attesting to the sufficiency of the ~~MCO~~DBPMs network as described in Section IV.I - Provider Network.	90 days prior to contract start date
Subcontracts	Submit all subcontracts for the provision of any services for prior review and approval as described in Section IV.K - Subcontracting.	90 days prior to contract start date

Continuity of Care	Submit policies and procedures for continuity of care.	60 days prior to contract start date
60 Days Prior to Contract Start Date	**Description**	**Due Date**
QAPI Work Plan	Submit QAPI work plan as described in Section IV.M – Quality Management.	60 days prior to contract start date
QAPI Program Description	Submit overview of QAPI program as described in Section IV.M - Quality Management	60 days prior to contract start date
Corrective Action Monitoring	Submit policies and procedures for evaluating corrective actions.	60 days prior to contract start date
Claims Dispute Process	Submit policies and procedures for addressing claims disputes as described in Section IV.S - Claims Management.	60 days prior to contract start date
Provider Incentive Plan Contract Templates	Submit contract templates for Physician Incentive Plan participants as described in Section IV.Q - Provider Reimbursement.	60 days prior to contract start date
Service Authorization	Submit policies and procedures for service authorization as described in Section IV.N - Utilization Management.	60 days prior to contract start date
Retrospective UR Functions	Submit policies for retrospective UR functions as described in Section IV.N - Utilization Management.	60 days prior to contract start date
Key Staff List	Submit the names, resumes and contact info for all key staff as described in Section IV.D – Staffing Requirements.	60 days prior to contract start date

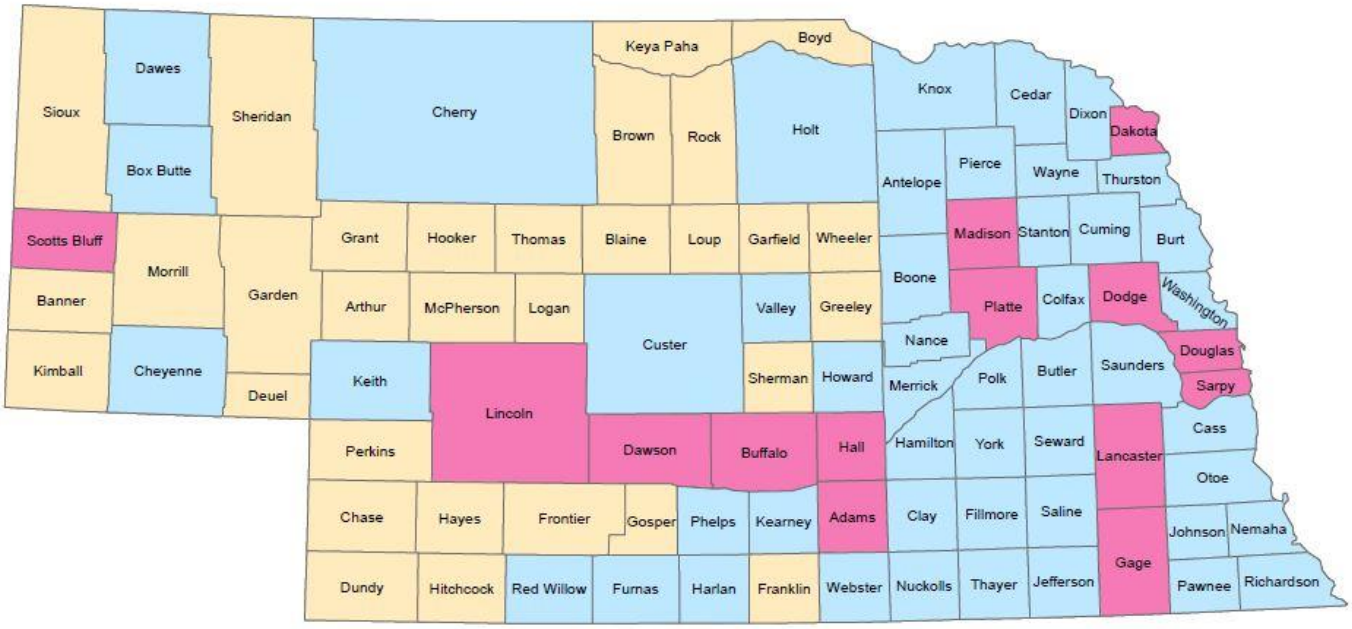
Grievances and Appeals	Submit policies and procedures for the handling of member/provider grievances and appeals as described in Section IV.H - Grievances and Appeals.	60 days prior to contract start date
45 Days Prior to Contract Start Date	**Description**	**Due Date**
Amount, Duration, and Scope Policies	Submit amount, duration and scope policies.	45 days prior to contract start date
Value-Added Services	Provide a description of the expanded services/benefits the DBPM will provided as described in Section IV.E - Covered Benefits and Services	45 days prior to contract start date
Credentialing/Recredentialing	Submit policies and procedures for credentialing and recredentialing providers as described in Section IV.I - Provider Network Requirements.	45 days prior to contract start date
Network - Communication of Change	Submit procedures for communicating contractual and/or program changes to providers.	45 days prior to contract start date
Network Compliance	Submit procedures for ensuring provider compliance with State and DBPM policies as described in Section IV.I - Provider Network Requirements.	45 days prior to contract start date
Network Service	Submit procedures for evaluating the quality of services provided by the network.	45 days prior to contract start date
Network Insufficiency	Submit policies and procedures for arranging for medically necessary services in the event of temporary network insufficiency as described in Section IV.I - Provider Network.	45 days prior to contract start date
Network Monitoring	Submit procedures for monitoring the adequacy, accessibility and availability of network providers as described in Section IV.I - Provider Network Requirements.	45 days prior to contract start date
Compliance Plan	Submit fraud, waste, abuse and erroneous payments compliance plan as described in Section IV.O - Program Integrity.	45 days prior to contract start date

Fraud, Waste, Abuse and Erroneous Payments	Submit fraud, waste, abuse and erroneous payments policies as described in Section IV.O - Program Integrity.	45 days prior to contract start date
Timely Access	Submit policies and procedures for the monitoring of timely access requirements as described in Attachment 4 - Access Standards.	45 days prior to contract start date
Member Privacy	Submit policies and procedures for protecting member privacy.	45 days prior to contract start date
Second Opinions	Submit policies and procedures regarding ensuring member access to a second opinion.	45 days prior to contract start date
30 Days Prior to Contract Start Date	**Description**	**Due Date**
Subcontractor Evaluation	Submit copies of subcontractor evaluations as described in Section IV.C - Business Requirements.	30 days prior to contract start date
Third Party Liability	Submit procedures for identifying TPL and administrating payment as described in Section IV.R - Claims Management.	30 days prior to contract start date
Clinical Practice Guidelines	Submit clinical practice guidelines developed in accordance with requirements in Section IV.N - Utilization Management.	30 days prior to contract start date
Emergency Dental Services	Submit policies and procedures for emergency dental services as described in Section IV.E - Covered Benefits and Services.	30 days prior to contract start date
Indian Health Protections	Submit policies and procedures for Indian health protections as described in Section IV.Q - Provider Reimbursement.	30 days prior to contract start date
EPSDT Services	Submit policies and procedures for EPSDT services as described in Section IV.E - Covered Benefits and Services.	30 days prior to contract start date
Staffing	Submit policies and procedures for staffing as described in Section IV.D - Staffing.	30 days prior to contract start date

Maintenance of Medical Records	Submit policies and procedures for the maintenance of medical records.	30 days prior to contract start date
Medical Record Confidentiality	Submit policies and procedures regarding maintaining the confidentiality of member medical records.	30 days prior to contract start date
Member Calls	Submit policies and procedures for managing member calls as described in Section IV.F - Member Services and Education.	30 days prior to contract start date
Referrals	Submit policies and procedures on referrals for specialty care and other benefits not provided by the member's Dental Home provider.	30 days prior to contract start date
Provider Quality Deficiencies	Submit policies and procedures for reporting provider quality deficiencies as described in Section IV.I – Provider Network.	30 days prior to contract start date

Attachment 13

Nebraska Counties Classified by Urban/Rural/Frontier Status



Source: 2010 Census, US Census Bureau

Attachment 14 - COA-level Rate Development

	Base Data - FY2014						Base Data - FY2015					
Age Band	**MMs**	**Dollars**	**Units**	**Util/K**	**Unit Cost**	**PMPM**	**MMs**	**Dollars**	**Units**	**Util/K**	**Unit Cost**	**PMPM**
0-1	291,732	$ 371,307	14,453	595	$ 25.69	$ 1.27	295,534	$ 412,207	14,648	595	$ 28.14	$ 1.39
2-5	485,415	$ 6,482,648	214,074	5,292	$ 30.28	$ 13.35	467,090	$ 6,608,776	207,739	5,337	$ 31.81	$ 14.15
6-18	1,162,507	$ 22,231,271	608,994	6,286	$ 36.50	$ 19.12	1,191,822	$ 25,189,922	640,990	6,454	$ 39.30	$ 21.14
19-24	127,623	$ 1,407,887	32,060	3,015	$ 43.91	$ 11.03	123,094	$ 1,345,770	29,941	2,919	$ 44.95	$ 10.93
25-54	507,171	$ 6,920,777	151,145	3,576	$ 45.79	$ 13.65	494,494	$ 6,876,193	146,567	3,557	$ 46.92	$ 13.91
55-64	121,345	$ 1,471,187	28,727	2,841	$ 51.21	$ 12.12	123,876	$ 1,582,010	29,590	2,866	$ 53.46	$ 12.77
65+	218,891	$ 1,861,102	36,698	2,012	$ 50.71	$ 8.50	218,284	$ 1,886,458	36,747	2,020	$ 51.34	$ 8.64
Total	**2,914,684**	**$ 40,746,179**	**1,086,151**	**4,472**	**$ 37.51**	**$ 13.98**	**2,914,194**	**$ 43,901,337**	**1,106,222**	**4,555**	**$ 39.69**	**$ 15.06**

Attachment 14 - COA-level Rate Development

	IBNR Adjustment - FY2014						IBNR Adjustment - FY2015					
Age Band	IBNR Factor	Dollars	Units	Util/K	Unit Cost	PMPM	IBNR Factor	Dollars	Units	Util/K	Unit Cost	PMPM
0-1	1.000	$ 371,315	14,453	595	$ 25.69	$ 1.27	1.000	$ 412,301	14,651	595	$ 28.14	$ 1.40
2-5	1.000	$ 6,482,746	214,079	5,292	$ 30.28	$ 13.36	1.000	$ 6,610,005	207,785	5,338	$ 31.81	$ 14.15
6-18	1.000	$ 22,231,559	609,007	6,286	$ 36.50	$ 19.12	1.000	$ 25,195,813	641,140	6,455	$ 39.30	$ 21.14
19-24	1.000	$ 1,407,904	32,061	3,015	$ 43.91	$ 11.03	1.000	$ 1,346,013	29,947	2,919	$ 44.95	$ 10.93
25-54	1.000	$ 6,920,860	151,148	3,576	$ 45.79	$ 13.65	1.000	$ 6,877,481	146,598	3,558	$ 46.91	$ 13.91
55-64	1.000	$ 1,471,199	28,727	2,841	$ 51.21	$ 12.12	1.000	$ 1,582,332	29,596	2,867	$ 53.46	$ 12.77
65+	1.000	$ 1,861,117	36,699	2,012	$ 50.71	$ 8.50	1.000	$ 1,886,864	36,755	2,021	$ 51.34	$ 8.64
Total	**1.000**	**$ 40,746,699**	**1,086,173**	**4,472**	**$ 37.51**	**$ 13.98**	**1.000**	**$ 43,910,808**	**1,106,473**	**4,556**	**$ 39.69**	**$ 15.07**

Attachment 14 - COA-level Rate Development

	UNMC Repricing - FY2014						UNMC Repricing - FY2015					
Age Band	**FY14 UNMC %**	**Dollars**	**Units**	**Util/K**	**Unit Cost**	**PMPM**	**FY15 UNMC %**	**Dollars**	**Units**	**Util/K**	**Unit Cost**	**PMPM**
0-1	6.9%	$ 396,921	14,453	595	$ 27.46	$ 1.36	7.0%	$ 441,320	14,651	595	$ 30.12	$ 1.49
2-5	6.3%	$ 6,893,542	214,079	5,292	$ 32.20	$ 14.20	5.7%	$ 6,986,517	207,785	5,338	$ 33.62	$ 14.96
6-18	4.2%	$ 23,165,977	609,007	6,286	$ 38.04	$ 19.93	3.8%	$ 26,141,533	641,140	6,455	$ 40.77	$ 21.93
19-24	4.7%	$ 1,473,974	32,061	3,015	$ 45.97	$ 11.55	3.9%	$ 1,397,963	29,947	2,919	$ 46.68	$ 11.36
25-54	5.8%	$ 7,325,596	151,148	3,576	$ 48.47	$ 14.44	5.8%	$ 7,279,525	146,598	3,558	$ 49.66	$ 14.72
55-64	8.2%	$ 1,592,250	28,727	2,841	$ 55.43	$ 13.12	8.2%	$ 1,712,148	29,596	2,867	$ 57.85	$ 13.82
65+	5.7%	$ 1,966,328	36,699	2,012	$ 53.58	$ 8.98	5.8%	$ 1,996,767	36,755	2,021	$ 54.33	$ 9.15
Total	**5.1%**	**$ 42,814,588**	**1,086,173**	**4,472**	**$ 39.42**	**$ 14.69**	**4.7%**	**$ 45,955,773**	**1,106,473**	**4,556**	**$ 41.53**	**$ 15.77**

Attachment 14 - COA-level Rate Development

	Historical Trend - FY2014							50/50 Base Data Blend		
Age Band	**Util/K Trend**	**UC Trend**	**Util/K Factor**	**UC Factor**	**Util/K**	**Unit Cost**	**PMPM**	**Util/K**	**Unit Cost**	**PMPM**
0-1	2.0%	1.8%	1.02	1.02	606	$ 27.94	$ 1.41	601	$ 29.02	$ 1.45
2-5	2.0%	1.8%	1.02	1.02	5,398	$ 32.77	$ 14.74	5,368	$ 33.19	$ 14.85
6-18	2.0%	3.5%	1.02	1.03	6,415	$ 39.35	$ 21.04	6,435	$ 40.06	$ 21.48
19-24	2.0%	1.9%	1.02	1.02	3,076	$ 46.84	$ 12.01	2,998	$ 46.76	$ 11.68
25-54	2.0%	1.8%	1.02	1.02	3,649	$ 49.34	$ 15.00	3,603	$ 49.49	$ 14.86
55-64	2.0%	1.7%	1.02	1.02	2,899	$ 56.37	$ 13.62	2,883	$ 57.11	$ 13.72
65+	2.0%	1.8%	1.02	1.02	2,053	$ 54.54	$ 9.33	2,037	$ 54.44	$ 9.24
Total	**2.0%**	**2.7%**	**1.02**	**1.03**	**4,563**	**$ 40.48**	**$ 15.39**	**4,566**	**$ 41.01**	**$ 15.60**

Attachment 14 - COA-level Rate Development

	Prospective Trend							Non-Medical Load	
Age Band	**Util/K Trend**	**UC Trend**	**Util/K Factor**	**UC Factor**	**Util/K**	**Unit Cost**	**PMPM**	**Admin Load**	**PMPM**
0-1	2.0%	2.0%	1.06	1.06	637	$ 30.76	$ 1.63	9.0%	$ 1.80
2-5	2.0%	2.0%	1.06	1.06	5,697	$ 35.19	$ 16.71	9.0%	$ 18.36
6-18	2.0%	3.9%	1.06	1.12	6,838	$ 44.93	$ 25.60	9.0%	$ 28.13
19-24	2.0%	2.1%	1.06	1.06	3,185	$ 49.74	$ 13.20	9.0%	$ 14.51
25-54	2.0%	2.0%	1.06	1.06	3,828	$ 52.49	$ 16.74	9.0%	$ 18.40
55-64	2.0%	2.0%	1.06	1.06	3,062	$ 60.53	$ 15.44	9.0%	$ 16.97
65+	2.0%	2.0%	1.06	1.06	2,163	$ 57.71	$ 10.40	9.0%	$ 11.43
Total	**2.0%**	**3.1%**	**1.06**	**1.09**	**4,851**	**$ 44.90**	**$ 18.15**	**9.0%**	**$ 19.94**

Department of Health & Human Services

DHHS

N E B R A S K A

BUSINESS ASSOCIATE AGREEMENT

THIS BUSINESS ASSOCIATE AGREEMENT is made and entered into this ___day of ____, _____ by and between the Nebraska Department of Health and Human Services also hereinafter referred to as "Covered Entity**"** and **Name of Business Associate Here,** hereinafter also referred to as "Business Associate."

Preamble

THIS BUSINESS ASSOCIATE AGREEMENT ("Agreement") constitutes a non-exclusive agreement between Covered Entity, and the Business Associate named above. The purpose of this Agreement is to authorize the Business Associate to use and disclose to specifically identified entities Protected Health Information as more fully described in this Agreement and in the attached Scope-of-Work.

The Covered Entity and Business Associate, have entered into this Agreement to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Privacy and Security Rule requirements for such an agreement.

The Covered Entity and Business Associate intend to protect and provide for the security of Protected Health Information disclosed to a Business Associate pursuant to the contract in compliance with HIPAA, the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act"), and regulations promulgated thereunder by the U.S. Department of Health and Human Services (the "HIPAA Regulations") and other applicable laws.

This Agreement also defines our duty to protect the confidentiality and integrity of Protected Health Information as required by the HIPAA regulations, Covered Entity policy, professional ethics, and accreditation requirements. Parties executing this Agreement understand that they mutually agree to comply with the provisions of the regulations implementing HIPAA.

The Covered Entity and the Business Associate may be parties to existing contracts that involve duties and obligations regulated by HIPAA and may enter into other such contracts in the future. This Agreement is intended to amend all such existing contracts and to be incorporated into all such future contracts between the parties.

The purpose of the Scope-of-Work Attachment is to identify specific requirements in such contracts for the safeguarding of Protected Health information and to identify any procedures necessary to the work performed on behalf of the Covered Entity by the Business Associate that is unique to its operation involving the use and disclosure of Protected Health Information.

This Agreement will have, at a minimum, the following attachments:

- Scope-of-Work Attachment;

This Agreement may include the following attachments:

- If this Agreement involves the use of Electronic Transactions regulated by HIPAA, 45 CFR Parts 160 and 162, then a Trading Partner Attachment must be included to facilitate the provision of billing, processing, collecting, modifying or transferring of Protected Health Information in agreed formats and to assure that such uses and disclosures comply with relevant laws, regulations and standards.
- Other attachments as appropriate and mutually agreed between the parties.

NOW THEREFORE, the parties intending to be legally bound agree to the following General Conditions:

I. Definitions As used in this Agreement the terms below shall have the following meanings: The following terms used in this Agreement shall have the same meaning as those terms in the Health Insurance Portability and Accountability Act Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required by Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

1. **Business Associate:** Business Associate shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party in this Agreement, shall mean [Insert Name of Business Associate].

2. **Covered Entity:** Covered Entity shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this Agreement, shall mean DHHS.

3. **HIPAA Rules:** HIPAA Rule shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

II Performance

1. The specific work that is performed by the Business Associate on behalf of the Covered Entity involving the minimum necessary use and disclosure of Protected Health Information for the performance of this Agreement is presented in the attached "Scope-of-Work."

2. The Scope-of-Work identifies, defines and delineates the Covered Entity and Business Associate's contracted performance responsibilities in this Agreement, existing contracts or any future contract that involves the Business Associate's use and disclosure of Protected Health Information (as identified within existing or future contracts) while performing a function on behalf of the Covered Entity.

3. The specific functions of performance and the authorized individuals or subcontractors is presumed to be identified within this Agreement, existing contracts or any future contract. Existing or future associated contract deliverables are considered unique and applicable to this Agreement's performance.

4. Based upon the written assurances specified in Section IV of this Agreement, the performance of work under this Agreement, existing and future contracts is considered to be in compliance with the HIPAA regulations regarding use, disclosure and safeguarding of the Protected Health Information involved in the performance of work in this Agreement and any associated contracts.

III. Notices.

1. Written notices to the Covered Entity concerning performance of this Agreement, or amendments shall be sent through U.S. Postal Service, First Class Mail, pre-paid, to the attention of:
   1.1 Contact: **Name and address of Contact Here**

2. Written notices to the Business Associate concerning performance of this Agreement, or amendments shall be sent through U.S. Postal Service, First Class Mail, pre-paid, to the attention of:
   2.1 Contact: **Name and address of Contact Here**

3. When either party changes the contact or the contact's address, they shall give the other party written notice of the change.

4. Notices shall be deemed received within three days after the date of mailing.

IV. HITECH Act

Business Associate – HITECH Section 13408
The HITECH Act requires that each entity that provides data transmission of protected health information to a covered entity and requires access on a routine basis shall be treated as a business associate and required to have a written contract.

Security Rule Duties HITECH Section 13401(a)
The HITECH Act requires that a business associate of a covered entity is required to comply with the HIPAA Security Rules including policies and procedures. If the business associate violates any of the Security Rules, the business associate may be subject to the HIPAA civil and criminal penalties.

Privacy Rules Duties HITECH Section 13404(a)
The HITECH Act requires that business associates use or disclose protected health information only if such use or disclosure is consistent with the terms of the business associate agreement between the entity and the business associate. If a business associate violates a Business Associate Agreement with respect to the new privacy requirement, the business associate may be subject to the same HIPAA civil and criminal penalties previously only applicable to covered entities.

Cure a Breach HITECH Section 13404(b)
The HITECH Act requires that a business associate take reasonable steps to cure breach of, or terminate, a business associate agreement if it becomes aware of a pattern of activity or practice by a covered entity the violates the agreement. The business associate may be liable for civil and or criminal penalties under HIPAA.

Breaches Treated as Discovered HITECH Section 13402(c)
A breach shall be treated as discovered by a covered entity or by a business associate as of the first day on which the breach is known.

Notification in the Case of a Breach HITECH Section 13402
A covered entity that accesses, maintains, retains, modifies, records, stores, destroys, or otherwise holds, uses, or discloses unsecured protected health information (as defined in subsection (h) (1)) shall, in the case of a breach of such information that is discovered by the covered entity, notify each individual whose unsecured protected health information has been, or is reasonably believed by the covered entity to have been, accessed, acquired, or disclosed as a result of such breach. Notifications shall be made no later than 60 days after the discovery of a breach. 13402(b) requires a business associate of a covered entity that accesses, maintains, retains, modifies, records, stores, destroys, or otherwise holds, uses, or discloses unsecured protected health information shall, following the discovery of a breach of such information, notify to the covered entity of such breach.

Civil and Criminal Penalties Tiers of Penalties
The HITECH Act specifies that business associates will be subject to the same civil and criminal penalties previously only imposed on covered entities. As amended by the HITECH Act, civil penalties range from $100 to $50,000 per violation, with caps of $1,500,000 for all violations of a single requirement in a calendar year. The amount of the civil penalty imposed will vary depending on whether the violation was not knowing, due to reasonable cause, or due to willful neglect. Criminal penalties include fines up to $50,000 and imprisonment for up to one year. In some instances, fines are mandatory.

V. Special Provisions to General Conditions:

1. Assurance of the Confidential Use and Disclosure of Protected Health Information.

1.1 Use of Protected Health Information. Business Associate shall not use or further disclose Protected Health Information other than as permitted or required by this Agreement or as required by law. Business Associate may use Protected Health Information for the purposes of managing its internal business processes relating to its functions and performance under this Agreement.

1.2 Business Associate shall use appropriate safeguards to prevent unauthorized use or disclosure of Protected Health Information, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of Protected Health Information other than as provided for by the Agreement. Failure to comply could result in civil and criminal penalties.

1.3 To the extent the Business Associate is to carry out one or more of the Covered Entity's obligations under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the Covered Entity in the performance of such obligations.

2. Permitted Uses and Disclosures

2.1 Covered Entity authorizes the use and disclosure of Protected Health Information by the Business Associate as follows:

2.1.1 To identified individuals and entities: Business Associate's employees, agents and subcontractors associated with the performance of this specific Agreement and other existing or future contracts involving the use and disclosure of Protected Health Information that are deemed minimally necessary to perform the work as identified in the attached Scope-of-Work; and,

2.1.2 For the purposes of: Business Associate's performance of work on behalf of the Covered Entity as specified in this Agreement and any existing or future contracts of this Agreement's attached Scope-of-Work.

2.2 Disclosure to Third Parties. Business Associate shall ensure that any of its agents and subcontractors that, create, receive, maintain, or transmit Protected Health Information received from Covered Entity (or created by or received from the Business Associate on behalf of Covered Entity) agree in writing to the same restrictions, and conditions relating to the, confidentiality, care, custody, and minimum use of Protected Health Information that apply to Business Associate in this Agreement by providing satisfactory assurances in accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2).

2.3 Disclosure to the Workforce. Business Associate shall not disclose Protected Health Information to any member of its workforce except to those persons who have been authorized access to this information.

2.4 Disclosure and Confidentiality. Business Associate may maintain a confidentiality agreement with the individuals of its workforce, who have access to Protected Health Information. This confidentiality agreement should be substantially similar to the sample Authorized Workforce Confidentiality Agreement included as Exhibit "A" to this Agreement.

2.5 Minimum Necessary Standard. Pursuant to 45 CFR §164.502(b); §164.514(d): The Business Associate shall make reasonable efforts to limit the use and disclosure of Protected Health Information to the minimum necessary to accomplish the intended purpose of the use or disclosure. The Business Associate must limit access to those persons within its workforce, agents or subcontractors who are authorized and need the information in order to carry out their duties, and provide access only to the category of information that is required.

2.6 The Business Associate is authorized to use Protected Health Information to de-identify the information in accordance with 45 CFR 164.514(a)-(c).

2.7 The Business Associate shall obtain reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware that the confidentiality of the information has been breached.

2.8 A violation of this Agreement may result in civil and criminal penalties to the Business Associate.

3. Assurance of Reasonable Safeguards of Protected Health Information.

3.1 Safeguards. Business Associate shall implement and maintain appropriate administrative, physical, and technical safeguards to prevent access to and the use and disclosure of Protected Health Information, other than as provided for in this Agreement. The Business Associate agrees to assess potential risks and vulnerabilities to the individual health data in its care and custody and develop, implement and maintain reasonable security measures.

4. Assurance of Accounting for Disclosures of Protected Health Information.

4.1 Accounting for Protected Health Information Disclosures. Business Associate shall maintain and make available to Covered Entity within fifteen (15) days of request, an accounting of disclosures of Protected Health Information as required by the HIPAA regulations.

4.2 Disclosure to the U.S. Department of Health and Human Services (USDHHS). Business Associate shall make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from Covered Entity (or created or received by Business Associate on behalf of Covered Entity) available to the Secretary of USDHHS or its designee for purposes of determining Covered Entity's compliance with HIPAA and with the Privacy and Security regulations. Business Associate shall provide Covered Entity with copies of any information it has made available to USDHHS under this section of this Agreement.

5. Assurance for the Reporting and Remediation of Known Unauthorized Use and Disclosure of Protected Health Information.

5.1 Reporting of unauthorized use, disclosures, or breach and remediation of risk conditions. Business Associate shall report to Covered Entity within fifteen (15) days from when it becomes aware of, any unauthorized use or disclosure of Protected Health Information made in violation of this Agreement or the HIPAA regulations, including any security incident that may put electronic Protected Health Information at risk. Business Associate shall, as instructed by Covered Entity, take immediate steps to mitigate any harmful effect of such unauthorized disclosure of Protected Health Information pursuant to the conditions of this Agreement through the preparation and completion of a written Corrective Action Plan subject to the review and approval by the Covered Entity. The Business Associate shall report any breach to the individuals affected and to the Secretary of USDHHS as required by the HIPAA regulations.

6. Assurance of Access and Amendments to Protected Health Information.

6.1 Right of Access. Business Associate shall make an individual's Protected Health Information available to the Covered Entity, within fifteen (15) days of notice under this Agreement.

6.2 Right of Amendment. Business Associate shall make any amendment(s) to an individual's Protected Health Information as directed or agreed to by DHHS pursuant to 45 CFR 164.526 within fifteen (15) days of notice under this Agreement, or take other measures as necessary to satisfy DHHS' obligations under 45 CFR 164.526.

7. Termination and Duties Upon Termination.

7.1 Termination. Covered Entity may immediately terminate this Agreement and any and all associated Agreements identified in the Scope of Work if Covered Entity determines that the Business Associate has violated a material term of a performance condition of this Agreement.

7.2 Covered Entity, at its sole discretion, may choose to issue a plan of correction to the Business Associate to set the conditions for remediation of any material breach of performance in an effort to mitigate the cause for breach or consequent termination. The plan of correction issued by the Covered Entity under this subsection shall supercede the provisions of any Corrective Action Plan prepared by the Business Associate that are in conflict.

7.3 This Agreement may be terminated by either party with not less than fifteen (15) days prior written notice to the other party, which notice shall specify the effective date of the termination; provided whenever a notice provision for termination in any associated Agreement identified in the Scope of Work specifies a longer notice period for termination, the longer period shall apply; provided further that any termination of this Agreement shall not affect the respective obligations or rights of the parties arising under any existing contracts or otherwise under this Agreement before the effective date of termination.

7.4 Within thirty (30) days of expiration or termination of this Agreement, or as agreed, unless Business Associate requests and Covered Entity authorizes a longer period of time, Business Associate shall return or at the written direction of the Covered Entity destroy all Protected Health Information received from Covered Entity (or created or received by Business Associate on behalf of Covered Entity) that Business Associate still maintains in any form and retain no copies of such Protected Health Information. Business Associate shall provide a written certification to the Covered Entity that all such Protected Health Information has been returned or destroyed (if so instructed), whichever is deemed appropriate. If such return or destruction is determined by the Covered Entity to be infeasible, Business Associate shall use such Protected Health Information only for purposes that makes such return or destruction infeasible and the- provisions of this Agreement shall survive with respect to such Protected Health Information.

7.5 Upon termination of this agreement for cause of violation of the performance conditions of this Agreement, or the HIPAA Privacy Rule standards for use and disclosure, all associated existing contracts as identified or referred to in the Scope of Work Attachment are deemed terminated, except as provided in 45 CFR 164.504(e)(1)(ii)(B).

7.6 The obligations of the Business Associate under this Section shall survive the termination of this Agreement.

8. Amendment.

8.1 Upon the enactment of any law or regulation affecting the use or disclosure of Protected Health Information required by the HIPAA regulations, or the publication

of any decision of a court of the United States or of the State of Nebraska relating to any such law, or the publication of any interpretive policy or opinion of any governmental agency charged with the enforcement of any such law or regulation, Covered Entity may provide written notice to the Business Associate to amend this Agreement in such a manner as Covered Entity determines necessary to comply with such law or regulation. If Business Associate disagrees with any such amendment, it shall so notify Covered Entity in writing within fifteen (15) days of Covered Entity's notice. If the parties are unable to agree on an amendment within fifteen (15) days thereafter, either of them may terminate this Agreement by reasonable written notice to the other.

9. Term of the Agreement.

9.1 The date of this Agreement is _____, upon the signature of both parties, and continue for the longest applicable period, as follows:

9.1.1 If this Agreement is attached to any existing contract through an amendment process, then the term of the Agreement shall coincide with the term of the existing contract.

9.1.2 If this Agreement is attached to and incorporated into any renegotiated existing contract, or new contract as identified within the Scope-of-Work Attachment to this Agreement, then the term of the Agreement shall coincide with the term of the renewed contract or the new contract.

9.1.3 If this Agreement is not attached to or incorporated into any other contract between the Covered Entity and the Business Associate, then the term of the Agreement shall be from the commencement date for a period of five (5) years.

10. Hold Harmless.

10.1 Business Associate agrees to hold the Covered Entity harmless for all loss or damage sustained by any person as a direct result of the negligent or willful acts by the Business Associate, its employees or agents in the performance of this Agreement, including all associated costs of defending any action.

11. Execution.

EACH PARTY has caused this Agreement to be properly executed on its behalf as of the date signed.

For: DHHS Covered Entity	**For: Contractor/ Business Associate**
Signature: _____	Signature: _____
Name: _____	Name: _____
Date _____	Date _____

Department of Health & Human Services

DHHS

N E B R A S K A

HIPAA/HITECH Business Associate Agreement
SCOPE-OF-WORK ATTACHMENT

THIS Scope-of-Work ATTACHMENT supplements and is incorporated into, and considered part of the Business Associate Agreement (herein referred to as ("Agreement") by and between the Nebraska Department of Health and Human Services consisting of the agencies of Division of Public Health, Division of Behavioral Health, Division of Children and Family Services, Division of Medicaid & Long Term Care, Division of Developmental Disabilities, Division of Veteran's Homes and represented herein collectively or singularly as the "Department of Health and Human Services" (DHHS also hereinafter referred to as "Covered Entity"), and **Name Here,** (hereinafter also referred to as "Business Associate").

I. GENERAL CONDITIONS

1. Covered Entity agrees to provide the following:
   - 1.1 Covered Entity will provide technical assistance directly to assist Business Associate with the use of any electronic formats for the transmission of Protected Health Information, such as magnetic tape. Covered Entity will provide advance notice whenever possible before making changes to the format or to the codes used in information processing.

2. Business Associate agrees to the following:
   - 2.1 The Business Associate must adhere to all relevant confidentiality and privacy laws, regulations, and contractual provisions as provided within the Agreement.
   - 2.2 The Business Associate shall have in place reasonable administrative, technical, and physical safeguards to ensure security and confidentiality of Protected Health Information.
   - 2.3 A Corrective Action Plan (CAP) will be developed by the Business Associate to address and remediate any condition of contractual non-performance.

II. SPECIAL PROVISIONS TO GENERAL CONDITIONS

This Scope-of-Work Attachment amends any contract between the parties listed in this attachment and all other existing contracts between the parties that involve the performance of work on behalf of the Covered Entity and that involve the processing, handling, use, or disclosure of Protected Health Information. This Scope-of-Work Attachment shall also incorporate the provisions of the Agreement and this Attachment into all renewals of such existing contracts and into all new contracts between the parties that involve performance of work on behalf of the Covered Entity and that involve the processing, handling, use, or disclosure of Protected Health Information.

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[Specifics to be included in this Scope of Work Attachment are:]

- **Scope of Work description**
- **Contract Number**

- Specific information required if this Scope of Work applies to the Agreement as a distinct standalone instrument. This information identifies:
    1. The Protected Health Information to be used or disclosed during the term of this Agreement;
    2. The authorized individuals or entities that are associated with the performance of this Agreement;
    3. The permitted uses and disclosures of Protected Health Information allowed during the term of this Agreement.
    4. The description of the administrative, physical, and technical security safeguards used to prevent use or disclosure of the Protected Health Information other than as provided for during the term of this Agreement.

State of Nebraska
Department of Health and Human Services

HIPAA Business Associate Agreement
Exhibit A
Authorized Workforce Confidentiality Agreement

This Agreement between _____ [**name of *Business Associate***] and _____ [employee name], an employee or contracted agent of _____ [Business Associate] hereby acknowledges that the employee or contractor's records and documents are subject to strict confidentiality requirements imposed by state and federal law.

I [initial] ____ acknowledge that my supervisor, or whoever administers the data has reviewed with me the appropriate provisions of the HIPAA federal laws and applicable State of Nebraska privacy laws including the penalties associated with breaches of confidentiality.

I [initial] ____ acknowledge that my supervisor or whoever administers the data has reviewed with me the security policies of the Business Associate.

I [initial] ____ acknowledge that unauthorized use, dissemination, or distribution of employer's Protected Health Information and confidential information is a crime.

I [initial] ____ hereby agree that I will not use, disseminate, or otherwise distribute confidential records or documents containing Protected Health Information either on paper or by electronic means other than in performance of the specific job roles I am authorized to perform.

I [initial] ___ also agree that unauthorized use, dissemination, or distribution of confidential information is grounds for immediate termination of my employment or contract with Business Associate and may subject me to penalties both civil and criminal.

_____ _____
Signed Date

Dcode Utilization (FY15, FY14)

Time Period: Incurred Fiscal Year		FY 2015		FY 2014	
		Claims	Net Payment	Claims	Net Payment
Age In Years Claim	**Procedure Nebraska Code**				
0 to 1	D0120	320	$5,801.80	414	$6,295.40
	D0140	301	$5,921.52	278	$4,616.80
	D0145	3,783	$122,162.57	3,668	$97,655.28
	D0150	477	$8,792.48	578	$8,873.00
	D0160	8	$201.00	4	$108.00
	D0170	3	$32.00	4	$48.00
	D0180	1	$27.00		
	D0210	4	$135.00	4	$180.00
	D0220	242	$1,320.00	237	$1,278.00
	D0230	130	$945.00	132	$884.00
	D0240	32	$347.00	30	$301.00
	D0270			2	$18.00
	D0272	68	$806.00	70	$871.00
	D0274	20	$95.00	28	$167.00
	D0330	5	$68.00	5	$57.00
	D0340			1	$0.00
	D0431			1	$0.00
	D0460			2	$0.00
	D1110	24	$155.00	32	$217.00
	D1120	3,587	$76,498.23	3,438	$72,164.65
	D1206	2,913	$41,515.98	2,816	$33,084.00
	D1208	2,714	$25,824.19	2,687	$22,525.60
	D1310	2	$0.00	1	$0.00
	D1330	7	$0.00	14	$0.00
	D1351	63	$3,335.00	54	$2,898.00
	D1510			1	$110.00
	D2140	11	$300.00	15	$1,000.00
	D2150	4	$0.00	13	$707.00
	D2160	4	$71.00	6	$142.00
	D2161			1	$142.00
	D2330	37	$2,979.00	34	$3,248.00
	D2331	11	$876.80	10	$1,008.00
	D2332	12	$1,660.00	12	$996.00

	D2335	18	$4,074.00	19	$3,977.00
	D2390	1	$0.00	1	$0.00
	D2391	37	$3,304.00	48	$4,602.00
	D2392	7	$392.00	15	$1,050.00
	D2393	1	$87.00	7	$348.00
	D2394	3	$194.00	6	$1,104.00
	D2740	1	$0.00		
	D2750	1	$0.00		
	D2920	3	$80.00	1	$20.00
	D2930	88	$24,492.00	64	$19,952.00
	D2931	2	$116.00	1	$0.00
	D2932	6	$1,648.00	5	$1,133.00
	D2933	24	$8,844.00	27	$10,050.00
	D2934	58	$18,913.04	49	$16,214.00
	D2940	3	$128.00	2	$64.00
	D2950	2	$0.00	1	$0.00
	D2999	6	$142.00	11	$2,728.00
	D3110			1	$0.00
	D3120	4	$0.00	4	$0.00
	D3220	17	$1,820.00	6	$770.00
	D3230	17	$2,635.00	27	$5,440.00
	D3240	4	$720.00	4	$540.00
	D3320	4	$0.00		
	D3330	1	$0.00	1	$0.00
	D3999	1	$40.00	1	$80.00
	D4341	1	$0.00		
	D4342	1	$0.00		
	D4355	3	$56.00	8	$56.00
	D5212	1	$377.00		
	D7111	3	$176.00	1	$44.00
	D7140	70	$9,794.00	63	$7,065.00
	D7210	1	$0.00		
	D7230			1	$334.00
	D7240	2	$202.00		
	D7270	1	$0.00		
	D7286			1	$85.00
	D7960	11	$1,012.00	12	$920.00
	D8999			1	$0.00
	D9110	5	$115.00	7	$159.00
	D9220	1	$0.00	1	$0.00
	D9221			1	$0.00

	D9230	12	$264.00	17	$330.00
	D9241			1	$94.00
	D9242			1	$43.00
	D9248	11	$1,650.00	8	$1,200.00
	D9310			5	$0.00
	D9420	78	$5,920.00	73	$5,840.00
	D9440	3	$135.00	4	$135.00
	D9970	8	$0.00	2	$0.00
	D9971			1	$0.00
	D9999	2	$0.00		
	Aggregate(Procedure Nebraska Code Values)	**6,839**	**$387,199.61**	**6,719**	**$343,971.73**
2 to 5	D0120	22,368	$442,504.23	23,326	$371,690.26
	D0140	3,731	$74,851.79	4,464	$71,132.85
	D0145	4,989	$159,995.41	4,465	$115,475.04
	D0150	7,794	$151,179.84	8,673	$136,940.49
	D0160	72	$1,890.00	59	$1,535.00
	D0170	25	$384.00	215	$2,496.00
	D0210	41	$1,710.00	51	$2,070.00
	D0220	11,745	$67,755.30	12,413	$71,440.72
	D0230	10,332	$64,693.50	11,145	$71,464.11
	D0240	3,185	$38,381.46	2,983	$35,238.00
	D0250	3	$0.00	1	$0.00
	D0260	1	$0.00		
	D0270	368	$3,186.00	319	$2,674.00
	D0272	14,834	$183,757.85	15,508	$190,611.90
	D0273	5	$75.00	7	$90.00
	D0274	156	$2,672.00	164	$2,712.00
	D0277			1	$18.00
	D0320	1	$0.00		
	D0330	372	$11,818.50	397	$11,819.40
	D0340	5	$260.10	2	$124.00
	D0350	5	$0.00	2	$0.00
	D0460			1	$0.00
	D0470	8	$368.00	6	$276.00
	D1110	43	$31.00	56	$0.00
	D1120	33,565	$702,078.97	34,615	$711,157.88
	D1206	21,930	$344,331.26	20,514	$264,279.06
	D1208	15,712	$239,390.56	18,103	$226,357.45
	D1310	8	$0.00		
	D1330	53	$0.00	89	$0.00
	D1351	3,292	$263,384.77	3,709	$297,929.05

	D1352	4	$0.00	5	$0.00
	D1353	1	$0.00		
	D1510	420	$49,577.00	417	$48,805.00
	D1515	60	$11,480.00	65	$12,730.00
	D1520			2	$0.00
	D1525	2	$0.00	1	$0.00
	D1550	61	$1,218.00	55	$1,092.00
	D1555	11	$252.00	6	$126.00
	D2140	490	$32,568.31	693	$47,817.24
	D2150	738	$63,416.61	940	$79,889.42
	D2160	83	$5,959.96	73	$5,041.00
	D2161	7	$568.00	3	$284.00
	D2330	1,188	$94,237.97	1,347	$100,483.02
	D2331	592	$56,466.52	680	$61,958.70
	D2332	439	$51,106.60	454	$56,281.08
	D2335	350	$61,495.00	365	$67,521.08
	D2390	24	$0.00	11	$0.00
	D2391	3,042	$261,750.48	3,246	$279,661.73
	D2392	2,779	$317,415.03	2,904	$317,748.17
	D2393	226	$24,048.26	256	$25,956.80
	D2394	36	$3,979.00	35	$3,484.00
	D2420	1	$0.00		
	D2751			2	$0.00
	D2920	201	$4,100.00	202	$4,082.07
	D2930	5,027	$1,675,318.52	5,161	$1,640,940.90
	D2931	3	$0.00	5	$580.00
	D2932	166	$36,462.00	111	$26,563.00
	D2933	212	$73,038.10	318	$100,443.92
	D2934	771	$223,750.97	654	$191,060.89
	D2940	112	$4,808.00	91	$4,256.00
	D2950	2	$219.00	7	$657.00
	D2960	1	$0.00		
	D2999	98	$15,215.97	101	$20,263.00
	D3110	5	$0.00	8	$0.00
	D3120	123	$0.00	173	$0.00
	D3220	1,399	$139,319.42	1,330	$130,818.69
	D3221	2	$0.00	20	$0.00
	D3230	218	$33,956.77	236	$33,656.20
	D3240	500	$74,744.08	546	$77,309.40
	D3310	1	$243.00	4	$486.00
	D3320	1	$0.00	1	$0.00

	D3330			2	$334.00
	D3999	41	$2,320.00	39	$2,920.00
	D4211	2	$284.00	2	$142.00
	D4355	26	$1,400.00	36	$1,736.00
	D5120			1	$0.00
	D5140	1	$0.00		
	D5640	1	$0.00		
	D5820			2	$236.00
	D5821			3	$236.00
	D5985			1	$0.00
	D6985	1	$0.00	1	$0.00
	D7111	147	$8,293.44	150	$8,712.00
	D7140	1,640	$170,484.22	1,703	$174,603.04
	D7210	11	$1,302.00	20	$2,511.00
	D7220	6	$732.00	2	$244.00
	D7230	3	$501.00	4	$835.00
	D7240	23	$5,656.00	23	$4,908.80
	D7250	1	$88.00	3	$352.00
	D7270			1	$150.00
	D7280	2	$280.00		
	D7286	2	$170.00	2	$170.00
	D7410	1	$88.00	5	$259.00
	D7510	8	$378.00		
	D7910	3	$0.00		
	D7911	1	$0.00		
	D7950			1	$0.00
	D7960	16	$1,472.00	18	$1,840.00
	D7971	1	$0.00		
	D7980	1	$0.00		
	D7999	1	$0.00		
	D8050			3	$0.00
	D8060	7	$2,601.00	11	$3,019.00
	D8090	1	$0.00	1	$1,025.00
	D8210			2	$277.00
	D8220	12	$2,266.00	14	$2,678.00
	D8660			1	$0.00
	D8691			1	$21.00
	D8692	4	$20.00	1	$95.00
	D8693	2	$63.00	1	$0.00
	D8999	23	$15.00	17	$510.00
	D9110	67	$1,447.00	69	$1,608.00

	D9210	1	$0.00	2	$0.00
	D9220	9	$1,458.00	5	$648.00
	D9221	2	$162.00	1	$81.00
	D9230	4,600	$96,039.40	4,749	$97,708.99
	D9241	2	$188.00	1	$94.00
	D9248	335	$49,142.00	315	$45,956.07
	D9310	5	$0.00	10	$0.00
	D9410	1	$0.00		
	D9420	1,446	$111,004.71	1,542	$114,800.00
	D9430	3	$0.00	4	$0.00
	D9440	15	$585.00	15	$675.00
	D9610	3	$0.00	2	$0.00
	D9612	1	$0.00		
	D9630	3	$0.00	1	$0.00
	D9920	1	$0.00	9	$0.00
	D9940			8	$679.00
	D9951	8	$0.00	3	$0.00
	D9970	131	$0.00	39	$0.00
	D9971	7	$0.00	2	$0.00
	D9999	9	$0.00	4	$0.00
	Aggregate(Procedure Nebraska Code Values)	**54,695**	**$6,529,853.88**	**56,744**	**$6,397,591.42**
6 to 18	D0120	78,732	$1,538,124.40	75,848	$1,196,637.55
	D0140	10,379	$203,980.00	12,558	$205,981.73
	D0145	17	$0.00	23	$0.00
	D0150	17,264	$322,644.35	17,659	$273,406.69
	D0160	863	$22,293.80	718	$18,573.56
	D0170	50	$768.00	94	$1,376.00
	D0171	2	$0.00		
	D0180	36	$859.00	38	$904.50
	D0210	623	$26,127.62	740	$30,162.20
	D0220	27,379	$156,619.16	27,019	$153,248.27
	D0230	18,816	$104,620.06	18,810	$102,887.74
	D0240	1,885	$22,426.00	1,347	$14,754.50
	D0250	3	$0.00	2	$0.00
	D0270	1,111	$9,467.00	916	$7,467.50
	D0272	49,488	$611,221.17	48,982	$598,155.49
	D0273	74	$1,078.00	73	$1,026.00
	D0274	20,145	$353,647.72	18,664	$318,943.90
	D0277	6	$108.00	8	$144.00
	D0290	1	$0.00	1	$0.00
	D0310			1	$0.00

	D0320	1	$0.00	1	$0.00
	D0321			1	$0.00
	D0322	1	$0.00		
	D0330	18,641	$549,314.79	18,392	$529,931.32
	D0340	3,464	$204,846.46	3,167	$182,525.94
	D0350	684	$0.00	654	$0.00
	D0351	2	$0.00		
	D0363			1	$0.00
	D0415	1	$0.00	2	$0.00
	D0460	30	$0.00	18	$0.00
	D0470	3,193	$139,371.16	3,076	$130,987.93
	D0472			1	$0.00
	D0474	1	$0.00		
	D0999	1	$0.00	2	$0.00
	D1110	22,171	$615,338.56	21,664	$590,722.48
	D1120	70,988	$1,447,313.36	69,249	$1,389,797.37
	D1206	47,447	$756,551.52	41,178	$540,743.05
	D1208	42,697	$675,514.59	46,464	$592,415.02
	D1310	1	$0.00	9	$0.00
	D1320			2	$0.00
	D1330	193	$0.00	246	$0.00
	D1351	27,320	$2,494,825.57	25,722	$2,216,581.53
	D1352	42	$0.00	68	$0.00
	D1353	20	$0.00		
	D1510	813	$93,153.05	852	$94,889.80
	D1515	947	$180,110.70	965	$187,777.40
	D1520	11	$0.00	12	$0.00
	D1525	4	$0.00	14	$0.00
	D1550	489	$9,834.27	450	$9,240.00
	D1555	425	$8,904.00	407	$8,710.62
	D2140	3,230	$203,099.80	3,198	$207,967.37
	D2150	4,118	$316,291.96	4,266	$326,645.93
	D2160	1,017	$79,895.87	954	$74,033.54
	D2161	159	$12,440.97	205	$16,255.00
	D2330	1,871	$131,384.02	1,789	$125,091.74
	D2331	1,688	$152,310.89	1,597	$143,874.60
	D2332	1,042	$105,863.91	983	$99,670.06
	D2335	1,147	$130,338.71	1,129	$123,487.06
	D2390	13	$0.00	22	$0.00
	D2391	14,118	$1,132,264.59	13,478	$1,077,390.09
	D2392	14,231	$1,471,032.76	13,454	$1,377,101.12

	D2393	2,601	$257,089.39	2,473	$236,232.94
	D2394	422	$44,101.06	463	$47,494.62
	D2410	2	$0.00	1	$0.00
	D2420			1	$0.00
	D2710	2	$194.00	3	$582.00
	D2740	100	$25,277.00	76	$18,145.00
	D2750	39	$12,870.00	43	$10,015.50
	D2751	87	$24,924.00	55	$17,489.00
	D2752	15	$2,676.60	16	$5,609.00
	D2790	2	$330.00	2	$660.00
	D2791	4	$364.50	9	$1,320.00
	D2792	4	$0.00	7	$0.00
	D2799	1	$0.00		
	D2910	2	$40.00		
	D2915			1	$38.00
	D2920	274	$5,579.55	279	$5,660.00
	D2930	4,622	$911,333.66	4,512	$839,096.69
	D2931	418	$53,277.60	385	$47,567.40
	D2932	30	$3,708.00	25	$2,884.00
	D2933	33	$6,432.00	25	$4,690.00
	D2934	59	$12,998.00	56	$12,345.01
	D2940	386	$12,058.16	377	$12,609.60
	D2950	364	$26,198.87	362	$25,494.74
	D2951	29	$352.00	39	$418.00
	D2952			1	$0.00
	D2954	46	$4,324.00	50	$4,961.00
	D2960	4	$0.00		
	D2961	1	$0.00		
	D2962	1	$0.00		
	D2970	3	$146.00	4	$292.00
	D2999	117	$2,231.00	169	$4,861.00
	D3110	101	$0.00	101	$0.00
	D3120	386	$0.00	426	$0.00
	D3220	1,205	$95,765.48	1,191	$90,233.42
	D3221	32	$0.00	50	$0.00
	D3230	23	$2,125.00	24	$2,550.00
	D3240	445	$46,680.87	514	$51,418.00
	D3310	223	$56,755.91	239	$57,616.00
	D3320	83	$18,905.40	93	$22,875.70
	D3330	462	$142,241.08	503	$150,354.30
	D3332			3	$0.00

	D3346	9	$1,767.00	7	$1,547.00
	D3347	1	$251.00		
	D3348	15	$4,675.00	21	$6,384.00
	D3351	26	$2,464.00	30	$2,464.00
	D3352	5	$0.00	5	$0.00
	D3353	1	$0.00	4	$0.00
	D3410	1	$171.00	5	$1,196.00
	D3999	127	$5,437.00	137	$5,801.00
	D4210	9	$1,222.00	13	$1,316.00
	D4211	67	$5,069.00	58	$4,317.00
	D4231			1	$0.00
	D4240	1	$0.00		
	D4266	2	$0.00		
	D4274			1	$0.00
	D4321	14	$0.00	4	$0.00
	D4341	16	$800.00	8	$524.00
	D4342	3	$104.00		
	D4355	1,134	$59,685.26	1,002	$51,498.13
	D4381			1	$0.00
	D4910	3	$58.00	1	$0.00
	D4999	1	$0.00		
	D5110	1	$538.00	4	$1,614.00
	D5120	2	$538.00	4	$1,614.00
	D5130			1	$538.00
	D5140			1	$538.00
	D5211	11	$1,131.00	5	$0.00
	D5212	1	$377.00	3	$754.00
	D5213	1	$472.00	4	$1,888.00
	D5214	2	$944.00	1	$472.00
	D5225	2	$0.00		
	D5281			1	$0.00
	D5410			2	$20.00
	D5411			1	$20.00
	D5421	3	$60.00	2	$40.00
	D5510			1	$94.00
	D5520			2	$0.00
	D5610	2	$188.00	5	$470.00
	D5620			1	$108.00
	D5630			3	$324.00
	D5640	4	$300.00	2	$150.00
	D5650			1	$103.00

	D5660	1	$103.00		
	D5751	1	$156.00		
	D5810			4	$838.82
	D5811			1	$128.32
	D5820	40	$6,265.00	26	$3,650.00
	D5821	2	$472.00		
	D5931			1	$0.00
	D5982			1	$0.00
	D5986			1	$0.00
	D5988			3	$0.00
	D6010	1	$0.00		
	D6057	1	$0.00		
	D6058	1	$0.00		
	D6251			2	$0.00
	D6740	1	$0.00		
	D6930	4	$210.00	5	$126.00
	D6985	1	$0.00		
	D7111	1,850	$112,540.99	1,840	$109,307.00
	D7140	8,392	$789,454.74	8,548	$787,193.10
	D7210	517	$66,886.22	474	$64,633.82
	D7220	424	$87,724.04	492	$98,996.80
	D7230	641	$193,436.37	606	$178,498.40
	D7240	1,251	$690,000.17	1,203	$674,934.05
	D7241	46	$18,232.00	55	$22,657.37
	D7250	22	$2,461.00	33	$3,380.24
	D7251	1	$0.00		
	D7260	1	$0.00		
	D7270	24	$4,500.00	23	$4,051.00
	D7280	196	$33,824.30	183	$29,076.20
	D7282	24	$2,818.00	40	$5,804.00
	D7283	116	$18,894.80	118	$17,367.00
	D7285	1	$94.00	6	$564.00
	D7286	20	$1,615.00	26	$1,955.00
	D7290	2	$0.00	4	$0.00
	D7291	1	$0.00	3	$0.00
	D7310			4	$880.00
	D7311	4	$355.00		
	D7321			1	$76.00
	D7410	12	$176.00	15	$621.00
	D7411	9	$542.00	9	$803.00
	D7412			1	$0.00

	D7440			1	$0.00
	D7450	11	$687.00	5	$94.00
	D7451	6	$220.00	3	$110.00
	D7460			1	$94.00
	D7461	1	$0.00		
	D7465	3	$288.00	3	$109.00
	D7471	1	$110.00		
	D7510	36	$1,344.00	27	$1,134.00
	D7511			1	$0.00
	D7520			3	$0.00
	D7530			1	$0.00
	D7540			1	$0.00
	D7620			1	$0.00
	D7670	1	$0.00		
	D7740	1	$0.00		
	D7820			1	$0.00
	D7830			2	$0.00
	D7871			2	$0.00
	D7880	3	$597.00	1	$0.00
	D7910	3	$0.00	4	$0.00
	D7911			1	$0.00
	D7912			1	$0.00
	D7941			1	$0.00
	D7943			1	$0.00
	D7945			1	$0.00
	D7953	4	$0.00		
	D7960	78	$6,622.92	88	$7,284.00
	D7963	1	$0.00	1	$0.00
	D7970	2	$0.00		
	D7971	11	$0.00	14	$0.00
	D7972	1	$0.00		
	D7980	2	$0.00		
	D7997	1	$0.00		
	D7999	1	$0.00	2	$0.00
	D8020			8	$0.00
	D8030	3	$0.00	5	$0.00
	D8040	5	$0.00	6	$0.00
	D8050	5	$0.00	2	$0.00
	D8060	529	$302,899.20	472	$274,217.19
	D8070	4	$0.00	2	$0.00
	D8080	17	$0.00	18	$0.00

	D8090	2,455	$5,816,852.25	1,904	$4,378,963.17
	D8210	29	$4,335.00	17	$2,280.00
	D8220	125	$23,806.00	125	$23,557.00
	D8660	190	$0.00	218	$0.00
	D8670	6	$0.00	7	$0.00
	D8680	10	$0.00	16	$0.00
	D8690			1	$0.00
	D8691	71	$1,218.00	51	$1,582.00
	D8692	354	$38,416.00	278	$28,819.00
	D8693	18	$70.00	14	$146.00
	D8999	71	$1,348.00	61	$1,143.00
	D9110	606	$13,491.80	592	$12,906.60
	D9120			1	$0.00
	D9210	2	$0.00	7	$0.00
	D9211			1	$0.00
	D9212	1	$0.00		
	D9215	4	$0.00	27	$0.00
	D9220	1,298	$189,895.58	1,245	$188,158.71
	D9221	438	$46,925.40	399	$47,390.43
	D9230	14,005	$294,023.96	12,337	$256,576.39
	D9241	163	$14,382.00	193	$16,832.00
	D9242	105	$7,981.00	111	$7,826.00
	D9248	393	$55,953.10	346	$47,543.98
	D9310	55	$0.00	63	$0.00
	D9410			2	$70.00
	D9420	554	$41,958.56	542	$39,410.00
	D9430	10	$0.00	10	$0.00
	D9440	71	$3,015.00	69	$2,880.00
	D9610	41	$0.00	78	$0.00
	D9612	354	$0.00	277	$0.00
	D9630	22	$0.00	29	$0.00
	D9910	14	$0.00	6	$0.00
	D9911			1	$0.00
	D9920	7	$0.00	5	$0.00
	D9930	2	$0.00	3	$0.00
	D9940	271	$40,451.25	219	$33,084.40
	D9941	9	$0.00	8	$0.00
	D9951	57	$0.00	54	$0.00
	D9952	1	$0.00		
	D9970	53	$0.00	33	$0.00
	D9971	18	$0.00	13	$0.00

	D9972			1	$0.00
	D9974	1	$0.00	3	$0.00
	D9999	282	$15.00	262	$56.00
	Aggregate(Procedure Nebraska Code Values)	**172,371**	**$25,076,882.83**	**168,962**	**$22,104,623.64**
19 to 24	D0120	2,315	$40,978.37	2,681	$37,847.50
	D0140	1,623	$30,246.69	1,734	$26,851.35
	D0145	1	$0.00	2	$0.00
	D0150	1,708	$31,649.10	1,915	$28,529.99
	D0160	46	$1,242.00	48	$1,286.00
	D0170	27	$390.77	34	$480.00
	D0180	26	$621.00	36	$859.00
	D0210	320	$13,136.56	302	$12,358.00
	D0220	2,149	$11,694.49	2,415	$12,608.16
	D0230	1,022	$6,904.40	1,248	$8,542.86
	D0240	7	$56.00	10	$77.00
	D0270	118	$959.00	122	$1,013.00
	D0272	489	$5,800.00	653	$7,191.00
	D0273	6	$89.00	8	$120.00
	D0274	2,284	$38,709.93	2,553	$41,343.18
	D0277	2	$36.00	2	$18.00
	D0321			2	$0.00
	D0330	1,307	$33,219.50	1,577	$39,756.03
	D0340	14	$496.00	14	$794.60
	D0350	5	$0.00	6	$0.00
	D0460	1	$0.00	7	$0.00
	D0470	16	$338.00	14	$460.00
	D1110	3,449	$94,053.46	3,954	$106,380.47
	D1120	26	$0.00	25	$0.00
	D1206	997	$15,093.70	793	$9,531.75
	D1208	821	$12,430.20	961	$11,799.51
	D1320	1	$0.00		
	D1330	6	$0.00	15	$0.00
	D1351	445	$55,739.00	449	$44,953.94
	D1352	2	$0.00		
	D1510	1	$0.00		
	D1555			1	$0.00
	D2140	371	$23,433.11	418	$25,169.31
	D2150	606	$45,614.18	596	$42,861.40
	D2160	293	$22,135.83	315	$24,721.76
	D2161	84	$6,488.60	88	$7,552.12
	D2330	322	$23,461.44	354	$25,163.20

	D2331	388	$34,296.16	374	$30,342.07
	D2332	297	$30,846.41	282	$27,750.98
	D2335	216	$25,950.24	229	$27,694.40
	D2390	2	$0.00	2	$0.00
	D2391	944	$78,652.70	954	$79,782.08
	D2392	1,189	$120,239.51	1,215	$121,587.61
	D2393	518	$51,177.01	583	$54,877.60
	D2394	203	$18,803.80	182	$18,350.80
	D2610			1	$0.00
	D2644			1	$0.00
	D2740	39	$9,391.65	30	$5,901.50
	D2750	17	$4,290.00	18	$2,065.80
	D2751	23	$6,724.00	19	$3,372.00
	D2752	1	$330.00	13	$3,309.00
	D2790	1	$330.00		
	D2791	1	$330.00	3	$493.00
	D2799	1	$0.00		
	D2920	7	$140.00	8	$140.00
	D2930	1	$116.00	3	$116.00
	D2931	80	$9,504.00	111	$12,387.50
	D2932	1	$103.00		
	D2940	72	$2,234.20	80	$2,464.00
	D2950	182	$11,662.76	145	$10,039.50
	D2951	10	$79.40	17	$198.00
	D2952			1	$0.00
	D2954	22	$1,692.00	41	$3,118.50
	D2970			1	$73.00
	D2980			1	$59.00
	D2999			1	$0.00
	D3110	12	$0.00	11	$0.00
	D3120	39	$0.00	38	$0.00
	D3220	11	$0.00	6	$0.00
	D3221	6	$0.00	14	$0.00
	D3240			1	$90.00
	D3310	66	$15,131.49	95	$19,518.00
	D3320	131	$26,567.00	123	$26,674.50
	D3330	161	$49,360.54	176	$52,816.90
	D3346	1	$221.00	1	$221.00
	D3347	1	$251.00		
	D3348	3	$1,002.00	4	$1,002.00
	D3410			1	$0.00

	D3999	26	$1,080.00	28	$1,000.00
	D4210	1	$188.00	2	$94.00
	D4211	13	$923.00	9	$355.00
	D4240			1	$0.00
	D4266			1	$0.00
	D4321			1	$0.00
	D4341	19	$124.00	17	$579.00
	D4342	6	$260.00	3	$0.00
	D4355	738	$39,173.85	757	$37,862.67
	D4910	5	$29.00	10	$79.80
	D4999			1	$0.00
	D5110	3	$1,438.00	4	$1,726.56
	D5120	2	$904.56	3	$1,432.50
	D5130	10	$4,128.06	4	$1,705.50
	D5140	3	$785.50	2	$1,038.00
	D5211	17	$2,183.56	8	$1,881.00
	D5212	2	$754.00	6	$1,501.00
	D5213			1	$62.50
	D5411			3	$40.00
	D5421	2	$40.00	4	$60.00
	D5422	1	$20.00		
	D5510	2	$188.00	1	$94.00
	D5520	1	$75.00	2	$75.00
	D5610	2	$188.00		
	D5640	4	$328.00	3	$253.00
	D5650	1	$131.00		
	D5660			1	$103.00
	D5730			2	$94.00
	D5731			1	$94.00
	D5740	2	$188.00		
	D5750	2	$312.00	3	$468.00
	D5751	1	$156.00	1	$49.00
	D5760			1	$156.00
	D5810	2	$664.00	1	$349.00
	D5820	16	$2,832.00	13	$2,117.00
	D5821	5	$378.65	2	$253.00
	D5850	3	$129.00	3	$86.00
	D5851	1	$43.00	1	$0.00
	D5931			1	$0.00
	D6240			2	$0.00
	D6245	1	$0.00		

	D6740	1	$0.00		
	D6750			2	$0.00
	D6930			1	$35.60
	D7111	4	$132.00	7	$264.00
	D7140	650	$56,300.90	686	$57,475.83
	D7210	388	$48,386.24	444	$57,871.07
	D7220	180	$28,848.42	188	$32,893.83
	D7230	204	$43,199.32	224	$59,823.10
	D7240	173	$67,219.06	197	$82,499.50
	D7241	14	$4,664.00	18	$5,512.00
	D7250	18	$1,760.00	21	$2,799.00
	D7251			1	$0.00
	D7261			1	$0.00
	D7270			1	$150.00
	D7280	3	$499.00	1	$0.00
	D7282			1	$0.00
	D7283	1	$135.00	1	$0.00
	D7286	1	$85.00	3	$255.00
	D7310	5	$764.64	5	$675.10
	D7311	1	$71.00	4	$284.00
	D7321	4	$152.00	2	$152.00
	D7410			1	$0.00
	D7465	1	$0.00		
	D7510	6	$210.00	4	$126.00
	D7871	1	$0.00		
	D7880	1	$164.00		
	D7910			1	$0.00
	D7953			1	$0.00
	D7960	3	$184.00	3	$276.00
	D7971	6	$0.00		
	D7999	1	$50.00	1	$0.00
	D8060	9	$175.00	1	$0.00
	D8090	10	$26,328.00	3	$8,152.00
	D8220			1	$0.00
	D8660	1	$0.00	1	$0.00
	D8680	2	$0.00		
	D8691	2	$0.00	1	$0.00
	D8692	3	$180.00	8	$655.00
	D8693	2	$42.00	4	$0.00
	D8999	2	$0.00	3	$105.00
	D9110	166	$3,824.68	189	$4,057.91

	D9215	2	$0.00	6	$0.00
	D9220	202	$25,532.59	241	$34,611.91
	D9221	55	$4,646.73	87	$8,497.38
	D9230	240	$4,579.00	230	$4,557.00
	D9241	64	$4,966.40	78	$6,493.10
	D9242	45	$2,400.20	50	$3,668.00
	D9248	16	$1,800.00	10	$750.00
	D9310	2	$0.00	4	$0.00
	D9420	65	$5,120.00	72	$5,280.00
	D9430	1	$0.00		
	D9440	3	$90.00	4	$180.00
	D9610	2	$0.00	4	$0.00
	D9612	28	$0.00	36	$0.00
	D9630	7	$0.00	6	$0.00
	D9910	6	$0.00	1	$0.00
	D9911	3	$0.00	2	$0.00
	D9930	2	$0.00	2	$0.00
	D9940	77	$12,070.40	94	$13,981.50
	D9941	1	$0.00	1	$0.00
	D9950			2	$0.00
	D9951	6	$0.00	6	$0.00
	D9999	12	$0.00	20	$0.00
	Aggregate(Procedure Nebraska Code Values)	**11,073**	**$1,416,665.96**	**11,928**	**$1,468,403.23**
25 to 54	D0120	11,632	$218,882.12	13,085	$196,230.21
	D0140	9,286	$176,527.96	9,668	$151,738.99
	D0145	12	$0.00	12	$0.00
	D0150	6,816	$126,030.12	7,148	$107,843.51
	D0160	157	$3,891.08	190	$4,804.00
	D0170	197	$3,046.00	265	$4,032.00
	D0171	1	$0.00		
	D0180	211	$5,229.00	198	$4,672.31
	D0210	1,897	$79,891.27	1,708	$70,318.31
	D0220	12,369	$68,011.69	13,129	$70,271.59
	D0230	5,209	$39,945.72	5,638	$41,786.89
	D0240	37	$266.00	48	$364.00
	D0250	1	$0.00		
	D0260	1	$0.00		
	D0270	782	$6,343.00	585	$4,575.23
	D0272	2,558	$30,381.02	2,920	$34,479.92
	D0273	80	$1,019.00	102	$1,321.00
	D0274	9,651	$167,193.24	10,309	$170,344.47

	D0277	14	$216.00	22	$342.00
	D0290			1	$0.00
	D0330	4,986	$127,828.27	5,772	$146,366.65
	D0340	4	$62.00	8	$308.00
	D0350	9	$0.00	13	$0.00
	D0351	1	$0.00		
	D0415			1	$0.00
	D0431	3	$0.00		
	D0460	28	$0.00	24	$0.00
	D0470	17	$0.00	22	$0.00
	D0999	2	$0.00		
	D1110	15,167	$433,638.39	17,000	$475,888.57
	D1120	112	$22.00	155	$0.00
	D1206	3,461	$52,895.89	2,872	$33,653.54
	D1208	3,035	$45,682.65	3,515	$44,103.18
	D1320	1	$0.00	6	$0.00
	D1330	61	$0.00	75	$0.00
	D1351	1,127	$133,997.63	965	$91,526.68
	D1352	7	$0.00	6	$0.00
	D1510	1	$0.00	1	$0.00
	D1515			1	$0.00
	D1550	1	$0.00	1	$0.00
	D1555	1	$0.00	1	$0.00
	D2140	1,392	$86,031.91	1,649	$95,845.56
	D2150	2,626	$185,054.21	2,840	$193,721.30
	D2160	1,463	$112,455.40	1,693	$126,544.43
	D2161	472	$38,726.61	563	$43,819.87
	D2330	1,954	$141,195.19	2,052	$150,100.37
	D2331	2,267	$202,981.25	2,377	$201,947.73
	D2332	1,681	$182,630.90	1,642	$167,026.28
	D2335	1,380	$166,072.41	1,445	$170,034.75
	D2390	1	$0.00	7	$0.00
	D2391	3,441	$273,793.78	3,640	$274,839.86
	D2392	4,531	$423,588.89	4,593	$422,963.00
	D2393	2,495	$235,935.55	2,455	$233,289.46
	D2394	1,053	$104,458.89	1,018	$101,752.62
	D2530			1	$0.00
	D2644	1	$0.00		
	D2710	4	$387.00	4	$1,071.00
	D2740	283	$67,085.24	195	$38,397.10
	D2750	202	$53,437.29	133	$35,410.00

	D2751	250	$63,537.43	219	$55,541.40
	D2752	50	$12,460.42	70	$16,135.20
	D2790	11	$2,217.41	11	$2,624.40
	D2791	10	$2,640.00	12	$1,650.00
	D2792	7	$990.00	3	$660.00
	D2910	3	$20.00	2	$140.00
	D2915	4	$114.00	4	$114.00
	D2920	166	$3,009.60	188	$3,514.50
	D2930	17	$703.12	12	$464.00
	D2931	753	$90,609.54	848	$97,027.36
	D2932	7	$927.00	7	$1,030.00
	D2933	4	$670.00	2	$132.00
	D2934			6	$1,030.00
	D2940	426	$13,176.78	469	$14,540.87
	D2950	945	$64,419.04	958	$62,290.41
	D2951	135	$1,592.76	155	$1,892.00
	D2952	10	$0.00	7	$0.00
	D2954	200	$17,817.67	265	$22,672.50
	D2962			1	$0.00
	D2970	21	$1,282.00	22	$1,963.00
	D2980	1	$0.00	6	$125.00
	D2999	3	$95.00	5	$0.00
	D3110	56	$0.00	70	$0.00
	D3120	151	$0.00	141	$0.00
	D3220	16	$280.00	29	$70.00
	D3221	35	$75.00	38	$130.00
	D3230	1	$0.00	1	$0.00
	D3240	2	$90.00	3	$270.00
	D3310	464	$107,699.47	559	$124,582.50
	D3320	746	$175,883.89	826	$179,400.90
	D3330	729	$216,539.13	772	$218,909.92
	D3331			1	$0.00
	D3332	2	$0.00	4	$0.00
	D3346	15	$2,431.00	13	$1,767.00
	D3347	19	$3,765.00	21	$4,725.00
	D3348	32	$9,696.53	20	$5,580.00
	D3351	3	$264.00		
	D3410	4	$855.00	6	$513.00
	D3425			1	$0.00
	D3426			1	$0.00
	D3430			3	$0.00

	D3920	1	$0.00		
	D3950	1	$0.00		
	D3999	160	$5,098.00	169	$5,723.00
	D4210	4	$491.75	5	$752.00
	D4211	24	$1,917.00	35	$2,363.00
	D4241			4	$0.00
	D4265			1	$0.00
	D4266			1	$0.00
	D4267	1	$0.00		
	D4273			1	$0.00
	D4274			1	$0.00
	D4320	1	$0.00		
	D4321	3	$0.00	6	$0.00
	D4341	185	$13,830.00	229	$15,142.00
	D4342	26	$857.00	36	$814.00
	D4355	3,730	$196,062.04	3,702	$191,411.29
	D4381	3	$0.00	4	$0.00
	D4910	200	$1,721.80	180	$1,065.00
	D4999	1	$0.00		
	D5110	314	$131,012.88	343	$147,442.50
	D5120	209	$83,776.60	232	$91,459.50
	D5130	176	$80,811.98	201	$90,025.91
	D5140	79	$33,006.79	76	$31,057.61
	D5211	358	$104,152.02	337	$98,520.00
	D5212	299	$94,472.06	261	$85,163.30
	D5213	8	$0.00	13	$0.00
	D5214	16	$0.00	15	$0.00
	D5225	4	$0.00	2	$0.00
	D5226	3	$0.00	1	$0.00
	D5410	145	$2,354.97	149	$2,205.00
	D5411	98	$1,740.00	145	$2,286.00
	D5421	105	$1,980.00	89	$1,520.00
	D5422	83	$1,530.37	88	$1,623.00
	D5510	71	$5,807.00	80	$6,222.00
	D5520	85	$5,024.00	76	$4,987.00
	D5610	145	$12,502.72	142	$12,919.50
	D5620	5	$540.00	10	$540.00
	D5630	14	$1,305.38	23	$2,462.00
	D5640	78	$5,005.89	73	$4,411.00
	D5650	110	$7,547.48	127	$8,927.00
	D5660	30	$2,496.00	37	$3,309.48

	D5710	45	$7,590.00	25	$3,920.00
	D5711	22	$3,595.00	13	$2,105.00
	D5720			3	$555.00
	D5721	2	$350.00	1	$185.00
	D5730	31	$2,282.12	65	$4,462.00
	D5731	19	$1,401.00	29	$2,165.00
	D5740	9	$737.00	8	$652.00
	D5741	3	$276.00	8	$464.00
	D5750	128	$17,340.26	127	$16,702.00
	D5751	64	$8,638.68	74	$10,823.00
	D5760	7	$921.00	11	$1,710.00
	D5761	11	$1,551.00	12	$1,860.00
	D5810	124	$36,416.05	125	$35,500.00
	D5811	79	$20,097.62	61	$14,673.00
	D5820	104	$18,664.92	110	$17,330.00
	D5821	31	$5,223.00	31	$3,375.00
	D5850	76	$2,798.00	77	$2,345.50
	D5851	42	$1,679.68	44	$1,308.50
	D5862	3	$0.00		
	D5899	4	$50.00		
	D5951	1	$0.00		
	D5954	1	$0.00		
	D5986	1	$0.00		
	D5999	4	$0.00		
	D6010	3	$0.00	1	$0.00
	D6056	1	$0.00		
	D6057	1	$0.00		
	D6061	1	$0.00		
	D6066	1	$0.00		
	D6080	1	$0.00		
	D6091			1	$0.00
	D6092			1	$0.00
	D6100			1	$0.00
	D6210	1	$0.00		
	D6240			4	$0.00
	D6241	1	$0.00	3	$0.00
	D6242	1	$0.00		
	D6245	3	$0.00		
	D6253	1	$0.00		
	D6740	3	$0.00		
	D6750	1	$0.00	3	$0.00

	D6751	1	$0.00	3	$0.00
	D6752	1	$0.00		
	D6790	1	$0.00		
	D6930	12	$420.00	19	$840.00
	D6980	6	$0.00		
	D6999	1	$0.00	1	$0.00
	D7111	11	$88.00	14	$264.00
	D7140	4,577	$515,594.96	4,929	$555,096.42
	D7210	2,315	$299,508.58	2,645	$336,766.90
	D7220	172	$24,199.87	187	$26,403.16
	D7230	216	$43,242.62	214	$43,580.10
	D7240	144	$38,497.93	149	$38,966.29
	D7241	15	$5,627.38	23	$7,252.00
	D7250	230	$31,889.10	262	$33,818.00
	D7251	4	$0.00	1	$0.00
	D7260	1	$0.00		
	D7261	1	$0.00	2	$0.00
	D7270	7	$1,050.00	1	$450.00
	D7280			3	$0.00
	D7283			2	$0.00
	D7285	5	$470.00	1	$94.00
	D7286	16	$1,190.00	24	$1,700.00
	D7288	1	$0.00		
	D7292			1	$0.00
	D7310	71	$6,127.86	90	$8,551.00
	D7311	28	$1,775.97	23	$1,398.00
	D7320	15	$1,034.00	19	$1,952.00
	D7321	16	$882.48	16	$1,063.00
	D7410	8	$352.00	7	$456.00
	D7411	2	$188.00	7	$470.00
	D7412			1	$0.00
	D7450	2	$0.00	1	$0.00
	D7451	5	$110.00	1	$0.00
	D7471	7	$1,045.92	5	$260.00
	D7472	3	$0.00		
	D7473	3	$0.00	6	$2.00
	D7510	56	$1,890.00	41	$1,554.00
	D7511	3	$0.00		
	D7520			3	$0.00
	D7521	1	$0.00		
	D7530	1	$0.00	1	$0.00

	D7540	1	$0.00		
	D7550	3	$0.00	3	$0.00
	D7620			1	$0.00
	D7640	1	$0.00		
	D7730	1	$0.00		
	D7880	3	$328.00	3	$328.00
	D7899	1	$0.00		
	D7950	2	$0.00		
	D7953	2	$0.00	6	$0.00
	D7960	10	$752.00	12	$828.00
	D7970			1	$0.00
	D7971	1	$0.00		
	D7999	7	$0.00	2	$0.00
	D8060	1	$0.00		
	D8220	2	$0.00	1	$0.00
	D8660	2	$0.00	1	$0.00
	D8680	1	$0.00		
	D8692			3	$190.00
	D8693	2	$0.00	2	$0.00
	D8999	3	$0.00	2	$21.00
	D9110	1,011	$22,233.39	1,010	$21,667.12
	D9120	1	$0.00		
	D9210	5	$0.00	1	$0.00
	D9215	6	$0.00	67	$0.00
	D9220	417	$54,035.10	394	$59,138.86
	D9221	137	$11,636.90	142	$13,721.40
	D9230	993	$19,865.17	1,170	$22,488.06
	D9241	165	$14,664.00	183	$14,338.24
	D9242	109	$7,478.12	117	$7,659.00
	D9248	41	$4,623.54	49	$2,036.00
	D9310	15	$0.00	16	$0.00
	D9410	57	$1,925.00	44	$1,575.00
	D9420	321	$23,004.77	275	$19,813.00
	D9430	12	$0.00	6	$0.00
	D9440	35	$1,562.80	38	$1,322.00
	D9610	6	$0.00	9	$0.00
	D9612	41	$0.00	38	$0.00
	D9630	19	$0.00	32	$0.00
	D9910	39	$0.00	61	$0.00
	D9911	7	$0.00	9	$0.00
	D9920	1	$0.00	1	$0.00

	D9930	13	$0.00	18	$0.00
	D9931	1	$0.00		
	D9940	510	$78,799.38	472	$70,096.94
	D9941	1	$0.00	2	$0.00
	D9942			4	$0.00
	D9950	1	$0.00		
	D9951	32	$0.00	33	$0.00
	D9952	1	$0.00		
	D9970	1	$0.00		
	D9971	3	$0.00	6	$0.00
	D9972	1	$0.00	1	$0.00
	D9973			1	$0.00
	D9974	1	$0.00	3	$0.00
	D9986	1	$0.00		
	D9999	42	$41.00	15	$0.00
	Aggregate(Procedure Nebraska Code Values)	**55,995**	**$6,929,484.26**	**59,970**	**$6,959,874.92**
55 to 64	D0120	2,833	$52,808.31	3,112	$46,531.17
	D0140	2,128	$39,434.38	2,063	$31,103.24
	D0150	1,228	$21,898.26	1,169	$17,315.23
	D0160	33	$729.00	50	$1,203.00
	D0170	112	$1,661.53	163	$2,494.00
	D0180	44	$1,129.00	32	$751.00
	D0210	377	$15,252.06	361	$14,630.00
	D0220	2,536	$13,546.92	2,481	$12,745.61
	D0230	1,075	$8,595.83	1,061	$8,459.68
	D0240	1	$14.00	7	$35.00
	D0270	133	$1,087.00	109	$818.50
	D0272	591	$7,027.50	664	$7,729.80
	D0273	39	$525.00	29	$418.00
	D0274	1,442	$24,156.63	1,420	$23,363.93
	D0277	3	$54.00	4	$72.00
	D0330	960	$25,871.06	937	$25,201.86
	D0350	1	$0.00		
	D0363			1	$0.00
	D0460	8	$0.00	1	$0.00
	D0470	6	$0.00	5	$0.00
	D0999			2	$88.00
	D1110	3,282	$93,761.32	3,552	$100,522.37
	D1120	9	$0.00	7	$0.00
	D1206	671	$9,828.00	546	$6,369.71
	D1208	632	$9,029.99	672	$8,445.00

	D1320			3	$0.00
	D1330	37	$0.00	26	$0.00
	D1351	61	$6,231.37	26	$1,998.00
	D1352	2	$0.00		
	D2140	204	$11,425.88	230	$12,942.20
	D2150	369	$22,652.85	410	$25,219.49
	D2160	196	$12,437.70	228	$15,801.00
	D2161	86	$6,604.00	97	$7,228.65
	D2330	498	$38,424.85	418	$30,772.71
	D2331	521	$44,677.89	483	$39,345.16
	D2332	407	$39,548.45	340	$30,721.60
	D2335	298	$33,645.01	313	$33,905.52
	D2390			1	$0.00
	D2391	491	$34,751.91	406	$27,246.80
	D2392	489	$38,925.56	502	$38,918.00
	D2393	306	$26,388.50	240	$22,439.29
	D2394	175	$17,975.89	154	$13,837.11
	D2644			1	$0.00
	D2650			1	$0.00
	D2710	1	$191.00		
	D2740	58	$11,885.60	42	$9,152.00
	D2750	36	$11,394.04	25	$8,049.00
	D2751	40	$11,325.00	35	$8,013.50
	D2752	19	$4,052.36	15	$2,403.00
	D2790	4	$591.00	5	$660.00
	D2791	2	$660.00	3	$990.00
	D2792			6	$0.00
	D2799	1	$0.00		
	D2910			3	$20.00
	D2915			2	$0.00
	D2920	68	$1,140.00	67	$1,179.00
	D2930	2	$0.00	3	$0.00
	D2931	185	$22,888.50	192	$21,644.30
	D2932	1	$103.00	2	$206.00
	D2934	1	$134.00	3	$402.00
	D2940	60	$1,749.60	57	$1,992.00
	D2950	139	$9,500.68	129	$8,322.00
	D2951	46	$572.00	44	$528.00
	D2952	3	$0.00	1	$0.00
	D2954	57	$4,621.70	48	$4,273.00
	D2970	5	$337.36	5	$292.00

D2980	4	$0.00		
D2999			2	$0.00
D3110	9	$0.00	3	$0.00
D3120	18	$0.00	14	$0.00
D3220	2	$0.00	4	$0.00
D3221	4	$0.00	7	$0.00
D3310	90	$20,592.53	71	$15,963.00
D3320	70	$14,652.00	68	$16,544.00
D3330	79	$21,624.00	65	$19,234.00
D3331	1	$0.00		
D3346	3	$442.00	2	$221.00
D3347	1	$251.00	2	$502.00
D3348	3	$834.00	3	$1,002.00
D3410	1	$171.00		
D3950	1	$0.00		
D3999	20	$800.00	16	$720.00
D4211	11	$722.00	7	$526.00
D4245	1	$0.00		
D4321	4	$0.00	3	$0.00
D4341	46	$2,795.00	62	$4,496.00
D4342	17	$761.50	30	$800.00
D4355	562	$28,493.46	560	$27,508.99
D4381	2	$0.00	1	$0.00
D4910	90	$725.00	89	$493.00
D5110	334	$134,716.53	315	$125,370.00
D5120	223	$86,433.74	218	$86,548.50
D5130	76	$32,447.05	64	$27,777.00
D5140	54	$21,991.23	49	$22,248.80
D5211	135	$43,994.30	110	$32,637.00
D5212	161	$49,570.61	146	$47,524.50
D5213	9	$0.00	9	$0.00
D5214	11	$0.00	12	$0.00
D5410	130	$2,281.00	135	$2,243.00
D5411	156	$2,726.00	138	$2,458.00
D5421	63	$1,180.00	61	$1,132.00
D5422	62	$1,200.00	92	$1,652.00
D5510	67	$5,504.80	58	$4,326.10
D5520	79	$5,067.56	74	$4,879.00
D5610	86	$7,495.84	88	$7,387.40
D5620	6	$408.93	10	$707.00
D5630	19	$1,699.00	14	$1,367.40

	D5640	56	$4,198.00	50	$3,650.00
	D5650	110	$7,717.81	89	$6,587.00
	D5660	28	$2,620.56	19	$1,602.00
	D5710	11	$1,900.00	16	$2,535.00
	D5711	4	$660.00	11	$1,825.00
	D5720			1	$185.00
	D5721	2	$370.00	1	$185.00
	D5730	39	$3,375.00	49	$3,696.00
	D5731	28	$2,429.00	29	$2,202.00
	D5740	9	$621.45	7	$555.00
	D5741	3	$182.00	9	$676.00
	D5750	94	$12,380.68	61	$7,639.00
	D5751	71	$9,322.92	46	$6,143.00
	D5760	12	$1,236.00	9	$1,230.00
	D5761	11	$1,707.00	19	$2,711.75
	D5810	41	$12,594.80	37	$11,288.00
	D5811	39	$11,585.04	22	$6,953.00
	D5820	36	$4,566.09	33	$4,328.60
	D5821	17	$1,554.80	7	$708.00
	D5850	63	$2,505.12	38	$1,046.00
	D5851	49	$1,903.00	32	$817.00
	D5982	1	$0.00		
	D5986	2	$0.00	2	$0.00
	D6057	1	$0.00	1	$0.00
	D6058	1	$0.00	1	$0.00
	D6240	1	$0.00		
	D6750	1	$0.00		
	D6930	10	$336.00	8	$336.00
	D6980	1	$0.00		
	D6999	1	$0.00		
	D7111	4	$0.00		
	D7140	1,313	$169,421.97	1,240	$168,696.95
	D7210	488	$59,764.70	478	$61,029.00
	D7220	5	$1,098.00	3	$366.00
	D7230	2	$334.00	3	$501.00
	D7240	4	$1,010.00	9	$1,215.00
	D7241	1	$212.00		
	D7250	52	$7,391.20	56	$8,621.20
	D7261			1	$0.00
	D7270	1	$300.00		
	D7285			1	$94.00

	D7286	9	$680.00	10	$850.00
	D7310	29	$2,816.48	33	$3,685.00
	D7311	19	$1,323.00	12	$651.00
	D7320	11	$940.00	7	$752.00
	D7321	14	$713.00	5	$532.00
	D7350	1	$0.00		
	D7410	3	$88.00	4	$233.00
	D7411			1	$188.80
	D7451	1	$110.00	1	$0.00
	D7471	5	$550.00	9	$1,100.00
	D7472	1	$0.00		
	D7473	6	$0.00	5	$0.00
	D7485	1	$0.00	1	$0.00
	D7510	9	$378.00	8	$294.00
	D7511	1	$0.00	1	$0.00
	D7520			1	$0.00
	D7550	1	$0.00		
	D7880	1	$0.00	2	$328.00
	D7953			1	$0.00
	D7960	1	$0.00	1	$92.00
	D7970	1	$0.00	1	$0.00
	D7999	1	$0.00	1	$0.00
	D9110	214	$4,634.80	198	$4,237.80
	D9120	1	$0.00	1	$0.00
	D9210	2	$0.00	1	$0.00
	D9215			22	$0.00
	D9220	37	$4,352.10	25	$3,663.00
	D9221	10	$580.56	6	$648.00
	D9230	115	$2,186.00	139	$2,425.00
	D9241	20	$1,692.00	11	$846.00
	D9242	9	$575.56	7	$387.00
	D9248	2	$150.00	10	$150.00
	D9310	7	$0.00	6	$0.00
	D9410	99	$3,148.12	89	$2,730.00
	D9420	79	$5,665.12	70	$5,093.00
	D9430	5	$0.00	3	$0.00
	D9440	5	$225.00	3	$135.00
	D9610			1	$0.00
	D9612	1	$0.00	1	$0.00
	D9630	6	$0.00	11	$0.00
	D9910	4	$0.00	8	$0.00

	D9911	2	$0.00	1	$0.00
	D9920	2	$0.00		
	D9930	1	$0.00	2	$0.00
	D9940	67	$10,168.00	56	$8,061.00
	D9942	1	$0.00	1	$0.00
	D9951	4	$0.00	6	$0.00
	D9971			1	$0.00
	D9999	7	$50.00	3	$0.00
	Aggregate(Procedure Nebraska Code Values)	**12,664**	**$1,595,148.45**	**12,661**	**$1,477,569.22**
65 and Over	D0120	3,968	$74,124.87	4,171	$63,762.53
	D0140	2,975	$56,075.70	2,892	$45,951.08
	D0145			1	$0.00
	D0150	1,531	$27,957.67	1,536	$23,419.95
	D0160	42	$1,107.00	114	$2,586.00
	D0170	262	$3,857.56	384	$5,524.20
	D0180	19	$486.00	20	$508.00
	D0210	524	$21,176.71	546	$21,474.50
	D0220	2,875	$15,618.84	2,739	$14,803.41
	D0230	1,256	$10,277.20	1,278	$10,857.64
	D0240			6	$56.00
	D0250			1	$0.00
	D0270	98	$731.00	74	$600.00
	D0272	817	$9,726.50	848	$10,018.52
	D0273	41	$600.00	40	$525.00
	D0274	1,354	$23,403.66	1,296	$21,874.10
	D0277	8	$108.00	11	$180.00
	D0330	771	$22,267.62	809	$23,640.20
	D0340	1	$0.00		
	D0350			2	$0.00
	D0363			1	$0.00
	D0431			1	$0.00
	D0460	3	$0.00	1	$0.00
	D0470	6	$0.00	8	$0.00
	D0999			1	$0.00
	D1110	4,386	$122,866.36	4,790	$133,534.91
	D1120	1	$0.00	7	$0.00
	D1206	704	$10,338.45	621	$7,294.31
	D1208	1,210	$17,530.11	1,121	$14,419.42
	D1320	1	$0.00	1	$0.00
	D1330	18	$0.00	11	$0.00
	D1351	27	$2,708.00	25	$2,340.00

	D1352	1	$0.00		
	D2140	301	$17,295.30	295	$16,422.54
	D2150	383	$24,105.59	360	$22,288.85
	D2160	188	$13,364.12	195	$13,250.51
	D2161	75	$6,146.00	101	$7,377.40
	D2330	584	$45,249.75	592	$45,531.98
	D2331	656	$54,188.44	669	$59,152.59
	D2332	427	$39,904.64	397	$38,725.54
	D2335	381	$41,116.81	344	$38,186.48
	D2390	1	$0.00	2	$0.00
	D2391	443	$29,946.01	452	$32,437.40
	D2392	452	$38,007.23	471	$39,260.11
	D2393	272	$23,417.27	241	$21,124.40
	D2394	133	$12,200.30	119	$10,318.08
	D2650	1	$0.00		
	D2710	2	$0.00	4	$194.00
	D2721			1	$0.00
	D2740	37	$10,307.00	17	$3,318.00
	D2750	29	$7,521.06	25	$6,068.00
	D2751	34	$10,635.60	36	$10,803.00
	D2752	15	$2,640.00	10	$2,204.00
	D2790	5	$1,079.80	1	$660.00
	D2791	4	$990.00	1	$0.00
	D2792	1	$0.00		
	D2799			1	$0.00
	D2910	2	$40.00	3	$60.00
	D2915			1	$38.00
	D2920	100	$1,760.00	95	$1,784.00
	D2930			2	$0.00
	D2931	191	$22,132.50	170	$19,865.80
	D2932			1	$0.00
	D2934	4	$402.00	4	$536.00
	D2940	42	$1,248.00	50	$1,404.00
	D2950	111	$8,327.12	97	$6,641.00
	D2951	46	$550.00	67	$936.50
	D2952			2	$0.00
	D2954	29	$2,500.00	39	$3,190.30
	D2970	2	$128.00	12	$730.00
	D2980	1	$0.00	2	$75.00
	D2999	1	$0.00	4	$0.00
	D3110	6	$0.00	6	$0.00

	D3120	8	$0.00	9	$0.00
	D3220	3	$0.00	3	$0.00
	D3221	7	$0.00	2	$0.00
	D3310	71	$15,718.00	75	$15,055.30
	D3320	53	$12,329.60	56	$12,184.30
	D3330	34	$9,310.65	24	$6,207.00
	D3332			1	$0.00
	D3346	1	$221.00	1	$221.00
	D3347	4	$753.00	2	$502.00
	D3348	1	$29.00	1	$334.00
	D3410			1	$171.00
	D3920			1	$0.00
	D3999	19	$680.00	13	$557.00
	D4210			3	$188.00
	D4211	9	$580.00	8	$502.00
	D4321	4	$0.00	4	$0.00
	D4341	25	$960.00	15	$1,249.80
	D4342	20	$1,282.00	5	$104.00
	D4355	554	$28,692.58	533	$26,183.98
	D4381	1	$0.00		
	D4910	65	$319.00	61	$609.00
	D4999	1	$0.00		
	D5110	421	$179,144.11	484	$196,188.25
	D5120	363	$140,198.07	423	$148,286.97
	D5130	75	$30,173.71	69	$30,719.04
	D5140	72	$25,278.17	57	$25,594.25
	D5211	142	$42,656.28	151	$43,251.00
	D5212	204	$63,582.81	181	$56,409.60
	D5213	5	$0.00	9	$0.00
	D5214	11	$0.00	13	$0.00
	D5225	1	$0.00	1	$0.00
	D5226	3	$0.00	1	$0.00
	D5410	339	$6,205.99	285	$5,166.00
	D5411	482	$8,700.45	409	$7,106.00
	D5421	112	$1,886.00	101	$1,760.00
	D5422	178	$3,165.80	207	$3,709.00
	D5510	167	$14,934.00	166	$14,229.34
	D5520	139	$10,051.00	136	$9,746.00
	D5610	151	$12,104.15	132	$10,484.50
	D5620	14	$1,330.06	15	$1,404.00
	D5630	31	$3,169.00	17	$1,944.00

	D5640	92	$6,249.98	100	$7,272.93
	D5650	195	$14,023.24	183	$12,925.00
	D5660	33	$3,010.50	41	$3,951.00
	D5710	27	$4,748.00	26	$4,291.00
	D5711	30	$4,774.17	27	$4,075.00
	D5720	5	$535.00	3	$350.00
	D5721	8	$1,105.00	5	$660.00
	D5730	127	$10,868.90	102	$8,133.00
	D5731	114	$10,081.09	104	$8,595.00
	D5740	19	$1,395.00	11	$937.00
	D5741	19	$1,501.85	16	$1,289.00
	D5750	176	$24,937.69	167	$23,165.00
	D5751	166	$23,690.56	135	$19,109.60
	D5760	14	$2,150.50	9	$1,398.00
	D5761	15	$2,172.00	27	$3,567.00
	D5810	25	$7,381.53	21	$6,065.00
	D5811	26	$6,877.12	16	$3,936.00
	D5820	20	$3,490.00	19	$2,348.00
	D5821	4	$702.00	8	$888.00
	D5850	72	$2,669.00	90	$3,461.84
	D5851	97	$3,569.00	101	$3,888.00
	D5867			1	$0.00
	D5899	4	$75.00	1	$0.00
	D5911	1	$0.00		
	D5993	1	$0.00		
	D6053			1	$0.00
	D6080	1	$0.00	1	$0.00
	D6090			1	$0.00
	D6091	1	$0.00		
	D6100			1	$0.00
	D6110	1	$0.00		
	D6111	2	$0.00		
	D6240			1	$0.00
	D6245			1	$0.00
	D6740			1	$0.00
	D6750			1	$0.00
	D6930	21	$966.00	13	$504.00
	D6950			1	$0.00
	D7111	1	$44.00	1	$0.00
	D7140	1,339	$165,985.80	1,248	$150,657.72
	D7210	528	$71,557.57	582	$86,845.37

	D7220	5	$551.00	3	$366.00
	D7230	4	$501.00	4	$668.00
	D7240	5	$576.56	1	$309.00
	D7241	1	$212.00		
	D7250	50	$7,382.36	60	$10,839.43
	D7251	1	$0.00	1	$0.00
	D7260	1	$0.00		
	D7285			1	$94.00
	D7286	6	$510.00	5	$333.00
	D7288	1	$0.00	1	$0.00
	D7310	35	$3,120.13	27	$3,255.00
	D7311	14	$951.00	5	$379.00
	D7320	7	$940.00	3	$376.00
	D7321	6	$360.12	4	$307.00
	D7410	3	$59.00	2	$0.00
	D7411	1	$0.00		
	D7471	4	$494.12	3	$330.00
	D7473	2	$214.92	4	$0.00
	D7485			1	$0.00
	D7510	6	$252.00	6	$170.00
	D7511	1	$0.00	1	$0.00
	D7520	1	$0.00		
	D7530			1	$0.00
	D7550	2	$0.00	1	$0.00
	D7953	1	$0.00		
	D7960			5	$330.00
	D7970			1	$0.00
	D7999	10	$0.00	4	$0.00
	D9110	278	$6,096.77	213	$4,692.35
	D9120	1	$0.00	4	$0.00
	D9215			3	$0.00
	D9220	12	$1,296.00	12	$1,806.00
	D9221	4	$162.00	5	$648.00
	D9230	71	$1,386.00	65	$1,337.00
	D9241	12	$1,026.00	10	$828.51
	D9242	3	$86.00	5	$206.96
	D9248			1	$0.00
	D9310	9	$0.00	9	$0.00
	D9410	573	$18,331.20	571	$17,840.70
	D9420	48	$3,520.00	81	$5,376.00
	D9430	6	$0.00	4	$0.00

	D9440	7	$315.00	4	$180.00
	D9610			2	$0.00
	D9612	1	$0.00	1	$0.00
	D9630	19	$0.00	15	$0.00
	D9910	6	$0.00	5	$0.00
	D9911	3	$0.00	3	$0.00
	D9920			2	$0.00
	D9930			3	$0.00
	D9931	1	$0.00		
	D9940	31	$4,995.00	34	$4,894.00
	D9951	6	$0.00	9	$0.00
	D9971	1	$0.00	2	$0.00
	D9999	14	$0.00	17	$0.00
	Aggregate(Procedure Nebraska Code Values)	**15,869**	**$1,877,516.90**	**16,199**	**$1,839,897.99**
Aggregate(Age In Years Claim Values)		**329,355**	**$43,812,751.89**	**332,955**	**$40,591,932.15**

RFP Number 5427 Z1
Attachment 17

CFS Service Areas	Estimated Members
Central	29,480
Eastern	93,980
Northern	38,150
Out of State	2,450
Southeast	50,670
Western	26,320
Grand Total	241,050

CODE	CATEGORY
D9110	Adjunctive General Services
D9223	Adjunctive General Services
D9230	Adjunctive General Services
D9243	Adjunctive General Services
D9248	Adjunctive General Services
D9410	Adjunctive General Services
D9420	Adjunctive General Services
D9440	Adjunctive General Services
D9940	Adjunctive General Services
D9220	Adjunctive General Services
D9221	Adjunctive General Services
D9241	Adjunctive General Services
D9999	Adjunctive General Services
D9242	Adjunctive General Services
D3220	Endodontics
D3230	Endodontics
D3240	Endodontics
D3310	Endodontics
D3320	Endodontics
D3330	Endodontics
D3346	Endodontics
D3347	Endodontics
D3348	Endodontics
D3351	Endodontics
D3410	Endodontics
D3999	Endodontics
D3221	Endodontics
D7111	Oral and Maxillofacial surgery
D7140	Oral and Maxillofacial surgery
D7210	Oral and Maxillofacial surgery
D7220	Oral and Maxillofacial surgery
D7230	Oral and Maxillofacial surgery
D7240	Oral and Maxillofacial surgery
D7241	Oral and Maxillofacial surgery
D7250	Oral and Maxillofacial surgery
D7270	Oral and Maxillofacial surgery
D7280	Oral and Maxillofacial surgery
D7282	Oral and Maxillofacial surgery
D7283	Oral and Maxillofacial surgery
D7285	Oral and Maxillofacial surgery
D7286	Oral and Maxillofacial surgery
D7310	Oral and Maxillofacial surgery
D7311	Oral and Maxillofacial surgery
D7320	Oral and Maxillofacial surgery
D7321	Oral and Maxillofacial surgery
D7410	Oral and Maxillofacial surgery
D7411	Oral and Maxillofacial surgery
D7412	Oral and Maxillofacial surgery
D7413	Oral and Maxillofacial surgery
D7414	Oral and Maxillofacial surgery
D7415	Oral and Maxillofacial surgery
D7440	Oral and Maxillofacial surgery
D7441	Oral and Maxillofacial surgery
D7450	Oral and Maxillofacial surgery

CODE	CATEGORY
D7451	Oral and Maxillofacial surgery
D7460	Oral and Maxillofacial surgery
D7461	Oral and Maxillofacial surgery
D7465	Oral and Maxillofacial surgery
D7471	Oral and Maxillofacial surgery
D7510	Oral and Maxillofacial surgery
D7880	Oral and Maxillofacial surgery
D7960	Oral and Maxillofacial surgery
D7473	Oral and Maxillofacial Surgery
D7999	Oral and Maxillofacial Surgery
D8060	Orthodontics
D8090	Orthodontics
D8210	Orthodontics
D8220	Orthodontics
D8691	Orthodontics
D8692	Orthodontics
D8999	Orthodontics
D8693	Orthodontics
D5211	Partial Dentures
D5212	Partial Dentures
D5213	Partial Dentures
D5214	Partial Dentures
D5410	Partial Dentures
D5411	Partial Dentures
D5421	Partial Dentures
D5422	Partial Dentures
D5510	Partial Dentures
D5520	Partial Dentures
D5610	Partial Dentures
D5620	Partial Dentures
D5630	Partial Dentures
D5640	Partial Dentures
D5650	Partial Dentures
D5660	Partial Dentures
D5710	Partial Dentures
D5711	Partial Dentures
D5720	Partial Dentures
D5721	Partial Dentures
D5730	Partial Dentures
D5731	Partial Dentures
D5740	Partial Dentures
D5741	Partial Dentures
D5750	Partial Dentures
D5751	Partial Dentures
D5760	Partial Dentures
D5761	Partial Dentures
D5810	Partial Dentures
D5811	Partial Dentures
D5820	Partial Dentures
D5821	Partial Dentures
D5850	Partial Dentures
D5851	Partial Dentures
D6930	Partial Dentures
D4210	Periodontics

CODE	CATEGORY
D4211	Periodontics
D4341	Periodontics
D4342	Periodontics
D4355	Periodontics
D4910	Periodontics
D0120	Preventative
D0140	Preventative
D0145	Preventative
D0150	Preventative
D0160	Preventative
D0170	Preventative
D0180	Preventative
D0210	Preventative
D0220	Preventative
D0230	Preventative
D0240	Preventative
D0270	Preventative
D0272	Preventative
D0273	Preventative
D0274	Preventative
D0330	Preventative
D0340	Preventative
D0470	Preventative
D1110	Preventative
D1120	Preventative
D1206	Preventative
D1208	Preventative
D1351	Preventative
D1510	Preventative
D1515	Preventative
D1550	Preventative
D1555	Preventative
D0277	Preventative
D0999	Preventative
D5110	Prosthodontics
D5120	Prosthodontics
D5130	Prosthodontics
D5140	Prosthodontics
D5899	Prosthodontics
D2140	Restorative
D2150	Restorative
D2160	Restorative
D2161	Restorative
D2330	Restorative
D2331	Restorative
D2332	Restorative
D2335	Restorative
D2391	Restorative
D2392	Restorative
D2393	Restorative
D2394	Restorative
D2710	Restorative
D2720	Restorative
D2721	Restorative

CODE	CATEGORY
D2722	Restorative
D2740	Restorative
D2750	Restorative
D2751	Restorative
D2752	Restorative
D2790	Restorative
D2791	Restorative
D2792	Restorative
D2910	Restorative
D2915	Restorative
D2920	Restorative
D2930	Restorative
D2931	Restorative
D2932	Restorative
D2933	Restorative
D2934	Restorative
D2940	Restorative
D2950	Restorative
D2951	Restorative
D2954	Restorative
D2980	Restorative
D2999	Restorative
D2970	Restorative

Attachment 19, Dental Providers removed due to confidential information

4 pages