LOUISIANA DEPARTMENT OF HEALTH

Bureau of Health Services Financing

Request for Proposals for
Dental Benefit
Program Management

REDACTED

DentaQuest USA Insurance Company, Inc.
RFP #3000013043
Proposal Due Date/Time: August 6, 2019 4:00pm CT

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2.15.4.1 COVER LETTER

August 6, 2019

Teresa Bravo
Louisiana Department of Health, Bureau of Health Services Financing
628 N 4th Street, 6th Floor
Baton Rouge, LA 70802

Dear Ms. Bravo,

DentaQuest USA Insurance Company, Inc. (Proposer) is pleased to submit our proposal for Dental Benefit Program Management (DBPM) pursuant to the Request for Proposals (RFP) #3000013043, issued by the Louisiana Department of Health (LDH), Bureau of Health Services Financing.

Throughout our response, we will demonstrate our experience with and ongoing commitment to serving the Medicaid population. The DentaQuest[1] family of companies leads the industry in designing and implementing innovative solutions for state Medicaid programs that take oral health care to new levels by increasing utilization and improving care. We look forward to working with the LDH to achieve its goals as outlined in the RFP, including, but not limited to, improved coordination of care; better outcomes; increased quality; improved access to essential specialty services; outreach and education to promote dental health; and increased enrollee responsibility and self-management.

Please note: All information below is provided on behalf of Proposer.

REQUIRED INFORMATION

2.15.4.1.1.1. Location of administrative office with full time personnel

Full time personnel are located in the following offices

465 Medford Street Boston, MA 02129	8300 NW 53rd Street, Suite #200 Doral, FL 33166	1333 Main Street, Suite #603 Columbia, SC 29201
3322 West End Avenue, Suite #100 Nashville, TN 37203	11100 W. Liberty Drive Milwaukee, WI 53224	11044 Research Boulevard Building D, #400 Austin, TX 78759

2.15.4.1.1.2. Name and address of principal corporate office registered with the Louisiana Secretary of State, email address, website URL, and telephone number

As confirmed by Answer to Question No. 12 in the "Response to Written Inquiries and Revisions to RFP Documents," dated July 9, 2019, a foreign insurer authorized by the Louisiana Department of Insurance ("LDI") to transact the business of insurance underwriting cannot register with the Louisiana Secretary of State. As such, Proposer has not registered the address of its principal corporate office with the Louisiana Secretary of State. Nevertheless, in an attempt to comply with this request, the address of Proposer's principal corporate office, which is on file with LDI, is 465 Medford Street Boston, MA 02129. Proposer's email address is: michael.kelly@dentaquest.com; Proposer's website URL is www.dentaquestgov.com; and Proposer's telephone number is: 617-886-1818.

2.15.4.1.1.3. Name and address for purpose of issuing checks and/or drafts

DentaQuest USA Insurance Company, Inc. | 465 Medford Street | Boston, MA 02129

2.15.4.1.1.4. A statement listing name(s) and address(es) of principal owners who hold five percent interest or more in the corporation

None. Proposer does not have principal owners who hold 5% interest or more in the corporation.

[1] Hereinafter, the term "DentaQuest" refers to the DentaQuest family of companies. Where information specific to the Proposer or its immediate parent company is provided in this Response to the RFP, that company is specifically identified.

2.15.4.1.1.5. If out-of-state Proposer, name and address of local representative, if none, so state
Christina Medina, Managing Client Partner | Office: 104 Brushfire Lane Slidell, LA 70458

2.15.4.1.1.6. If any of the planned personnel is a current Louisiana state employee, or was employed within the past two (2) years, provide a listing to include the employee name, state agency, and termination date, if applicable
Not applicable; none of the planned personnel meet these criteria to our knowledge.

2.15.4.1.1.7. Proposer's state and federal tax identification numbers, LaGov vendor number, and Louisiana Department of Revenue number, if available
- State tax identification number (in Texas): 12029701856
- Federal tax identification number: 20-2970185
- LaGov vendor number: V31004617501
- Louisiana Department of Revenue number: 2004011

2.15.4.1.1.8. A graphical summary of whether Proposer meets mandatory and preferred qualifications to propose
Proposer meets or exceeds all mandatory and preferred qualifications detailed in Section 1.5. The **graphical summary** of those qualifications appear below.

DentaQuest

2.15.4.1.1.9 A brief statement of the Proposer's involvement in litigation related to the delivery of Medicaid dental benefits in the last ten (10) years performance.

2.15.4.1.1.10 A brief statement of the Proposer's having had a DBPM contract terminated or not renewed for non-performance or poor performance within the last ten (10) years. The Proposer must provide the principal terminating party name and contact information.

2.15.4.1.2. The cover letter should include the stipulation that the proposal is valid for a period of at least ninety (90) calendar days from the date of submission.

Proposer's proposal is valid for at least ninety (90) calendar days from the date of submission. This time period may be extended upon request.

2.15.4.1.3. The cover letter should include a positive statement of compliance with the contract terms defined herein. If the Proposer cannot comply with any of the contract terms, an explanation of each exception should be supplied. The Proposer should indicate the specific section and language in the RFP and submit exceptions or exact contract modifications that it may seek.

Proposer agrees to comply with the contract terms defined in the RFP.

DentaQuest

Sincerely,

Steven Pollock
President of DentaQuest USA Insurance Company, Inc.

SECTION 2.15.4.2 TABLE OF CONTENTS

SECTION 2.15.4.3 BACKGROUND AND EXPERIENCE

2.15.4.3.1 HISTORY, CORPORATE STRUCTURE, NUMBER OF YEARS IN BUSINESS

The Proposer should give a brief description of their company, including history, corporate structure, and the number of years in business.

Brief Description

DentaQuest[1], a leader in oral health, is a purpose-driven enterprise. With more than 25 million enrollees (22 million of whom are in government-sponsored programs), benefits administration under numerous affiliates in 30 states, care delivery practices in 5 states and a national network of oral health advocates, DentaQuest is uniquely positioned to make a difference. With deep expertise in benefits administration and care delivery, along with extensive involvement in philanthropy and public health, DentaQuest is redefining what prevention means, transforming standards across the industry, and working to expand access to oral health for all. By empowering people to be healthier through better oral health, DentaQuest is helping build stronger communities. Across everything DentaQuest does is a powerful commitment to drive economic value through social impact, furthering its ultimate mission to improve the oral health of all.

Corporate Structure

The DentaQuest organization, through a network of affiliates, contracts with state agencies in Colorado, Florida, Illinois, Massachusetts, Oregon, South Carolina, Tennessee, Texas, and Virginia to administer Medicaid and CHIP dental programs, giving us extensive experience providing the full array of preventive, diagnostic, restorative, endodontic, periodontal, and prosthodontic services, and oral and maxillofacial surgery[2]. For the purposes of this proposal, there are two entities that are relevant with the organization's corporate structure: (highlighted **Figure 2.15.4.3-1**):

- **DentaQuest, LLC:** This entity is the **immediate parent company** of the Proposer and provides almost all management and administrative services for the Proposer. DentaQuest, LLC is the largest and most experienced dental benefit program manager (DBPM) for Medicaid and CHIP programs in the nation. DentaQuest, LLC, both directly, and as a subcontractor to other DentaQuest corporate affiliates, administers Medicaid and/or CHIP dental benefits on behalf of nine state agencies and serves as the dental subcontractor to more than 100 health plans across 30 states. DentaQuest, LLC has been administering Medicaid and CHIP dental programs since 2003. Its predecessor company commenced such business in 1993.

Figure 2.15.4.3-1: Relevant entities

- **DentaQuest USA Insurance Company, Inc.:** This entity is **the Proposer** for the Louisiana Department of Health, Dental Benefit Program Management, RFP #3000013043. DentaQuest USA Insurance Company, Inc. (DentaQuest USA) has been doing business for 13 years, and is licensed to conduct business in 16 states, including Louisiana.

As described above, Proposer relies on its Immediate Parent Company DentaQuest, LLC to provide almost all management and administrative services for Proposer. As such, we believe it is important to provide information on DentaQuest, LLC as well in our proposal.

History and Years in Business

Proposer and its Immediate Parent Company are part of a larger DentaQuest enterprise, which was initially founded in 1966. Following is a brief history of the DentaQuest enterprise.

1966 Massachusetts Dental Service Corporation (MDSC) is established as the state's first non-profit prepaid insurance corporation and Blue Cross functioned as their management company.

[1] The term "DentaQuest" refers to the DentaQuest family of companies. Where information specific to the Proposer or its immediate parent company is provided in this Response to the RFP, that company is specifically identified.

[2] DentaQuest's state contracts are held by a variety of DentaQuest subsidiary companies. All state contracts, however, with the exception of Oregon, are administered by DentaQuest, LLC, the administrative and managerial arm of DentaQuest's benefits business.

1985 MDSC, now known as Dental Service of Massachusetts, Inc. (DSM), begins operating as Delta Dental of Massachusetts and quickly becomes the largest dental plan in the state.

2001 DSM establishes a DentaQuest for-profit subsidiary in order to expand its footprint and mission outside of Massachusetts. DentaQuest purchases Consumer Dental Care in Maryland.

2004 DentaQuest acquires Doral Dental USA, based in Mequon, Wisconsin. Doral was covering approximately 6M enrollees at the time.

2008 DentaQuest acquires the stock of Healthcare Atlantic, Inc. (HCA), which, together with its subsidiaries, operates a dental benefits administration and insurance business in Florida.

2013 DentaQuest acquires an insurance company with a national footprint, bringing the number of U.S. jurisdictions in which DentaQuest is licensed to conduct insurance business to more than 40.

2016 DentaQuest acquires Oregon-based Advantage Dental, one of the first accountable care organizations in the country, to expand the reach and impact of our DentaQuest Care Delivery Group. The Care Delivery Group seeks to improve health and control costs through the integration of benefit management and care delivery.

2018 Effective January 1, 2018, Catalyst Institute, Inc. (“Catalyst”), a Massachusetts charitable corporation with no members, becomes the ultimate parent entity of the DentaQuest companies. Catalyst has a board of directors comprised of the same individuals serving on the board of directors of the previous ultimate parent entity, DSM.

2.15.4.3.2 ACCREDITATION STATUS

The Proposer must give a statement as to its National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation status.

DentaQuest is NCQA certified for Credentialing/Recredentialing, and has been since 2014.

2.15.4.3.3 MANDATORY AND PREFERRED QUALIFICATIONS

The proposer should give an item-by-item response to mandatory and preferred qualifications to propose.

Proposer has provided the required information in the chart below. Additionally, where applicable, information has been provided on the Immediate Parent Company as well.

2.15.4.3.4 REGULATORY ACTIONS, SANCTIONS, AND/OR FINES

The Proposer must briefly describe any regulatory action, sanctions, and/or fines related to the delivery of Medicaid dental benefits imposed by any federal or Louisiana regulatory entity or a regulatory entity in another state within the last three (3) years, including a description of any letters of deficiencies, corrective actions, findings of non-compliance, and/or sanctions. Please indicate which of these actions or fines, if any, were related to Medicaid or CHIP programs. LDH may, at its option, contact these clients or regulatory agencies and any other individual or organization whether or not identified by the Proposer. Proposer must identify the representative of the client or regulatory agency who can attest to the regulatory action. Contact information must be provided and include the contact name, email address, and telephone number for the representative.

We have provided this information for the Proposer and the Immediate Parent Company in **Attachment 14.**

2.15.4.3.5 LITIGATION RELATED TO MEDICAID BENEFITS

A detailed statement of the proposer's involvement in litigation related to the delivery of Medicaid dental benefits in the last ten (10) years.

We have provided this information for the Proposer and the Immediate Parent Company in **Attachment 9.**

2.15.4.3.6 CONTRACT NON-PERFORMANCE

A detailed statement of the Proposer's having had a DBPM contract terminated or not renewed for non-performance or poor performance within the last ten (10) years. The Proposer must provide the principal terminating party name and contact information.

Neither the Proposer DentaQuest USA, nor its Immediate Parent Company DentaQuest, LLC have ever had a contract terminated or not renewed for non-performance or poor performance.

2.15.4.3.7 HISTORY OF CLAIMS PAYMENT ACCURACY AND TIMELINESS

2.15.4.3.8 PRIOR EXPERIENCE

2.15.4.3.9 MEDICAID CONTRACT CONTACTS

As it relates to all contracts to provide Medicaid dental services during the past five (5) years, Proposer must identify the state representative who can attest to the performance of Proposer. Contact information must be provided and include the contact name, email address, and telephone number for the representative. LDH reserves the right to contact any or all of these representatives.

As required, we are including the contact information of state representatives who may be able to attest to our performance. We are including the contact information of state representatives in cases where we are the prime contractor with the state Medicaid agency, as well as cases where we are a subcontractor to another organization. In cases where we are a subcontractor to another organization, such as a Medicaid health plan, we do not have a direct line of communication with the state Medicaid agency. Therefore, they may not be in a position to attest to our performance and so we are also including a client reference who can provide additional detail. The requested information appears in **Figure 2.15.4.3-4**. It is organized by state and is inclusive of contracts held by Proposer and the Immediate Parent Company.

2.15.4.3.10 ABILITY TO MEET OR EXCEED QUALIFICATIONS TO PROPOSE

2.15.4.3.11 HISTORY OF MEETING OR EXCEEDING NETWORK ADEQUACY STANDARDS

2.15.4.3.12 HISTORY OF ACHIEVING HIGH PROVIDER SATISFACTION

2.15.4.3.13 HISTORY OF MEETING MEDICAID DENTAL PERFORMANCE MEASURES

2.15.4.3.14 EXPERIENCE SUCCESSFULLY RESOLVING PROVIDER DISPUTES

2.15.4.3.15 HOW OUR ORGANIZATIONAL COMPONENTS WORK TOGETHER

SECTION 2.15.4.4 APPROACH TO SCOPE OF SERVICES

DentaQuest[3] has responded to each Scope of Services section separately on the following pages; and each section contains a strategic overview and describes the functional approach and manner of performance. Please note:

- We have outlined our approach to timely and accurate implementation in our response to Section 6.16, and have included a detailed implementation schedule in **Attachment 11**.
- We have included information on our subcontractors in our response to Section 6.15.

SECTION 6.1 DENTAL BENEFIT PROGRAM REQUIREMENTS

STRATEGIC OVERVIEW

DentaQuest brings 26 years of experience providing medically necessary covered dental services in programs across the country with a core focus on serving Medicaid and CHIP populations. If awarded a contract pursuant to the RFP, we will focus on increasing access and utilization of medically necessary services that improve dental outcomes.

FUNCTIONAL APPROACH AND MANNER OF PERFORMANCE

6.1.1 HIGH QUALITY COVERAGE OF DENTAL BENEFITS AND SERVICES

We are committed to end-to-end contract compliance and performance excellence and will comply with all dental benefit program requirements outlined in Section 6.1.1 of the RFP. We will implement policies, procedures, and processes to fully meet or exceed the Louisiana Department of Health's (LDH's) expectations and requirements. We will deliver high quality, covered dental benefits and services in compliance with all state, federal, and contractual requirements, and in accordance with prevailing dental community standards. In no case will DentaQuest impose coverage or services limitations or exclusions that are more stringent than outlined in the Contract, the Louisiana Medicaid State Plan, and other state and federal statutes, administrative rules, or guidance. For additional information, see our response to RFP Section 6.4 Coverage and Authorization of Services.

At DentaQuest, we also embrace continuous quality improvement across all levels of our organization. Instead of locating all quality functions within a single department, everyone is responsible for improving quality and every operational area is connected to a quality outcome. Our Quality Improvement program (QI program) provides a rigorous, multi-disciplinary approach to assuring and improving quality. The program is data driven and monitors and analyzes key metrics to improve outcomes, enrollee and provider satisfaction, patient safety, and access. For additional information regarding our QI program, see our response to RFP Section 6.11 Quality Management.

6.1.2 DELIVERY OF SERVICES IN A CULTURALLY COMPETENT MANNER

DentaQuest understands the critical role culture plays in how our enrollees engage in care and access medically necessary covered services and will comply with all requirements outlined in Section 6.1.2. We are committed to meeting the diverse needs of all our enrollees, in compliance with the National Standards on Culturally and Linguistically Appropriate Services

[3] The term "DentaQuest" refers to the DentaQuest family of companies. Where information specific to the Proposer or its immediate parent company is provided in this Response to the RFP, that company is specifically identified.

(CLAS Standards) and believe doing so will lead to improved dental health outcomes. We also acknowledge and agree to participate in the State's efforts to promote culturally competent care delivery.

6.1.3 CULTURAL COMPETENCY PLAN

Our Cultural Competency Plan documents our approach, is integrated throughout our organization, and overseen by our Quality Improvement Utilization Management committee. It will comply with all requirements outlined in Section 6.1.3 of the RFP. Our plan is reviewed and revised annually to document how we provide cultural, linguistic, and ability/disability-related access to care in adherence to all applicable federal and state standards and will be submitted to the State during readiness reviews.

6.1.4 CONFIDENTIALITY

DentaQuest has the expertise and resources necessary to comply with all confidentiality requirements outlined in Section 6.1.4.1 through 6.1.4.2 of the RFP. We employ strict Health Insurance Portability and Accountability Act (HIPAA) privacy controls on all systems that contain clinical information to ensure confidentiality. Information is accessible only on a need-to-know basis. In addition to these technology controls, all staff participate in HIPAA and privacy training annually. We also inform all enrollees of their right to privacy through a HIPAA compliant and LDH approved privacy notice that is part of the new enrollee welcome packet. This notice is also published in the enrollee handbook and posted on our website. For additional information regarding our HIPAA compliant systems, see our response to Section 6.13 of the RFP.

6.1.5 REQUIRED DOCUMENT SUBMISSION

DentaQuest has the expertise and resources necessary to comply with all required document submission requirements outlined in Section 6.1.5.1 through 6.1.5.2 of the RFP and contained in other state and federal statutes, administrative rules, or guidance including, but not limited to, the following:

- DentaQuest will submit our formal policies and procedures for initial review during the readiness review process. We will submit all subsequent changes to policy and procedures impacting provider payment, network adequacy, or enrollee services, to LDH for review and approval 60 calendar days prior to the effective date of the change.
- DentaQuest will submit documentation demonstrating our capacity to serve the expected enrollment under the contract in accordance with state's standards for access to care outlined in Section 6.6 of the RFP. This documentation will be submitted as specified by the state, but no less frequently than upon contract initiation, on an annual basis thereafter, and at such other times when a significant change has occurred that could impact access, as defined and determined by the state.

6.1.6 COMMUNICATION WITH LDH

DentaQuest has the expertise and resources necessary to comply with the communication requirements outlined in Section 6.1.6 of the RFP. We are a trusted and responsive partner to the states that we serve. If awarded a contract pursuant to the RFP, we will work every day to establish and maintain effective working relationships with LDH staff and promptly respond to questions, issues, and other requests as they arise. DentaQuest further agrees to acknowledge inquiries from LDH by the next business day and to communicate the resolution, or process for resolution, to LDH within 24 hours. Our Contract Operations Manager will serve as the primary point of contact with LDH for this purpose.

SECTION 6.2 STAFFING REQUIREMENTS

Please see our response to Section 2.15.4.6.

SECTION 6.3 ELIGIBILITY AND ENROLLMENT

STRATEGIC OVERVIEW

FUNCTIONAL APPROACH AND MANNER OF PERFORMANCE

SECTION 6.4 COVERAGE AND AUTHORIZATION OF SERVICES
STRATEGIC OVERVIEW

FUNCTIONAL APPROACH AND MANNER OF PERFORMANCE

SECTION 6.5 UTILIZATION MANAGEMENT
STRATEGIC OVERVIEW

FUNCTIONAL APPROACH AND MANNER OF PERFORMANCE

6.5.10 CHANGES TO UTILIZATION MANAGEMENT COMPONENTS

SECTION 6.6 PROVIDER NETWORK REQUIREMENTS

STRATEGIC OVERVIEW

DentaQuest manages provider networks for Medicaid and CHIP populations in 30 states, representing more than 40,000

dental providers. We have the strategies and expertise to build and maintain a sustainable, high-quality provider network capable of serving the oral health needs of Medicaid and CHIP enrollees in Louisiana, and in fact, already have a head start on building our Medicaid Dental Benefit Program network, thanks to the provider network we have in place for our Medicaid MCO clients who offer additional adult dental benefits to their enrollees. As a full-service DBPM, DentaQuest does not delegate provider network functions to any non-affiliated subcontractors for any of its clients.

FUNCTIONAL APPROACH AND MANNER OF PERFORMANCE

A critical first step as DentaQuest contemplates each new state opportunity is to listen and learn from the provider and stakeholder community. Over the past year and a half, DentaQuest's Network Development staff have visited dental providers in each region of the state to expand our provider network and enhance our understanding of the uniqueness and challenges within each dental community. The team also leveraged these visits to collect provider concerns, issues, and suggestions about the current program. Common concerns, complaints, and suggestions about the current administration of the Medicaid Dental Benefit Program we heard from these visits include:

- **Enrollee education**: Some providers believe enrollees need better education on their benefits, the dental home concept, the need to keep appointments, general oral health guidelines, and the importance of following through with their aftercare instructions
- **Coverage inconsistencies:** Some providers described several inconsistencies between the dental benefits authorized/reimbursed under the current DBPM and those covered under the Medicaid state plan (e.g., pulp caps, root canals, emergency exams, and wisdom teeth extractions)
- **Provider support**: Some providers feel there is a lack of communication or availability of representatives with the current DBPM
- **Administrative processes**: Some providers indicate the current prior authorization process is burdensome, and explanation of denial reasons on authorizations and claims needs to be more explicit

DentaQuest has a host of proven, effective solutions, highlighted in **Figure 6.6-1**, to address these concerns.

Figure 6.6-1 Solutions to Louisiana Provider Concerns

Louisiana Dental Provider Concern	DentaQuest's Solutions
Enrollee Education	DentaQuest employs a variety of effective enrollee education activities and tools to improve engagement. We provide education through welcome calls, age-specific preventive services calling campaigns, broken appointment outreach and through our Smiling Stork initiative targeted to high-risk pregnant enrollees. We utilize a variety of culturally and linguistically appropriate written materials provided through mailings, website and innovative mobile health (mHealth) technology. A full description of our approach is in our response to Section 6.9.6 Marketing and Education Plan.
Coverage Inconsistency	Our Provider Manual, provider website, and secure Provider Portal clearly describe covered benefits and services, pre-payment review and prior authorization requirements, and medical necessity criteria. Our established Early and Periodic Screening, Diagnostic and Treatment (EPSDT) authorization process ensures access to medically necessary non-covered services and services in excess of benefit limitations. Our utilization management (UM) program meets both URAC and NCQA standards for UM and we ensure the consistent application of medical necessity criteria through: robust clinical training of UM staff; maintaining inter-rater reliability; intelligent clinical decision support algorithms; and prohibiting incentives to deny care.
Provider Support	We will assign two in-state Provider Partner Representatives to serve and support our network. Representatives will be assigned to dental offices, visit each office annually, provide initial and ongoing education, and assist with problem resolution. Providers across 30 states consistently cite the personalized service provided by our assigned representatives as one of the most important resources we offer.
Administrative Processes	Providers have the flexibility to submit either a prior authorization (PA) or a pre-payment review request for any service that requires clinical review (except orthodontia and outpatient dental care, which always require PA). Pre-payment review allows providers to perform services the same day, without PA, so long as they submit documentation supporting delivery of the service before the claim is processed. We use clear and concise language to explain denials and providers have the option of speaking with one of our Dental Directors through our peer-to-peer consultation.

6.6.2 NETWORK CAPACITY AND GEOGRAPHIC ACCESS STANDARDS

As an existing DBPM in Louisiana for the provision of extra adult benefits for two of Louisiana's MCOs, we currently exceed the network adequacy requirements for that program and can comply with all of the requirements outlined in Sections 6.6.2.1 through 6.6.2.11.2 of the RFP. We will leverage our existing network of qualified providers to build a network that exceeds network capacity standards. DentaQuest will provide at least one full-time equivalent (FTE) PDP per 2,500 enrollees. PDPs that have a minimum of 32 hours of practice time per week are defined as FTE. We will report the number of linkages per PDP and remaining capacity to LDH on a quarterly basis in a manner and format specified by LDH. DentaQuest will ensure network providers do not offer office hours less than those offered to members of commercial plans and that enrollees have options for network providers that offer extended office hours. **77% of DentaQuest's existing Louisiana dental provider network already offer extended hours**, and we plan to increase that percentage as a DBPM for this program.

Distance Requirements

As we build and maintain our network, we will use Quest Analytics mapping software to measure and monitor our network to ensure that we meet the requirements for primary and specialty dentists as outlined in Section 6.6.2.6 of the RFP and below:

- Distance to Primary Dental Services - Travel distance from the enrollee's place of residence shall not exceed 30 miles or 60 minutes one-way for rural areas and 10 miles or 20 minutes for urban areas.
- Distance to Specialty Dental Services - Travel distance shall not exceed 60 miles one-way from the enrollee's place of residence for at least 75% of enrollees and shall not exceed 90 minutes one-way from the enrollee's place of residence for all enrollees.

Access to Specialty Providers

We will ensure that our network is adequate and reasonable in number, specialty type, and geographic distribution to meet the dental needs of all enrollees. We will ensure adequate numbers of specialists and other providers are available for enrollees under the age of 21 years (Group A enrollees) in accordance with the RFP: endodontists; maxillofacial surgeons; oral surgeons; orthodontists; pedodontists & special needs pedodontists; periodontists; and prosthodontists.

Additionally, our network will include specialists with pediatric expertise, providers offering conscious sedation, general/deep sedation, and pediatric conscious sedation, as medically necessary. DentaQuest is looking at possible partnerships with mobile anesthesia groups as we have successfully done in other markets to not only increase enrollee choice but to ensure proper techniques are followed during any administration of anesthesia.

6.6.3 PROVIDER ENROLLMENT

DentaQuest only credentials and contracts with providers that have been successfully screened by and enrolled with the State of Louisiana in accordance with 42 CFR §455 Subparts B and E. As part of our ongoing monitoring process, we ensure network providers are not excluded/terminated from participation in federal health care programs in accordance with Section 6.6.3.3 on a regular basis and that we do not pay claims from excluded individuals.

Other Enrollment and Disenrollment Requirements

As in our other Medicaid programs, we will follow a documented process in Louisiana for credentialing and re-credentialing network providers in a manner which does not discriminate with respect to participation in the program, payment or indemnification against any provider solely on the provider's type of licensure or certification, or populations served.

6.6.4 DEMONSTRATION OF NETWORK ADEQUACY

DentaQuest will submit a provider network file on a weekly basis and upon request of LDH. The file will include detail to substantiate our network's capacity to provide covered services, including: range of services, number and type of providers, provider mix and availability, and geographic distribution. We are accustomed to demonstrating network adequacy to our clients using a variety of reports, but most commonly through geo access reports and maps. Our reports capture and report the following data points:

- Overall access for the specific population (can be generated for each specialty that has specific standards) expressed as a percentage of enrollees with and without access in the required miles/minutes
- The average travel times and or distances to the three closets provider options
- On a county-by-county basis: Number of enrollees; Number of providers; Access standard (miles/minutes); Percentage and number of enrollees with and without access; Ratio of enrollees to providers; Percentage of enrollees with access to one provider within the access standard

DentaQuest understands that LDH may select a different provider network file and we will comply that format.

6.6.5 TIMELY ACCESS STANDARDS

DentaQuest will develop and maintain a provider network sufficient to meet the timely access standards specified in Sections 6.6.5.1 through 6.6.5.9 of the RFP and establish mechanisms, in accordance with federal regulations, to ensure network providers comply with the specified standards. We will have written policies and procedures for educating network providers about timely access standards. Our Provider Agreements and Provider Manual will include appointment standards that must be met. In the event appointment standards change, we will disseminate changes to both our providers and enrollees 60 days prior to implementing any changes.

Access Standards

DentaQuest will monitor to ensure that PDP services and referrals to participating specialists are available on a timely basis, as follows:

- Urgent care services – within 24 hours of a request for services that do not require prior authorization and within 48 hours for a request for services that do require prior authorization;
- Primary Dental Care – within 30 days; and
- Follow-up Dental Services – within 30 days after assessment

DentaQuest is held to similar standards for other state Medicaid programs it administers. For example, in Virginia, we ensure our network exceeds the state's expectations on appointment wait times, demonstrated in **Figure 6.6-5**

Figure 6.6-5 DentaQuest's Virginia Network Exceed Appointment Availability Requirements in 2018

Indicator	Goal	2018 Actual result
Appointment waiting time for emergency care	95% of offices will see an enrollee within 24 hours	96%
Appointment waiting time for urgent care	95% of offices will see an enrollee within 48 hours	96%
Appointment waiting time for routine care	95% of offices will see an enrollee within 6 weeks	97%

For enrollees needing a course of treatment, DentaQuest ensures that they can directly access a specialist as appropriate for their condition and identified needs – we never require referrals for any specialty care services.

Network Timely Access Monitoring

DentaQuest maintains established mechanisms to monitor provider compliance with timely access requirements to verify that medically necessary covered services are available and accessible to enrollees in compliance with access standards. Whenever our monitoring reveals that a provider is out of compliance with the access standards set forth in the Provider Agreement, we provide them with prompt feedback and work closely with them to implement a corrective action plan. Our goal is to work with providers to bring them into compliance whenever feasible. Our process begins with the Provider Partner Representative assigned to the dental office reaching out to the provider. The Representative provides clear feedback regarding the issue, education regarding the requirements/ expectations and develops a plan of correction. To ensure compliance, the Representative monitors the provider to ensure compliance. In the event the provider does not

correct the issue, additional actions may be taken, including restricting enrollee linkages and/or referrals to the provider and ultimately termination from our network. Monitoring strategies specific to timely access standards include:

- **Secret Shopper Calls:** We conduct statistically valid Secret Shopper calls quarterly with provider offices to ensure that they comply with appointment availability requirements including urgent care, primary dental care, and follow-up dental care (as described in Section 6.6.5.4 of the RFP) and specialty care (e.g., endodontists, orthodontists, or oral surgeons) as detailed in Section 6.6.5.5 of the RFP.
- **Quarterly Verification Surveys:** DentaQuest conducts quarterly verification surveys to determine if provider offices are complying with requirements such as appointment system and availability requirements per Section 6.6.5.6 of the RFP. We also use these surveys to verify that provider hours of operation, addresses, telephone numbers and other information are up to date.
- **Enrollee Complaint and Grievances:** We monitor data sources such as enrollee grievances to identify trends or specific provider concerns about timely access.

We will submit the results of our Secret Shopper calls to LDH to demonstrate our network's compliance with the timely access requirements.

Process to Monitor and Reduce Appointment No-Show Rates

We are attuned to the recommendations made by the Louisiana Dental Association (LDA) Medicaid Task Force around the need for strategies to address enrollee "no-shows." Missed dental appointments foster deferred or avoided care for enrollees that can lead to long-term negative health impacts and higher costs to the system. Additionally, missed appointments cause aggravation to providers that can lead to dentists leaving the program and provider shortages in key areas. To address these challenges, DentaQuest has developed a Broken Appointment program, which has been successfully implemented in other states. This initiative is comprised of both preventive measures to ensure the enrollee goes to their appointment and follow-up education in the event an enrollee misses an appointment.

Best Practices to Prevent Broken Appointments

DentaQuest will provide its dental offices with best practice information that has been used successfully across the other Medicaid dental programs that we serve. Indicative of DentaQuest's unique capabilities, this information was developed by the DentaQuest Partnership for Oral Health Advancement, which is a recognized expert on broken appointment prevention. Some best practices include:

- Creating and distributing a strong, no-tolerance policy for all patients (not just Medicaid enrollees)
- Creating a contract committing to the broken appointment policy for all patients to sign
- Providing reminder messages to patients 48 hours prior to appointments
- Scheduling appointments no further out than 30-45 days
- Having patients with emergency situations call back to schedule their follow-up appointment a few days after the emergency visit

Interventions to Address Broken Appointments

In the event an enrollee misses or breaks/cancels an appointment, providers will need only to complete a simple form on DentaQuest's Provider Portal to notify us of the missed appointment. All providers will be encouraged to participate in this program. Twice a month, DentaQuest will generate a report based on provider logs of all enrollees who missed an appointment and contact them with scripting that reiterates the importance of keeping their appointment or calling to cancel at least 24 hours ahead of time. DentaQuest will also offer assistance in rescheduling the appointment and transportation assistance. To address "repeat offenders," defined as an enrollee with two or more missed/broken appointments in a six-month period, DentaQuest will conduct a live call to provide education and assistance with rescheduling the appointment and offer transportation assistance.

6.6.6 PROVIDER NETWORK DEVELOPMENT AND MANAGEMENT PLAN

6.6.7 MATERIAL CHANGE TO PROVIDER NETWORK

DentaQuest shall provide written notice to LDH, in accordance with the terms of the contract, when there is a material change to the provider network. Written notice within 7 days of the change will include a network impact analysis and the events that led to the change. We will follow the requirements for material change notification as defined in Sections 6.6.7.1.1 through 6.6.7.6 of the RFP.

6.6.8 PROVIDER CREDENTIALING

6.6.9 PROVIDER AGREEMENT REQUIREMENTS

As a DBPM administering the extra adult benefits for two of Louisiana's Medicaid managed care plans, our Provider Agreements comply with the current requirements set by LDH. We will submit updated Provider Agreements specific to the Medicaid Dental Benefit Program for review and approval within the timeframes specified in the RFP, should we be awarded a contract. Our Provider Agreements will comply with all requirements in Sections 6.6.9.1 through 6.6.9.5.29 of the RFP, including but not limited to: 1) Timely access standards; 2) Methods for reimbursement; 3)Timeframes for submitting a provider notice of withdrawal from the network; 4) Clauses for continuity of care in the event a Provider Agreement is terminated; 5) Provider termination protections (with cause only and appeals process); and 6) Provider participation requirements (e.g. participate in peer review process, etc.).

Our Provider Agreements also allow for any possible changes and/or amendments to any type of regulation and/or stipulation by any overseeing agency. DentaQuest will give providers at least 60 days' notice prior to any change within the Provider Agreements.

Network Participation

DentaQuest is committed to developing and maintaining a high-quality provider network that provides enrollees with access to care in locations that are convenient to them. We will offer a provider agreement to all Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and Indian Health Care Providers (IHCPs) throughout the state. Additionally, we will make a good faith effort to contract with any Medicaid provider that requests to participate in our network. At the time of our RFP submission, 87% of all FQHCs offering dental services have agreed to join the DentaQuest Medicaid network; the remaining 13% are still reviewing information at this time. However, our experience shows that upon award, most if not all will agree to contract to keep their market share.

6.6.10 PROVIDER DISCRIMINATION PROHIBITED

In compliance with Section 6.6.10.1 of the RFP, DentaQuest will not discriminate with respect to participation in the Medicaid Dental Benefit Program against any provider who is acting within the scope of his or her license or certification.

6.6.11 NOTICE OF PROVIDER TERMINATION

In the event DentaQuest has cause to terminate a provider from our network we will notify the provider, affected enrollees, and LDH as specified in Sections 6.6.11.1 through 6.6.11.5 of the RFP. Specifically, we will notify the provider immediately via electronic communication, conduct a follow-up phone call if necessary, and send the termination notice to the provider via U.S. mail within one business day of the decision. Communications will include the date of the decision, effective date of the termination, reason for the decision and procedures related to filing an appeal.

We will notify enrollees impacted due to a provider becoming unavailable or terminated from the network in writing within the timeframes specified in the RFP. Our written communications will provide enrollees with recommended network providers available in their surrounding area and offer assistance through our toll-free Enrollee Help Line. Additionally, DentaQuest can initiate outbound calls to enrollees receiving a prior authorized course of treatment to facilitate coordination of care. Enrollees engaged in our Care Coordination and Case Management program will also receive additional assistance selecting a new provider. We will ensure that our Care Coordination team is informed about all network changes immediately so that they can facilitate transitions to new network providers for our high needs enrollees in a timely manner. DentaQuest understands that timely communication with LDH is an essential component of the success of the Medicaid Dental Benefit Program. We will provide LDH with timely and complete notification of all provider credentialing and/or termination decisions including those related to program integrity-related reasons.

SECTION 6.7 PROVIDER SERVICES

STRATEGIC OVERVIEW

DentaQuest understands that maintaining a high performing, engaged provider network is critical to managing program costs and ensuring the delivery of high quality dental care. We take steps to ensure that providers have the tools, information, educational resources, and support they need to effectively serve enrollees, resulting in a more robust, engaged provider network.

FUNCTIONAL APPROACH AND MANNER OF PERFORMANCE

6.7.1 GENERAL PROVISIONS

DentaQuest is equipped and experienced to ensure the general provisions outlined in Sections 6.7.1.1 through 6.7.1.3 of the RFP are met. DentaQuest will establish a provider services function comprised of both a Provider Relations Help Desk, and in-state Provider Partner Representatives.

DentaQuest maintains a robust provider training program that assures providers are knowledgeable about the dental program and applicable contract provisions, as well as state and federal rules.

Through continuous provider network improvement and assessment activities, we ensure that our network reflects the cultural and linguistic diversity of enrollees, and that all providers feel supported to treat their enrollee population. We monitor our enrollee feedback through satisfaction surveys and our Grievance and Appeals system for any signs of poor care experiences that might be perceived as related to their adherence of compliance, culture, or other traits, and take these concerns very seriously. In such cases, we follow up to assess the practice, and identify improvement steps.

Figure 6.7-4: DentaQuest's Website and Provider Portal promote efficiencies for busy dental offices

Public Website Content	Provider Portal Capabilities
• DBPM Provider Manual • DBPM-relevant bulletins • Information on upcoming provider trainings • Provider training manual • Information on provider complaint system • Information on obtaining prior authorizations • Information on how to contact DentaQuest's provider reps • Access our Find-A-Dentist interactive provider search tool for specialty care referrals	• Check enrollee eligibility in a HIPAA compliant manner • Check enrollee dental history • Submit electronic claims, including batch processing, and check status of requests • Submit prior authorization requests and check status of requests • Send and receive secure messages to DentaQuest • Access Remittance Advices • Complete our annual Provider Satisfaction Survey

Within the first 30 days of joining our network, we provide in-person training to each new provider's staff on how to use the Provider Portal. Additional guidance and ongoing training is available through their Provider Partner Representatives. We are continually looking for opportunities to enhance and add new capabilities to our Provider Portal and use our annual Provider Satisfaction Survey to solicit feedback regarding (a) frequency of Portal use, (b) purpose of portal use, (c) ease of Portal use, and (d) to rate our portal compared to other insurance web portals.

6.7.4 PROVIDER MANUAL

Fostering a collaborative partnership with providers is critical to the success of a network and a clear and comprehensive Provider Manual is an important element to that success. Our Provider Manual, which serves as the cornerstone of our provider training and communications, will be easily accessible to anyone via our public website, and will offer an in-depth, systematic overview of topics, as required by Section 6.7.4. of the RFP. Our Provider Manual is typically divided into two sections. The front end will contain rules, regulations, criteria, and forms specific to the dental program. The back end will contain benefit tables, lists each covered benefit (CDT code), describes the code, provides age limitations, lists teeth covered, states whether an authorization is required, details benefit limitations, and outlines documentation that may be required with the claim or authorization.

Providers may request a hard copy of the manual by calling the Provider Help Desk. As the manual is updated with changes, DentaQuest will notify providers prior to those changes through online messages, fax blasts, and in the provider newsletter. DentaQuest will develop and issue its Provider Manual within 30 days of signing the Contract with LDH.

6.7.5 PROVIDER EDUCATION AND TRAINING

6.7.6 PROVIDER-PATIENT COMMUNICATION

DentaQuest confirms that we will meet the requirements outlined in Sections 6.7.6.1 and 6.7.6.2 of the RFP, including that we will ensure the integrity of professional advice to enrollees with regard to provider-patient communications, including protections from interference with a provider's advice to enrollees. Our providers will be informed that they are free to communicate with enrollees about their oral health status, dental care or treatment options including any risks, benefits and consequences of those options regardless of coverage, within the provider's licensed scope of practice. DentaQuest will also fully comply with information disclosure requirements related to provide incentive plans.

6.7.7 PROVIDER COMPLAINT SYSTEM

DentaQuest will establish and maintain a provider complaint system for in-network and out of network providers that permits a provider to dispute DentaQuest's administrative functions, including proposed actions, claims/billing disputes, and service authorizations in compliance with the requirements outlined in Sections 6.7.7.1 through 6.7.7.7 of the RFP.

DentaQuest's Grievances and Appeals Department receives provider complaints and has office hours from Monday - Friday, 8:00 a.m. to 5:30 p.m. Central time. Providers may also contact the Provider Helpline or their Provider Partner Representative via the Provider Portal, electronic mail, telephone, surface mail, and in person to ask questions, file a provider complaint, and resolve problems.

A high-level overview of our complaint review and resolution process is detailed in **Figure 6.7-6.**

Figure 6.7-6: DentaQuest Provider Complaint Process

Step	Process
1. Route and Record	Upon receipt of the complaint, it is routed to DentaQuest's Grievances and Appeals department. Each complaint is logged in Windward and assigned to a Grievances and Appeals Specialist. The following information is captured in Windward for tracking and reporting purposes: 1) Identify the means in which the complaint was received; 2) name of patient, provider and/or facility involved in the complaint; 3) details of the complaint.
2. Acknowledge	We acknowledge all provider complaints within three business days of when we received the complaint in compliance with LDH's requirement outlined in Section 6.7.7.6. The letter will include the name, address and phone number of the Grievance and Appeals specialist assigned to investigate, and a statement that the provider has a right to submit documentation to support their complaint.
3. Investigate	The assigned Grievance and Appeals Specialist will investigate the complaint based on all available information in our system, such as the initial claim or authorization, as well as information from the provider. We will use applicable statutory, regulatory, contractual and Provider Agreement provisions to thoroughly investigate the complaint, as required in Section 6.7.7.5.3. As part of this process, the Grievance and Appeals Specialist may route the case to appropriate individuals within DentaQuest, depending on the nature of the complaint. The provider will also have the option of presenting their case in person, if they so choose.

4. Resolution and Notification	DentaQuest will resolve the complaint within 30 calendar days of the request. Under certain circumstances, this timeframe may be extended up to 15 days. If there are any delays or extensions, DentaQuest will inform the provider. Once we have made a decision in the case, the provider will receive a resolution letter detailing the information.

DentaQuest Distinction: Successfully Resolving Providers Disputes in a Timely Manner

We are required to resolve provider disputes for South Carolina's Medicaid providers within 30 calendar days. In 2018, we surpassed this requirement by successfully resolving provider disputes on average within 19 calendar days. Additionally, specific to claims, only 0.2% of all claims processed resulted in a provider dispute.

It's important to note that the administrative and clinical staff involved in investigated and resolving provider complaints are not involved in the decision-making process for any service authorization requests nor non-clinical determinations. Additionally, all complaints that are clinical in nature, including Quality of Care Complaints, are reviewed and determined by a Dental Director, who was not involved in the decision process for a Service Authorization Request.

DentaQuest logs, tracks, and trends all provider complaints and disputes and will provide a status of all provider complains and their resolution to LDH on a monthly basis.

All information, including claims-dispute data, is maintained in our Windward system, allowing us to easily generate reports for internal quality improvement opportunities. If trends emerge, DentaQuest will work to discover root causes and initiate process improvements to correct systems or processes to remedy the issue so that it does not continue to affect other providers. This may include training with specific internal departments that focus on the relevant issue.

SECTION 6.8 PROVIDER PAYMENT

STRATEGIC OVERVIEW

DentaQuest is committed to partnering closely with our Louisiana providers to give them the tools they need to not only address critical concerns quickly, but also to receive education, support, technical assistance, and appropriate reimbursement for the services they provide.

FUNCTIONAL APPROACH AND MANNER OF PERFORMANCE

DentaQuest will process claims and pay providers as required by the contract, state law, and agreements with our providers. We see value-based care delivery and reimbursement strategies as an important mechanism to engage enrollees and providers. Such strategies support the Quadruple Aim of improving enrollee access, reducing costs while improving health, improving the patient experience, and improving provider satisfaction. DentaQuest is currently contracting with providers who are willing to partner with us and explore new models of reimbursement in other markets. We look forward to working with providers in Louisiana to develop opportunities to enter into incentive arrangements with providers, as allowed under this Contract.

6.8.1 GENERAL PROVISIONS

6.8.2 MINIMUM PAYMENT TO IN-NETWORK PROVIDERS

DentaQuest will provide payment for covered dental benefits and services provided by in-network providers. The rates of payment will be no less that the rates on the published Medicaid dental fee schedule at the time of service.

6.8.3 PAYMENT FOR EMERGENCY DENTAL SERVICES

Our providers will not be required to receive service authorizations of any kind for emergency dental services. In addition, DentaQuest will follow all of the requirements outlined in Section 6.8.3 of the RFP.

6.8.4 INDIAN HEALTH PROTECTIONS

DentaQuest is committed to encouraging Indian Health Care Providers (IHCPs) to participate in our provider network to ensure timely access to services. We will meet all requirements outlined in Section 6.8.4 of the RFP.

6.8.5 PAYMENT TO FQHCS AND RHCS

DentaQuest knows that relationships with safety net clinics – such as FQHCs and RHCs – are an important part of a strong Medicaid dental network. It is important to us that these providers have the support and resources necessary to participate in our network. We often provide customized technical assistance to these providers. We will reimburse FQHCs and RHCs the prospective payment system (PPS) rate in effect on the day of service for each encounter. Many of the FQHCs in Louisiana participate with DentaQuest today in the programs that we administer in the state and we pay them according to their PPS rate. DentaQuest will meet all the requirements outlined in Section 6.8.5 of the RFP.

6.8.6 INAPPROPRIATE PAYMENT DENIALS

DentaQuest understands the requirements of Section 6.8.6 of the RFP.

6.8.7 DENTAL FULL MEDICAID PAYMENT (FMP)

As required in Section 6.8.7 of the RFP, DentaQuest will ensure that any amounts designated in the per member per month (PMPM) for Dental FMP are used for payments to dentists pursuant to a provider network agreement and for a specific service or benefit provided to a specific enrollee covered under the Contract, or any other payment mechanism that is allowed pursuant to 42 CFR 438.6.

SECTION 6.9 ENROLLEE MARKETING, EDUCATION AND SERVICES

STRATEGIC OVERVIEW

FUNCTIONAL APPROACH AND MANNER OF PERFORMANCE

DentaQuest will design and implement an outreach program with policies, procedures, and processes that fully meet state and federal laws and requirements and comply with the Louisiana Department of Health's (LDH) contract and expectations outlined in Section 6.9 of the RFP. We have provided similar, comprehensive outreach services to state Medicaid and CHIP enrollees across the country for 26 years. In Texas, for example, our **extensive enrollee outreach program for the past seven years exceeds that State's requirements, contributing to HEDIS® Annual Dental Visit rates that surpass Texas' standards and to DentaQuest being the plan of choice of most Texas Medicaid and CHIP enrollees.**

6.9.1 GENERAL PROVISIONS

6.9.3 PROHIBITED STATEMENTS AND CLAIMS & 6.9.4 PROHIBITED ACTIVITIES

DentaQuest will not make any of the prohibited statements and claims outlined in Sections 6.9.3.1 through 6.9.3.3 of the RFP. DentaQuest will not engage in any of the prohibited activities outlined in Sections 6.9.4.1 through 6.9.4.7 of the RFP.

6.9.5 PROVIDER-BASED ACTIVITIES

Network providers will be permitted to post DentaQuest materials in their common areas but will not be permitted to participate in or be compensated for any other type of marketing activities on our behalf. Our providers will be contractually prohibited from participating in the activities outlined in Sections 6.9.5.2.1 through 6.9.5.2.2 of the RFP.

6.9.6 MARKETING AND EDUCATION PLAN

6.9.7 MATERIALS APPROVAL PROCESS AND STANDARDS

We will submit all marketing and educational materials to LDH for pre-approval prior to use, in compliance with Sections 6.9.7.1 through 6.9.7.6.3 of the RFP, in an electronic or other format requested by LDH. Our enrollee handbook, based on the state-developed model, will comply with 42 CFR §438.10(g). If changes are requested, we will re-submit materials in a timely manner. We understand and will comply with LDH's right to withdraw or modify its approval at any time.

6.9.8 REQUIRED MATERIALS AND SERVICES

DentaQuest will comply with the requirements for enrollee materials outlined in Sections 6.9.8.1 - 6.9.8.5.1 of the RFP.

6.9.9 IDENTIFICATION CARDS

We understand that LDH will issue enrollee Medicaid identification cards, which are not proof of eligibility but may be used by DentaQuest providers to access LDH's electronic eligibility verification system. We further understand that LDH may require DentaQuest to issue a separate card to enrollees and are well equipped to meet such requirements.

DentaQuest Distinction: Managing Enrollee Education and Outreach in Texas

In 2018, DentaQuest sent more than 1.6 million packets and more than 617,000 postcards, and conducted nearly 2.9 million automated calls to provide education and outreach to our Texas Medicaid and CHIP enrollees. The average turnaround time for sending enrollee fulfillment requests was 5 days.

6.9.10 TOLL-FREE ENROLLEE HELP LINE

DentaQuest's toll-free Enrollee Help Line has been established to assist enrollees in obtaining the information they need to access their dental program services. DentaQuest has service centers in four locations (Austin TX, Columbia SC, Doral FL, and Milwaukee WI) in addition to a remote workforce (comprises 24% of total call center staff) to ensure coverage at all times and weather conditions. Our Enrollee Help Line is staffed with representatives who will be specifically trained on the Medicaid Dental Benefit Program to respond to questions, including policies and procedures, prior authorizations, access information, locating a provider and other provider information, referrals to specialists, resolving dental delivery problems, and grievances. We are proud to have received the **highest score in Customer Satisfaction with Dental Plans in the J.D. Power and Associates 2016, 2017 and 2018 Dental Plan Satisfaction reports**. Our Louisiana Enrollee Help Line will meet all requirements outlined in Sections 6.9.10.1 through 6.9.10.10.

Hours of Operation and After-Hours Assistance

The toll-free Enrollee Help Line will be staffed from 7:00 a.m.–7:00 p.m. Central Time Monday through Friday excluding state-approved holidays. When enrollees call our toll-free Help Line during non-business hours, they are greeted by our automated Nuance Interactive Voice Response (IVR) system, which is available in both English and Spanish, and allows callers to speak naturally. It allows enrollees to locate a provider, verify eligibility and benefits, check on prior authorization or claim status, and learn operating hours and what to do in a dental emergency. Enrollees may leave a message in our secure voicemail box which will be retrieved in the morning and returned on the following working day.

Sufficient Support to Managing Call Volume Flow

DentaQuest understands the dynamics of call volume fluctuations and employs two methods: 1) accurately predicting call

volumes to anticipate staffing requirements and 2) using "call re-routing," which temporarily transfers calls from call centers experiencing higher volumes to those with available capacity. We use the NICE Workforce Management scheduling and forecasting tool to accurately forecast staffing needs based on current demand, potential demand and staff characteristics at half-hour intervals. It provides our management team with in-depth, real-time views and control over workforce planning schedules to avoid understaffing. Under the call re-routing program, DentaQuest has the capability to transfer calls to staff in neighboring call centers in the event we anticipate larger call volumes in a specific market. To ensure that our customer service is upheld, our Agents are trained in multiple markets.

Operational Manual

Upon initial employment, DentaQuest's help desk Agents participate in robust training for three weeks (two weeks of classroom, one week of shadowing) to ensure a full understanding of the nuances of this Contract. Our goal is to enable our help desk Agents to efficiently and accurately offer assistance to enrollees regarding program operations and requirements. Help desk Agents are trained to navigate our established operational manual, and how to use **Knowledge**, our-cloud-based tool that allows our team to access program specific information instantly. Knowledge serves as DentaQuest's internal Google-like search tool to quickly provide accurate information related to enrollee inquiries, as well as various procedures including processing enrollee inquiries, call scripts, call handling procedures, first call resolution and escalation protocols.

Call Center Criteria and Protocols

We hold ourselves to the highest standards when it comes to answering calls in a timely manner and addressing the associated issues in a thorough fashion. For quality assurance purposes, we monitor agents for quality eight times per month. Quality assurance auditors listen to calls and record representatives' desktop to ensure inquiries are being appropriately handled. 100% of calls are recorded. An individual score is calculated for each call as shown in **Figure 6.9-3.**

Figure 6.9-3 Call Monitoring Quality Scoring Criteria

Quality Criteria	Score Value	Criteria
Greeting the caller	5%	Was the greeting accurate and appropriate?
Validating caller identity	15%	Did agent properly validate the caller and their right to PHI?
Call resolution	35%	Did agent provide complete, accurate information; was call documented appropriately & completely?
Ending the call	10%	Did agent use proper call ending and closing procedures?
Soft skills	15%	Was agent professional? How was demeanor, language, tone?
Telephony skills	10%	Did agent use proper hold and transfer procedures?
State specific requirements	10%	Did agent follow state-specific client requirements?

Each agent must maintain an average score of 95 percent to be compliant with DentaQuest standards. **We are pleased to share that our average quality monitoring score last year was nearly 96%.**

ACD System

We use a combination of our IVR system and an automatic call distribution system (ACD) to manage and route calls and our system meets the requirements of Section 6.9.10.8. Calls are first routed to our IVR system (described above), and the caller can state they would like to speak with a live Help Line Agent at any time. The call will then be routed to an available Agent using our ACD system that directs calls to an Agent who specializes in the specific type of request. If an Agent is not available, the call enters the queue most appropriate to the type of call. Calls enter the queue at the bottom and move up until they are delivered to an Agent assigned to that queue. Identifying information from the IVR is passed to the Help Line Agent as part of the "screen pop," promoting a more personalized experience and eliminating the need for an enrollee to repeat information.

DentaQuest will bring our successful communications systems, educational and outreach experience, and excellent customer service to exceed LDH requirements and ensure enrollees understand and access their benefits, becoming active participants in their oral health care.

DentaQuest Distinction: IVR Dental Care Gap Alerts

Our IVR system serves as a dental care gap alert system—every enrollee who calls our Enrollee Help Line and is due for a dental cleaning will be reminded by the IVR of the date they can receive their next dental cleaning.

Performance Standards to Ensure Quality

DentaQuest monitors performance standards specific to each client's unique needs and requirements. **Figure 6.9-4** highlights our Enrollee Help Line performance for our existing Louisiana Medicaid dental business, which requires us to meet similar standards as those outlined in the RFP, demonstrating that we are prepared to meet or exceed LDH standards.

Figure 6.9-4 DentaQuest Enrollee Help Line Performance

Metric	Standard	DentaQuest Performance 2018 Average
Speed to Answer	Not to exceed 30 seconds	4 seconds
Call Blockage Rate	Not to exceed 0.5%	0.49%
Call Abandonment Rate	Not to exceed 3%	0.1%

DentaQuest's workforce management team monitors call metrics through a dashboard report, updated in real time. In DentaQuest's brick and mortal call center locations, we have installed large screens that display our call center performance metrics for real time tracking.

SECTION 6.10 ENROLLEE GRIEVANCES, APPEALS, AND STATE FAIR HEARINGS

STRATEGIC OVERVIEW

DentaQuest is an enrollee-focused organization and ensures our enrollees are given a voice to communicate needs and escalate issues as they arise. To facilitate this, we have developed, implemented, and continually maintain systems for enrollees and their representatives to submit Grievances, Appeals, or State Fair Hearing requests. We use this system to quickly identify quality concerns or network adequacy issues, understand trends, assure timely access to covered medically necessary services, and improve our operations.

With 26 years of Medicaid and CHIP experience, DentaQuest has a long history of tracking, resolving, and reporting to our clients in accordance with federal and state requirements. We will ensure our staff receives Louisiana-specific training that will incorporate the requirements and nuances of the program. The Grievances and Appeals process is also closely linked to our Quality Improvement program. We submit reports to our Quality Improvement Committee to identify any trends that may require the implementation of a corrective action plan or a performance improvement project.

FUNCTIONAL APPROACH AND MANNER OF PERFORMANCE

Our exisiting infastructure, processes and industry knowledge ensure we are capable of meeting the requirements outlined in Section 6.10 of the RFP. Our approach is built around compliance with state and federal requirements, prioritizes timeliness of decisions, and supports ease-of-use for enrollees.

6.10.1 GENERAL PROVISIONS

DentaQuest maintains separate and distinct processes to manage grievances, appeals, and accessing State Fair Hearings, and these processes will comply with the general provisions outlined in Sections 6.10.1.1 through 6.10.1.11 of the RFP.

Informing and Assisting Enrollees with filing Grievances, Appeals and State Fair Hearings

We support multiple pathways to receive enrollee grievances. Enrollees can express a grievance by calling our Enrollee Help Line, through a dedicated e-mail inbox, by mail or in person during normal hours of operation. We understand that all enrollees who express dissatisfaction will be referred the grievance system.

We provide complete information on the avenues available to seek redress in writing via our Enrollee Handbook and on our website, including downloadable forms. We support enrollees during this process by assisting them as needed with required paperwork and informing them of time frames for completion. Our staff will explain unfamiliar terminology, help the enrollee fill out the right form, and in general make the experience as comfortable and stress-free as possible. Further, we ensure enrollees or their authorized representative understand they may request their records and applicable documentation to examine as part of the appeal or State Fair Hearing process.

Our Grievances and Appeals system is accessible to all enrollees, including those with disabilities or who speak languages other than English. We can provide materials in alternative formats, including audio format, large print, and Braille. Further, callers with a hearing impairment may call our toll-free TTD service line at 800.466.7566 during regular business hours to receive assistance with filing their grievance or appeal. For enrollees who do not speak English, DentaQuest has in-house Spanish/English speaking staff, and uses the services of a translation company for enrollees with LEP.

As part of our Grievance and Appeals process, we also make sure providers understand they have the right to file appeals and State Fair Hearing requests on behalf of their patients. This information is shared with them during initial and ongoing training and appears in our Provider Manual.

Windward: DentaQuest's System for Managing the Grievance, Appeals and State Fair Hearings Process

DentaQuest will use its state-of-the-art system, Windward, to electronically record, track investigations, analyze, and track resolutions in compliance with federal and state regulations. Our system is based on Medicaid best practices and Louisiana's process will be tailored to meet the specific requirements that pertain to this key area of program management.

All decisions are made by dental professionals and our enrollee Grievances, Appeals, and State Fair Hearing processes comply with 42 CFR 438 Subpart F (Subsections 400-424), 42 CFR 431.206(b) (3), 431.210(c) and (d), 431.213, 431.214, 431.230(b), 438.10(c) and (d) and (g) (1), 438.210(c), 483.23(a) (5) (ii), and 438.404(c) (4).

Windward allows us to aggregate and analyze appeal data at both a high level and in a granular capacity. We use this information to not only keep our clients informed of programmatic dynamics, but also to extensively review such information to identify trends that may need attention to ensure program optimization.

Windward has a variety of reportable fields to accurately capture the type of communication and the date and subject of each call. The following fields are logged into our system:

- Name of staff who spoke with enrollee
- Date grievance or appeal received
- Name of complainant
- Name of enrollee (if different from complainant)
- Medicaid identification number
- Nature of the grievance
- Provider name (if applicable)
- Explanation of how grievance was resolved
- Date of resolution
- Name of person resolving grievance or appeal

Windward allows Grievances and Appeals Specialists to enter details on the case for tracking purposes, inclusive of date resolved and the resolution obtained, and attach supporting documents. The system is also able to generate reports that prioritize cases to assure timely resolutions, such as Open Cases by Specialist or Market and an Open Case Aging report. We can provide the Louisiana Department of Health (LDH) with any appropriate data in a format determined and approved by LDH. All applicable records/files will also be made available to the enrollee upon request without charge within seven days of request.

6.10.2 PROCESS FOR GRIEVANCES

DentaQuest maintains an enrollee grievance process that is comprised of four steps: route and record, acknowledge, investigate, and resolution and notification. This process complies with the requirements outlined in Sections 6.10.2.1 through 6.10.2.5 of the RFP, and is outlined in **Figure 6.10-1**. Enrollees or their representatives can file a grievance orally or in writing at any time, and it will go through our process steps. We balance a thorough review of each case with timely decision-making to resolve enrollees' grievances and enhance their experience.

Figure 6.10-1: DentaQuest's Grievances Process

Step	Process
1. Route & Record	The enrollee grievance is routed to DentaQuest's Grievances and Appeals department. Each grievance is logged in our core Management Information System (MIS), Windward, and assigned to a Grievances and Appeals Specialist.
2. Acknowledge	We acknowledge all complaints in writing within five business days of when we received the grievance in compliance with LDH's requirement outlined in Section 6.10.2.2 of the RFP. The letter acknowledges that we received the grievance, describes the timeline for the enrollee to receive a resolution from DentaQuest, notifies the enrollee that they can submit documentation to support or counter the grievance submitted, and provides contact information for the assigned Grievances and Appeals Specialist.
3. Investigate	The assigned Grievances and Appeals Specialist investigates the issue based on all available information in our system, such as the initial claim or authorization, as well as information from the provider or enrollee. As part of this process, the Grievances and Appeals Specialist may route the case to appropriate individuals within DentaQuest, depending on the nature of the grievance. For example, a quality of care issue would be routed to a licensed Dental Director, whereas a claims processing issue would be routed to our Claims department. It's important to note that the Dental Director reviewing the request would not have been involved in the initial decision, nor would he or she be a subordinate to the initial reviewer.
4. Resolution & Notification	DentaQuest will resolve the grievance within 90 calendar days of the request. Under certain circumstances, this timeframe may be extended up to 14 days. If there are any delays or extensions, DentaQuest will inform the affected parties on the same day verbally and by a written notice within 2 calendar days. All enrollees will receive a grievance resolution letter detailing our decision, as well as information on how to file an appeal if they disagree with our decision.

DentaQuest Distinction: Exceeding Louisiana's Turnaround Times for Grievances

The average turnaround time for grievance resolution in 2018 for our Texas Medicaid program was 21 calendar days, surpassing the standard for that program (30 days), as well as the 90-calendar day standard stipulated in Section 6.10.2.3. of the RFP.

6.10.3 STANDARD RESOLUTION OF APPEALS

Our process for resolving enrollee appeals is also in place and is comprised of the same four steps as for grievances: route and record, acknowledge, investigate, and resolution and notification, outlined in **Figure 6.10-2,** and will comply with the requirements outlined in Sections 6.10.3.1 through 6.10.3.9 of the RFP. During each step, we try to make this process easy for our enrollees to understand, navigate and complete. To assure a fair process for all, we utilize Dental Directors in our appeals process so that decisions are made in keeping with best dental practices. All Dental Directors are licensed dentists with at least five years of clinical dental experience.

Figure 6.10-2: DentaQuest's Appeals Process

Step	Process
1. Route & Record	An enrollee, authorized representative, or legal representative of the estate may file an appeal orally or in writing within 60 calendar days after receiving an Adverse Benefit Determination. The appeal is routed to DentaQuest's Grievances and Appeals department. Each appeal is logged in Windward and assigned to a Grievances and Appeals Specialist.
2. Acknowledge	If the appeal was made orally, we will verbally inform the enrollee that written notice is required within 15 days and send a written request as well, attaching a signature form for the enrollee to fax or mail back to DentaQuest. If the enrollee does not send back written notice, we will inform them of their ability to re-file the appeal if it is within the 60-day time frame and establish a new appeal date. We support enrollees and provide them with any assistance they need to comply with each required step in the process. We acknowledge all written appeals in writing within four business days of when we received the appeal. A letter is sent to acknowledge that we received the appeal; it describes the timeline for the enrollee to receive a resolution from DentaQuest, notifies the enrollee that they can submit documentation to support the appeal, and provides contact information for the assigned Grievance and Appeals Specialist.
3. Investigate	The assigned Grievances and Appeals Specialist investigates the issue based on all available information in our system, such as the initial claim or authorization, as well as information from the provider or enrollee. Enrollees are allowed sufficient time to provide documentation of any applicable allegations or evidence and are free to review information in their file. As part of this process, the Grievance and Appeals Specialist may route the case to appropriate individuals within DentaQuest, depending on the nature of the appeal. For example, a quality of care issue would be routed to a licensed Dental Director, whereas a claims processing issue would be routed to our Claims department. When reviewing and resolving appeals, we ensure that the final decision maker for all appeals – whether clinical or non-clinical – was not involved in any previous related decisions, nor is a subordinate of the original decision maker.
4. Resolution & Notification	DentaQuest will resolve the appeal within 30 calendar days of the request. The enrollee will receive an appeal resolution letter detailing our decision, as well as information on how to file for a State Fair Hearing if their request is denied.

DentaQuest Distinction: Exceeding Louisiana's Turnaround Standards for Appeal Resolution

The average resolution time of appeals for our Texas Medicaid program in 2018 was 13 days, surpassing the standard for that program (30 days), as well as the 30-calendar-day standard established in Section 6.10.3.7 of the RFP.

6.10.4 EXPEDITED RESOLUTION FOR APPEALS

DentaQuest currently maintains a process for expedited resolution for appeals, and we will ensure it complies with Sections 6.10.4.1 through 6.10.4.5 of this RFP. When an appeal is flagged to be expedited we will route the case to a Dental Director to determine if it meets the criteria for an expedited appeal. If an enrollee or provider submits an appeal on behalf of the enrollee who has requested an expedited appeal, we always treat it as an expedited appeal.

Each enrollee—and provider, when applicable—receives a notification of a decision on the expedited appeal as soon as possible, but no later than 72 hours after DentaQuest receives the initial expedited appeal. Enrollees who request an expedited appeal are always informed of the short time frames involved; if they request an extension of the timeframe, the expedited appeal is then handled as a denial and transferred to the regular appeals queue and timeframe. When an expedited appeals request is denied, the enrollee will be informed verbally of the denial by the end of the same day and in writing within 2 calendar days.

6.10.5 NOTICE OF APPEAL RESOLUTION

In either the case of a regular or expedited appeal, DentaQuest will notify the enrollee, the authorized enrollee representative, and the provider (when applicable) of the resolution decision based on a template approved by LDH and in accordance with the requirements outlined in Sections 6.10.5.1 through 6.10.5.3 of the RFP. Using an identification number that matches the number used in the original Adverse Determination letter, this communication will contain a detailed reason for the decision, the clinical basis, and a description of appeal rights including the right to a Medicaid State Fair Hearing. We also contact the enrollee and provider by phone to allow them to ask questions and ensure they understand the determination and their rights.

6.10.6 PROCESS FOR STATE FAIR HEARINGS

While DentaQuest makes every effort to come to a fair and equitable decision regarding a grievance or appeal within the confines of state and federal laws and regulations, we appreciate an enrollee's right to a Medicaid State Fair Hearing. Our process for State Fair Hearings will comply with the requirements outlined in Sections 6.10.6.1 through 6.10.6.12.

In the event a State Fair Hearing is requested by an enrollee, his or her guardian, and/or provider, we will establish an email address that will be used to share informaton between all involved parties, including the LDH. DentaQuest will assign a Grievances and Appeals Specialist to the case. The Grievances & Appeals Specialist will review the documentation provided for the hearing to determine if there is new information that was not previously available for the internal appeal decision:

- If there is new information available, the Grievances and Appeals Specialist will have a Dental Director conduct a second review to determine if the case should be approved. The Dental Director completes the second review before the hearing date and before compilation of the appeal summary packet.
- If the second review results in a determination that services are approved, DentaQuest will send the enrollee an approval letter and copy the LDH

During this time, the specialist will assemble an appeal summary packet that includes all relevant documents needed to proceed to the hearing:

- Original documents submitted by the provider for the initial decision
- Copies of documents provided by the enrollee and providers for the initial decision
- All documentation used for the internal appeal decision
- Copies of the written notification of the internal appeal decision sent to the enrollee and providers

We will submit a complete evidence packet to the LDH and the enrollee within 10 business days from the time we receive notification of the hearing. DentaQuest will attend all State Fair Hearings, and supply evidence and witnesses as necessary. A full-time Dental Director will be made available for expert clinical consultation during any State Fair Hearing process. We will continue the enrollee's benefits while the fair hearing is pending if that enrollee files for a continuance of benefits within 10 calendar days after we send the appeal resolution.

DentaQuest will abide by the decision of the administrative judge and will not create any barriers to timely due process at the risk of incurring penalties from LDH. If the enrollee had requested continuation of benefits during the hearing process, benefits will be provided if one of these situations occurs: the enrollee withdraws the case; the enrollee did not file for a hearing within the timeframe required; or, the administrative judge delivers an adverse decision for the enrollee. If the administrative judge reverses DentaQuest's action and services have not been provided pending the hearing outcome, they must then be approved within 72 hours of the judge's determination.

SECTION 6.11 QUALITY MANAGEMENT

STRATEGIC OVERVIEW

6.11.1 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM

6.11.2 QAPI COMMITTEE

We have built an interdependent quality committee structure to govern continuous quality improvement that together, achieves the goals and requirements outlined in Sections 6.11.2.1 through 6.11.2.4.2 of the RFP. Our quality committees and subcommittees meet regularly to establish and review key performance indicators and other quality measures and to define and assure quick problem resolution. Interdepartmental representation on our committees promotes collaboration across the organization.

In addition to sharing enrollee satisfaction survey results with the committees, we will create a mechanism such as focus groups or additional survey questions to elicit feedback from enrollees as needed to inform the committees and the QAPI program. Through our Dental Advisory Committee, we will receive regular feedback on provider issues and concerns, and we will include PDPs with experience serving enrollees with Intellectual and Developmental Disabilities (I/DD) and other special need populations to have a better understanding of how we can meet the needs of these individuals. The committees establish annual goals, mitigate risks, monitor progress, and ensure follow up occurs. **Figure 6.11-2** outlines the various committees that form our quality governance structure.

Figure 6.11-2: Quality Governance and Committee Structure

Committee Name/Membership/Frequency	Committee Responsibilities
Executive Committee ***Chair: DentaQuest's Chief Executive Officer*** Membership: Senior Management of DentaQuest and Board of Directors	• Governing body of our organization responsible for all quality improvement activities and ensuring they are incorporated into all processes throughout the organization
Quality Oversight Committee (QOC) ***Co-Chair: Vice President Clinical Management/Dental Director and Director of Quality and Outreach*** Membership: Representatives from: • Quality Management • Claims • Utilization Management • Fraud Prevention and Recovery Review • Customer Service • Complaints and Grievances • Provider Operations • Client Services Meets quarterly and reports to Executive Committee	• The QOC manages the QAPI program, provides oversight of all clinical and service aspects of the organization, and reviews the reports and activities of various subcommittees • Provides strategic direction, oversight, and accountability for the QAPI program • Annually reviews and approves the QAPI program description, work plan, annual evaluation, policies, procedures, clinical guidelines and workplans, and ensures ongoing compliance with regulatory and other accreditation requirements • Closely monitors key performance indicators and other access and quality measures • Allows for early issue detection, risk mitigation, and rapid resolution
Quality Improvement Utilization Management Committee (QIUM) ***Chair: Director of Quality and Outreach*** Membership: • Quality Compliance Program Manager • Director of Quality and Business Solutions • Quality Utilization Review Manager • Director of Operations • Director of Provider Services • Credentialing Manager • Director of Client Services • Utilization Review Manager • Louisiana Dental Director • Enrollee Outreach Specialist Meets monthly and reports to QOC	• Presents the quality program description, evaluation and work plan for approval annually • Establishes a priority for QI activities • Directs and reviews QI activities (including suggesting new and/or improved activities) • Establishes goals and criteria • Designs evaluation and study design procedures • Evaluates data against outcomes • Educates providers about QI and UM methods • Ensures all aspects of QI and UM programs are compliant with NCQA, URAC and other accreditation and regulatory organizations • Monitors performance improvement project • Designates committees to review areas of concern in providing health care (e.g., quality performance measure reporting, review of service utilization patterns)
Delegation Oversight Committee ***Chair: Director of Quality and Outreach*** Membership: • Provider and Enrollment Credentialing Specialist • Supervisor Utilization Management Support • Director Business Optimization • Manager Scanning and Intake • Director Information Technology Security • Regional Director Provider Engagement • Provider Operations Director Meets annually or as necessary	• Oversees the activities of all subcontracted and delegated entities according to NCQA standards • Reviews subcontractor performance against key metrics and determines whether corrective action is necessary • Discusses and agrees upon appropriate action when subcontractors fail to meet performance standards or other contract requirements • Approves all corrective action plans & assures follow up • Annually suggests new performance metrics, subcontractor evaluation criteria and additional data to effectively evaluate subcontractor performance
Credentialing Committee ***Chair: Vice President Clinical Management/Dental Director*** Membership: • Dental Directors • Director of Fraud Prevention and Recovery • Credentialing Specialists Meets bi-weekly	• Administers the credentialing policies on behalf of DentaQuest and subject to review by the Executive Committee and QOC. • Reviews all providers subject to initial credentialing, re-credentialing or reconsideration decisions • Reviews provider licensing actions or other sanctions including Medicare and Medicaid participation • Recommends credentialing policies for review by QOC
Peer Review Committee ***Chair: Vice President Clinical Management/Dental Director*** Membership: • Dental Directors • Senior Clinical Investigators • Clinical Investigators Meets quarterly or as necessary	• Reviews and assesses provider performance and utilization to support the delivery of quality services to enrollees • Reviews compliance with performance standards, survey results, and grievances and appeals and recommends action
Dental Advisory Committee ***Co-Chairs: DBPM CEO/Louisiana Dental Director*** Membership: Network Providers Meets quarterly or as necessary	• Comprised of network providers that provide input, feedback, and address concerns

QAPI Work Plan

The QAPI work plan, submitted to LDH annually, will incorporate our strategic direction and dental program objectives. The plan will reflect a coordinated interdepartmental strategy in planning, decision-making, intervention, and assessment to implement the QAPI program. It will provide a clear scope of work for the upcoming year, including the key areas of focus, planned activities/interventions to accomplish goals, data to be collected and analyzed to assess effectiveness, responsible staff for each activity (with their training), time frame over the year, and the role providers play and how they may offer input about the program. The plan, along with our QAPI Program Description, provides a road map for short- and long-term goals, documenting objectives, scope of activities, processes, systems, and strategies for evaluating and improving quality of care. We will outline specific quality indicators, feasibly ambitious timelines, and annual targets for each indicator, and we continually update progress based on concurrent and retrospective performance and compliance reviews. We also incorporate specific actions to better manage and promote interventions for enrollees with special healthcare needs.

Quality Reporting

DentaQuest annually evaluates the level of success achieved in realizing set clinical and service performance goals through quantitative and qualitative analysis and trending of prior-year data. This assessment will be documented in our annual evaluation and reported to LDH. We will report on and recommend new and/or improved QI activities, identify goals, objectives, and activities for the following year. We will also implement any necessary changes to maintain our standards of excellence and ensure our initiatives meet or exceed industry benchmarks.

6.11.3. PERFORMANCE IMPROVEMENT PROJECTS

6.11.4 ANNUAL ENROLLEE SATISFACTION SURVEY

6.11.5 PROVIDER SATISFACTION SURVEY

DentaQuest understands the importance of assessing provider satisfaction with our service, and will comply with the requirements outlined in Sections 6.11.5.1 and 6.11.5.2 of the RFP. We target network providers who have submitted a claim in the past year to participate in our annual online provider satisfaction survey. We send a postcard and emails on how to access the survey through the Provider Portal. The survey tool will be submitted to LDH for review and approval prior to use. Data is used to gauge provider satisfaction, identify areas for improvement and optimize network engagement. The survey will also assess credentialing, communication, education, complaint resolution, claims processing, claims payment, prior authorization procedures, and utilization management processes. It helps identify trends and issues such as the effectiveness of the website, ease of online claim filing, responsiveness of our staff, and whether the provider intends to stay in the network. Provider survey results will be reported to LDH within 120 calendars days after the end of each calendar year.

DentaQuest Distinction: Highly Satisfied Providers

In 2018 in 94% of South Carolina Medicaid and 91% of Texas Medicaid providers expressed satisfaction with DentaQuest. As further testament to their satisfaction, 97% of South Carolina providers and 97% of Texas providers planned to continue in the network in the coming year.

6.11.6 EXTERNAL QUALITY REVIEW ORGANIZATION

DentaQuest is accustomed to working with External Quality Review Organizations (EQRO) and will comply with the requirements of Sections 6.11.6.1 and 6.11.6.2. DentaQuest is pleased to cooperate and assist with requests from EQROs at any time to make individual dental records available for review and identify and collect management and utilization data. Our intake process manages client audits to ensure complete and timely responses to data requests by dedicated subject matter experts in each operational area.

DentaQuest understands the importance of assessing and improving the quality, timeliness, and access to health care services for Medicaid and CHIP recipients. We will bring our staff dedication, systems, processes and success with continuous quality improvement to Louisiana's Dental Benefit Program.

SECTION 6.12 PROGRAM INTEGRITY

STRATEGIC OVERVIEW

DentaQuest brings 26 years of experience as a DBPM administering dental benefits that improve enrollee health outcomes while safeguarding public funds. Our comprehensive Fraud, Waste and Abuse (FWA) program, highly qualified and experienced Special Investigative Unit (SIU) staff, and advanced analytics offer a rigorous and outcomes-driven program that detects, investigates and reports suspected FWA, adhering to all requirements of Section 6.12 of the RFP.

FUNCTIONAL APPROACH AND MANNER OF PERFORMANCE

DentaQuest believes a robust FWA program improves quality while containing costs, improves use of preventive services, and enhances the health of our enrollees. Our approach is comprehensive and includes all functional areas, providers, subcontractors, and enrollees, in collaboration with state and federal partners. Our Program Integrity activities encompass utilization management, prior authorization and pre-payment reviews, up-front system edits, and retrospective investigations and recovery. We use predictive modeling and other data-driven best practices to predict and identify high-risk providers, uncover and stop suspicious behaviors on the front end, and recover fraudulent payments when we confirm fraud.

Our approach is constantly evolving and improving as we innovate, adopt best practices from our industry and others, and anticipate and react to a changing environment. For example, DentaQuest applies the intelligence from retrospective investigations to up-front edits when new patterns of FWA emerge. In Florida, we identified providers billing separately for

panoramic and bitewing X-rays performed within days of each other, maximizing their billing. We implemented a new edit requiring billing for a full-mouth series when both procedures occurred within a single 30-day period, saving over $600,000 in claims avoidance.

6.12.1 GENERAL PROVISIONS

DentaQuest will provide LDH with one of the most comprehensive program integrity solutions in the industry that will comply with the requirements outlined in Sections 6.12.1 through 6.12.1.9, as well as federal and state laws, regulations, policies, and procedures, including but not limited to 42 CFR §438.1-438.812; La. R.S. 46:437.1-437.14; 42 CFR §455.12-455.23; LAC 50:I.4101-4235; and Sections 1128, 1156, and 1902(a)(68) of the Social Security Act.

Program Integrity Structure

Our overall Program Integrity structure is led by DentaQuest's Vice President of Fraud Prevention and Recovery, Nick Messuri, JD, who oversees our FWA activities and Special Investigations Unit (SIU). Our fraud prevention and recovery leadership has over 60 years cumulative Program Integrity experience: Nick has more than 30 years' experience encompassing FWA and law enforcement and our Vice-President of Clinical Management has over 30 years of clinical and coding program integrity experience. Nick, as well as our Louisiana DBPM Compliance Officer, will meet with LDH and the Attorney General's Medicaid Fraud Control Unit periodically to discuss relevant issues referred to FWA.

DentaQuest's Special Investigations Unit (SIU)

Our SIU, comprised of highly-trained professionals, is responsible for day-to-day implementation of the Compliance Plan and is at the forefront of investigations, responsible for initiating data mining, performing exposure assessments, prioritizing an audit plan, completing investigations and recoveries, and developing referrals to the Inspector General (IG), attorney general, or other law enforcement agency. The Compliance Department and SIU work together to ensure a robust FWA program that meets all elements specified in 42 CFR 438.608 and guides ethical and compliant practices of our officers, employees, contractors, providers, and subcontractors.

Compliance and Cooperation

We developed our FWA programs, procedures, and internal controls pursuant to 42 CFR §438.608(a)(1) to safeguard limited state and federal funds against unnecessary or inappropriate utilization and improper payments. We ensure our staff, providers and subcontractors comply with all state and federal FWA Medicaid and CHIP requirements through our education, training and oversight process. DentaQuest cooperates fully with state and federal agencies during the identification, investigation, or prosecution of suspected FWA and ensures all program and financial records are made available as originals or copies as requested and service delivery sites are open to inspection. We willingly assist with interviews, consultations, grand jury and pre-trial conferences. We comply with federal requirements on exclusion and debarment screening and make sure subcontractors and providers comply with these requirements also.

Technology

Our state-of-the-art analytical tools and technology, case referral systems and intake systems support pre- and post-case identification of aberrant billing and coding patterns, and abusive practices. Our technology resources also facilitate creation and maintenance of reporting and dashboard performance metrics for internal and external stakeholders, including cost-avoidance and recovery savings.

6.12.2 POLICIES AND PROCEDURES

6.12.3 PROHIBITED AFFILIATIONS

DentaQuest will comply with the requirements outlined in Sections 6.12.3.1 through 6.12.3.6 of the RFP. DentaQuest performs rigorous background checks for all prospective employees, subcontractors, and providers in compliance with 42 CFR §438.608, §438.610, and §455.436. Additionally, we confirm DentaQuest is not controlled by a sanctioned individual under Section 1128(b)(8) of the Social Security Act.

Our credentialing program is NCQA certified, meeting applicable state and federal requirements, meaning our providers must undergo initial credentialing and re-credentialing every 36 months. We also screen providers monthly against all federal exclusion databases in compliance with all federal requirements identified in 42 CFR §1002, including the OIG List of Excluded Individuals/Entities (LEIE), General Services Administration Excluded Parties List System (GSA-EPLS), Social Security Administration Death Master File, all 33 State Medicaid exclusion lists, and will search Louisiana Adverse Actions List Search, the System of Award Management (SAM), and other applicable sites as specified by LDH.

If we discover exclusion information about an employee, subcontractor, or provider, we will report the information to LDH within three business days. All excluded providers are prevented from joining the DentaQuest network and any participating providers identified on the exclusion lists are immediately removed from the network. We also monitor network providers for license sanctions on a regular basis and take appropriate action when sanctions are identified up to and including immediate termination from the network when warranted. We will provide a monthly attestation to LDH that a search of the websites referenced in this section has been completed to capture all exclusions.

6.12.4 PAYMENTS TO EXCLUDED PROVIDERS

DentaQuest understands Federal Financial Participation is not available for services rendered by excluded providers as specified in 42 CFR §1001.1901 and will withhold claim payments for those providers per Section 6.12.4 of the RFP. We will return such payments to the State within 30 days of discovery. DentaQuest will assume primary responsibility for the identification of all potential FWA associated with dental services and related billing generated under this Contract.

SECTION 6.13 SYSTEM AND TECHNICAL REQUIREMENTS

STRATEGIC OVERVIEW

DentaQuest's fully implemented Management Information System (MIS) currently serves 22 million government-sponsored program enrollees and is ready to serve Louisiana enrollees and LDH. Our MIS was designed and refined by nationally leading experts in dental services for Medicaid and CHIP populations and capitalizes on the bandwidth of our national footprint to offer robust and fully integrated technology solutions that are supporting the provision of dental services to millions of enrollees today. We will customize our state-of-the-art information technology solutions in Louisiana to streamline and optimize our delivery of the Medicaid Dental Benefit Program.

FUNCTIONAL APPROACH AND MANNER OF PERFORMANCE

6.13.1 GENERAL PROVISIONS

Leveraging our extensive experience gained from operating in other Medicaid programs, we will confirm that all of our hardware and software are compatible and interoperable with LDH requirements, as well as all requirements outlined in Sections 6.13.1.1 through 6.13.1.11.2.2. We will maintain a MIS that meets all LDH functionality requirements, and adhere to federal, state and industry standards for maintaining sufficient resources, capacity, data security, confidentiality, relational architecture, interoperability, reliable performance, and contingencies. All confidential information will be encrypted to FIPS 140-2 standards when at rest or in transit, and all of our resources are HIPAA compliant with industry-standard physical and procedural safeguards. If we use a flash drive or hard drive for storage of LDH data, we will obtain written approval from LDH first. We also use a Virtual Private Network (VPN) with two-factor user authentication for remote users.

Our fully scalable MIS includes several seamlessly integrated platforms that operate without manual intervention and support all core business functions of our organization. These systems, which will be interoperable with LDH systems and conform to standards and specifications set by LDH, include:

- **Windward core management system:** Our proprietary core management system with distinct modules that support each aspect of program administration using web-based interfaces, simplify deployment to individual users without the need for local software. Modules support claims, encounter processes/reconciliation, operations, benefits tracking/limitations, enrollee enrollment and eligibility, encounter/claims processing, third party recovery sub-system, interface systems, customer service, client configuration, and provider and utilization management
- **Oracle financial system:** Oracle® E-Business Suite, including Accounts Payable, Accounts Receivable, Cash Management, Fixed Asset, General Ledger, Incentive Compensation, and Procurement, along with Oracle Revenue Management and Billing, provide extensive financial management, and back-end billing capabilities
- **Aldera:** For hosting our web portals

- **Cactus Provider Management**: For automated credentialing, privileging, & provider enrollment
- **Data warehouse and reporting system:** We use several tools to support high-quality reporting solutions, including Microsoft® Reporting Services, geo-mapping reports, Cognos® ReportNet®, and SAS® Analytics. The reporting architecture underlying our enterprise system fully supports end users to access the information they need timely. Our enterprise and reporting systems are built on MS SQL Server® 2008 databases and operate with the Microsoft Visual Studio® Net Framework.

Through these systems, we will capture, synthesize and utilize data from LDH, our providers, enrollees, and internal systems to produce actionable information that communicates our enrollee's outcomes, provider performance, and our own performance related to LDH goals. We will work directly with the State's Enterprise Architecture (EA) Governance Team and the State's EA contractor to validate that our MIS solution integrates into the State's EA components using standard API. Our current system already meets the requirements listed below for other state agencies, and our Louisiana Medicaid Dental Benefit Program system will also:

- Be HIPAA compliant, process transactions according to LDH-defined business rules, and securely maintain privacy of all enrollees
- Securely collect and maintain demographic data related to enrollees and providers
- Interface and communicate with LDH and its designee systems via a secure protocol with encryption governed in adherence with LDH security policies
- Successfully and securely interface, integrate and exchange files with LDH and all its designees with no more than a 0.01% file or transmission failure rate
- Maintain telecommunications with an uptime at or above 99.99% outside of planned maintenance downtimes
- Perform data cleansing and validation to assure a random sampling data error rate of under 5.00%
- Include all ANSI ASC X12N batch transaction types related to dental transactions.

We operate a comprehensive MIS that supports all functions related to the delivery of high-quality dental services and the effective use of our dental program data. We are currently working with various states to integrate our system into the MARS-E compliant framework to meet CMS MITA requirements, and we assure appropriate protections of shared Personally Identifiable Information (PII), in accordance with 45 CFR §155.260. Additionally, we are HITRUST compliant. We will adhere to all applicable published State security policies and transmit via Secure File Transfer Protocol (SFTP) all data relevant for analytical purposes on a regular schedule and in XML format to LDH.

6.13.2 RESOURCE AVAILABILITY

DentaQuest will ensure proper resource availability to LDH and the Medicaid Fiscal Intermediary (FI) for relevant system and data needs, complying with all requirements outlined in Sections 6.13.2.1 through 6.13.2.1.5 of the RFP. Our systems help desk will:

- Be available from 7 a.m. to 7 p.m., Central Time, Mon - Fri, and if requested, on designated state holidays, Sat, or Sun
- Be able to answer questions regarding our system functions and capabilities, and report recurring programmatic and operational problems to appropriate staff for follow-up
- Redirect problems or queries that are not supported by the systems help desk, as appropriate, and redirect problems or queries related to data access authorization to the applicable LDH staff
- Include an option for individuals calling after hours to leave a message, and we will respond to the message by noon the following business day
- Document and report reoccurring system issues to LDH within one business day of identification
- Use ServiceNow to provide automated recording, tracking and reporting of all questions or problems that come into the systems help desk.

6.13.3 SYSTEMS CHANGES

We currently operate in 9 Medicaid and CHIP markets where we hold contracts directly with a state agency, and we assure that our systems in these markets conform to future federal and state standards for encounter data exchange within 90 days prior to the new standard's effective date. We will operate within this same timeframe in Louisiana.

If a system update or change is necessary, we manage it through our change management process, which covers planning, coordinating, implementing, and monitoring changes affecting any production platform in our IT infrastructure. Our change management processes and procedures are well-defined, documented, consistent, and measurable; improve our change success rate; reduce the incidence of unplanned outages; and will support prompt communications with LDH and other

stakeholders about planned system updates and any issues that may occur. As part of our standard process if a change or update is necessary, we will draft appropriate revisions for our documentation or manuals and present them to LDH for review and approval 30 calendar days before we implement the upgrade or change. Our documentation revisions are completed electronically and will be available to LDH in an easily accessible and near real-time format while our printed manual revisions will occur within 10 business days of the revision.

When we identify a required system update, change, or fix, we will submit a written notice (including a problem overview, impact, and timeframe for implementing the correction) to LDH within 10 calendar days of our identification of the required system update, change, or fix. We will also notify LDH of changes to our system within our span of control 90 calendar days prior to the date of the change or within a timeframe specified and approved by LDH. We document system change requests and review them to identify gaps between requested and current operations, and then we:

- Create, review, and approve a functional design
- Create a technical specification
- Code and test the change
- Approve test results that pass user acceptance criteria and assign the change to a specific release.

We go through a full cycle of testing prior to production. For example, a standard Windward release will have software quality assurance (SQA) Regression testing, SQA testing, User Acceptance testing (UAT), and Performance testing before approval to release to production. Our releases follow ITIL compliance and are represented on the Change Advisory Board (CAB) for approvals each week. Once we promote a change to production, users also conduct post-implementation testing to confirm the change was applied correctly into production. We require approval from the business owner or end-user and the production control staff to confirm the change has been properly implemented. For each change request, we can also schedule a readiness review with LDH, if desired. Each review will include documentation and proof of compliance.

Our Change Management and Change Control Standard Operating Procedure governs modifications to our core production systems, which include the systems listed in Sections 6.13.3.4.1 through 6.13.3.4.6 of the RFP, and establishes standardized methods and processes to minimize the number and impact of incidents affecting end-users or the services we provide, including:

- A set of organizational objectives, standards, and principles to guide planning, decision making, prioritization, communication, accountability, documentation, and process
- A Change Advisory Board that oversees and approves modifications to our core systems
- Different policies and procedures for Normal, Standard, and Emergency changes, as well as new projects, system enhancements, and “hot fixes”
- A detailed workflow of steps in our change management process, beginning with the creation of a Change Request and ending with formal review and closure procedures.

We will work closely with LDH, and when we are notified of system problems that are not a result of system unavailability, we will respond within the timeframes of Sections 6.13.3.5.1 through 6.13.3.5.3 of the RFP. Our system records any change to a software module or subsystem, and we will have procedures and measures for safeguarding against unauthorized modification to our systems. Our processes and procedures also confirm that we avoid scheduling any kind of systems unavailability, such as system maintenance, repair, or upgrade activities, during business hours or other critical hours. We will work closely with LDH in advance of testing or upgrading initiatives and provide system access to allow LDH to sufficiently test our system.

6.13.4 SYSTEMS REFRESH PLAN

We will provide LDH with an annual Systems Refresh Plan that meets the requirements of Sections 6.13.4.1 and 6.13.4.2 of the RFP. Our plan will outline how systems within our span of control are systematically assessed to determine the need to modify, upgrade or replace application software, operating hardware and software, telecommunications capabilities, information management policies and procedures, and systems management policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover and other relevant factors. We perform annual systematic assessments of all technologies and systems to determine all versions and release levels are always supported by the original equipment manufacturer (OEM), software development firm (SDF), or a third party authorized by the OEM or SDF to support the systems component.

6.13.5 OTHER ELECTRONIC DATA EXCHANGE

In compliance with Section 6.13.5 of the RFP, our core management system Windward houses indexed electronic images of

documents that can be used by enrollees and providers to transact with us. All documents received are scanned and digitized to create an image, and each image receives a document number and is housed in our Windward system.

All records are tied together using unique keys generating a common index, or Master Patient Index, in our Windward system. Unique keys include enrollee identification, provider identification, and claim number among others. These unique identifiers simplify and accelerate searches related to a given event, transaction or issue. We also assure that records associated with a common event, transaction or customer service issue have a common index that will facilitate timely search, retrieval and analysis of related activities, such as interactions with a particular enrollee about a reported problem.

6.13.6 ELECTRONIC MESSAGING

To comply with the electronic messaging requirements outlined in Sections 6.13.6.1 through 6.13.6.3, DentaQuest uses Microsoft Exchange and Outlook via Microsoft Office 365 for our email system, and we will use this system for communication with LDH. Our email system is continuously available and is capable of securely attaching and sending documents created with the Microsoft Office suite of applications. We are experienced and able to communicate through a secure VPN, and we will do so as requested by LDH. We implement and maintain physical and electronic security of all Protected Health Information (PHI) in compliance with HIPAA, state and federal laws and regulations, and our email system is password protected for sending and receiving PHI.

6.13.7 PROVIDER ENROLLMENT

DentaQuest's provider enrollment system will comply with the requirements outlined in Sections 6.13.7.1 through 6.13.7.3 of the RFP. We will use the published list of Louisiana Medicaid provider types, specialty, and sub-specialty codes in all provider data communications with LDH and the FI. We conduct federal and State mandated exclusion background checks on all providers (owners and managers), and we will confirm that our providers perform these exclusion checks on all their employees annually.

For provider enrollment we use our core management system, Windward, and Cactus Provider Management software to collect all pertinent information including provider service and billing name, practice and billing addresses, licensing information, ownership information, NPI, provider tax ID, and payment information, which is stored in Windward. Windward uses Cactus Provider Management software to allow for easy access and storage of audit trail and history of changes made to provider files, and all changes are tracked with change information and time of change. Windward with Cactus interfaces with all licensing and dental boards, and provides automated alerts when provider licenses expire. Our system also includes linkages of individual providers to their associated groups, allows for verification and retention of NPI requirements, and includes provider office hours, provider languages spoken, and credentialing information. We will work collaboratively with LDH and the FI and submit provider enrollment information as a "registry" weekly in accordance with the Systems Companion Guide. If LDH or the FI find errors or issues with our registry submissions, we will work to correct the errors within 20 business days.

6.13.8 INFORMATION SECURITY AND ACCESS MANAGEMENT

6.13.10 CONTINGENCY PLAN

Our Contingency Plan will comply with all requirements outlined in Sections 6.13.10.1 through 6.13.10.7.2.3. DentaQuest's multiple offices, cross-trained staff, and flexibility enable us to respond quickly to disasters striking our brick and mortar facilities, & shift support to any location when needed.

DentaQuest Distinction: Our Contingency Plan in Action during Hurricane Irma

Because of Hurricane Irma storm damage in southern Florida, our Florida Call Center was closed between Monday, September 11, 2017 and Wednesday, September 20, 2017. To support the volume of calls typically associated with our Florida Call Center, we seamlessly directed the immediate routing of those calls to our Call Centers in Texas, South Carolina, Milwaukee, and Boston. We also leveraged 100-plus remote Call Center Agents who field calls off-site, approved an extended-hour policy, and seven of our Florida Call Center Agents were flown to our Boston office to conduct their jobs. Our response & Contingency Plan assured enrollees received seamless and uninterrupted service.

Our Contingency Plan maintains two interrelated plans (Disaster Recovery Plan and Business Continuity Plan) to handle emergency preparedness and disaster recovery. These plans cover the restoration of software, current master files, hardware, backup, and operational functions. Our Disaster Recovery Plan outlines the processes, procedures, and management actions we take to protect data access, security and integrity if a disaster occurs to information systems or telecommunications while our Business Continuity Plan outlines the processes, procedures, and management actions we take if a disaster occurs to facilities or departments.

Our Contingency Plan addresses all of the scenarios in Sections 6.13.10.4.1 through 6.13.10.4.5 of the RFP, aligns with the most current version of the National Institute of Standards and Technology Contingency Planning Guide for Federal Information Systems (Special Publication 800-34), and has specific operational and system redundancies in place. Our Technical Recovery Team is responsible for providing and recovering essential technical operations and services during and following a disaster or serious emergency, and we conduct training and a comprehensive exercise with the Technical Recovery Team twice a year. If we fail to demonstrate we can restore systems functions through these tests, we will submit

a corrective action plan to LDH describing how the failure shall be resolved within 10 business days of the conclusion of our test. Our most recent test was conducted on April 11, 2019. We will submit our Contingency Plan to LDH for approval 30 days before our Readiness Review.

Emergency Management Plan

We maintain an Emergency Management Plan that specifies the actions we take to assure the continuous provision of health services in an epidemic, disaster or manmade emergency including, but not limited to, localized acts of nature, accidents, and technological or attack-related emergencies. Our Emergency Management Plan includes all the elements in Sections 6.13.10.7.2.1 through 6.13.10.7.2.3 of the RFP, and we will provide a copy of our plan to LDH during the contract execution process. When we have revisions to our Emergency Management Plan after initial LDH approval, we will submit the revised plan to LDH for approval 30 calendar days before implementation of requested changes. We will also submit an annual certification (from the date our most recently approved plan) to LDH certifying that our Emergency Management Plan is unchanged from the previously approved plan.

6.13.11 OFF-SITE STORAGE AND REMOTE BACK-UP

DentaQuest's back-up solution provides for off-site storage and a remote back-up of operating instructions, procedures, reference files, system documentation, and operational files and will meet the requirements outlined in Sections 6.13.11.1 through 6.13.11.8 of the RFP. We employ a network-based backup solution to protect and preserve enrollee, provider and business data, and our solution is managed and maintained 24 X 365 by DELL EMC, a trusted DentaQuest partner. We perform a full back-up every Saturday to our back-up facility in Phoenix, AZ. Sunday through Friday, we do daily back-ups to our back-up facility in Phoenix. We use Dell EMC Networker to conduct our back-ups. Back-ups stored in Phoenix remain there for 30 days and then are backed-up to our secondary back-up site in Waltham, MA. All back-ups remain in Waltham for 90 days until they are backed-up to our final back-up site in Pennsylvania, where they remain for 10 years. Our back-up policies, processes, and procedures include all elements of Sections 6.13.11.2.1 through 6.13.11.2.5 of the RFP, assure the back-up, archival, and ready retrieval of server and PC data.

We will provide LDH with a list of all back-up files to be stored at remote locations and the frequency with which these files are updated. We have security and back-up measures in place to assure our network hardware is protected from electrical surges, power fluctuations, and power outages by using the appropriate uninterruptible power system (UPS) and surge protection devices. We also have generator back-up power to supply necessary power for more than four calendar days.

6.13.12 RECORDS RETENTION

DentaQuest exceeds LDH requirements for records retention outlined in Sections 6.13.12.1 through 6.13.12.3. We keep all records, including documents, images, and files for 10 years in live systems for audit and reporting purposes, and provide for data back-up to three off-site locations. Other data, including history and edits are archived and retained for 10 years. Documents, images and files are kept for 10 years using Dell EMC Centera, which provides content storage, compliance, long-term retention, and online retrieval within 48 hours or less. We regularly turn around requests for access to information, live or archived, in less than 48 hours. We also maintain audit trails and additional history online for 10 years with access in less than 48 hours.

We will keep services denoted on LDH's procedure formulary file and claims with a once in a life-time indicator in our active claims history that is used in claims editing, and we will not archive or purge them. We store data using several identifiers, and we can look up claims processing data using enrollee ID, provider ID or internal control number (ICN). We keep all information involved with active or unresolved audits or administrative, civil or criminal investigations or prosecutions in electronic form until all tasks or proceedings are completed. We also follow generally accepted retention guidelines and retain historical encounter data submissions for 10 years.

SECTION 6.14 CLAIMS MANAGEMENT

STRATEGIC OVERVIEW

FUNCTIONAL APPROACH AND MANNER OF PERFORMANCE

6.14.1 GENERAL PROVISIONS

6.14.2 FUNCTIONALITY

6.14.3 PAYMENTS TO PROVIDERS

DentaQuest understands the stipulations for capitated provider payments, and if we choose to offer a capitated arrangement with a provider, we will adhere to the provisions outlined in Sections 6.14.3.1 through 6.14.3.1.1.2 of the RFP.

In compliance with Section 6.14.3.1.2 of the RFP, DentaQuest checks for excluded providers on a monthly basis as part of our ongoing provider monitoring process. This ensures we do not pay claims submitted by providers who are excluded from participating in Medicare, Medicaid or CHIP, or who are not in good standing with LDH.

DentaQuest understands the importance of meeting LDH's turnaround times for timely claims processing and will adhere to the requirements outlined in Section 6.14.3.1.1 through 6.14.3.1.4 of the RFP. We further understand that we will be required to pay 12% per annum, calculated daily, for the full period in which clean claims remain unadjudicated beyond the 30 calendar day claims proceeding deadline.

6.14.4 REMITTANCE ADVICE

DentaQuest's EOB and RAs will identify at a minimum: name, enrollee ID, claim or account number, date of service, charges, liability (co-insurance, deductible, copayment if permitted), amount paid by DentaQuest, amount denied, and reason, adjustments or voids, along with the false claim statement. DentaQuest will generate and mail EOBs to enrollees, if required, and provide RAs to providers along with the denial or adjustment notice, as required.

We accommodate all provider needs, such as offering mailed paper checks and EOBs, however, we also encourage electronic RAs, EFT, and electronic EOBs through our portal, so providers receive payment more quickly and so their office staff can easily reconcile payment records and claims submissions.

6.14.5 THIRD PARTY LIABILITY (TPL)

As an experienced DBPM, we understand that by law, Medicaid must be the payer of last resort. We developed an effective coordination of benefits (COB) process to ensure third party liability (TPL) is captured and pursued. Our process will comply with the requirements outlined in Sections 6.14.5.1 through 6.14.5.6.1 of the RFP. We conduct cost avoidance and recovery efforts in Windward with systematic methodologies that identify and flag claims and tailor our program based on program requirements. **For example, our effective COB program saved more than $2.9 million for the state of Texas in 2018**.

Capturing TPL Information

To identify TPL, we use several methods including: 1) Monthly enrollee information received from our client; 2) COB indication on the claim form submitted by the provider; 3) COB indication on the enrollee eligibility/enrollment file; 4) EOBs from the other insurance plan(s) attached to the claim submitted to DentaQuest; and 5) Reports containing certain CDT procedure codes that identify claims qualifying for cost recovery.

COB is captured in Windward when the claim is entered. It suspends the claim into an electronic queue for manual review and to gather additional information to determine what has been paid and calculate the balance payable. We track third-party information within Windward and base remittances on the presence of the reported COB/TPL. Windward stores and retrieves information on deductibles and copayments, tracks deductibles and denies claims when deductibles are met, associates family members even if they are separate cases, and associates resubmitted claims with the original denied claim. We can exchange information with state agencies and TPL contractors to identify third party coverage. Claims are flagged and routed to our Recovery and Subrogation Unit for additional review and processing. Notifications and written recovery requests are generated when potential TPL is identified with second and third requests if needed. Once the correct order of benefits is determined, Windward automatically identifies COB during adjudication. Post payment recoveries are applied and credited.

Cost Avoidance

DentaQuest checks for other insurance to ensure that Medicaid is the payer of last resort. If COB is marked on the claim or enrollee's enrollment file, Windward pends it for manual review to determine what has been paid and calculate the remaining balance. If cost avoidance is indicated, but the appropriate payment cannot be determined, notice is given to the provider to collect additional information for payment to be appropriately calculated. All claims will be adjudicated in compliance with federal and state EPSDT requirements.

Post-Payment Recovery

DentaQuest will follow our established procedures for post-payment recovery where there was no probable existence of TPL. Upon identification, we will notify the LDH Fiscal Intermediary (FI) weekly and seek payment based on RFP thresholds and requirements. DentaQuest will review the enrollee's history for any paid claims for possible recovery from the same third-party source. We also use TPL information for the subrogation process, seeking reimbursement, reporting, and refunding a subrogation payment or lien settlement to LDH. We will use our best efforts for reimbursement, make notes in the file, and credit subrogation payment to the correct internal account.

TPL Reporting

DentaQuest will provide LDH with TLP information to demonstrate our reasonable efforts to seek, collect, and/or report TPL and recovery including collections and claim information in the encounter data, and any retrospective findings in the encounter adjustments. Windward stores information on savings from COB efforts through our reporting tools. We will also provide an annual report of all health insurance collections plus any Form 1099s received. Our COB Savings Report provides information on claims cost-avoided or payment recoveries and reports enrollees with third-party coverage including

additions and updates in the desired format and medium. We will provide TPL information within 30 calendar days of LDH's request including records to determine if liability exists for services rendered.

6.14.6 SAMPLING OF PAID CLAIMS

DentaQuest maintains a well-established process to ensure that services billed were in fact provided and the enrollee was satisfied. In compliance with the requirements in Sections 6.14.6.1 through 6.14.6.4 of the RFP and with 42 CFR §455.20 and §433.116(e), we will provide EOB notices monthly to a sample group of enrollees within 45 days of the date of payment. In easily understood language, we will describe the service furnished, name of provider, date of service, and amount of payment. We will perform surveys (typically by phone or mail) based on a stratified sample of paid claims to ensure that all claim types are proportionally represented. We will also track and resolve any complaints received from enrollees identified during the survey process. Our Market Research department will report the verification of service findings/ outcomes including the total number of surveys completed; total services requested for validation; number of services validated; analysis of interventions; and number of surveys referred for further review. These reports will be delivered by DentaQuest's Operations Manager to LDH.

6.14.7-6.14.9 CLAIMS DISPUTE MANAGEMENT

We have established processes and procedures for claims dispute resolution and will comply with the requirements relating to requests for reconsideration and or adjustment as outlined in Sections 6.14.7.1 through 6.14.9 of the RFP. Providers with claims-related questions or disputes may contact our Grievances and Appeals department though a designated phone line (Monday through Friday 8:00 a.m. to 5:30 p.m.), or by mail, email, or in-person. We will collect information, inform the provider of any additional required information, processes and procedures, and answer any questions. DentaQuest will adjudicate the claims to a paid or denied status within 30 days of receiving the disputed claim. **DentaQuest experiences very low volume of claim disputes. For example, for claims processed in 2018 for the South Carolina Medicaid dental program, only 0.2% of all claims resulted in a dispute.**

Providers will have the right to an independent review of claims subject to an adverse determination. In accordance with La. R.S. 46:460.90. We will resolve all claims within 24 months from the service date. **Our average turnaround time to resolve disputes with South Carolina providers was 19 calendar days in 2018.**

6.14.10 CLAIMS PAYMENT ACCURACY

DentaQuest's Quality Assurance Audit team, a separate and distinct team from our Claims Management team, is responsible for auditing our payment accuracy. This team will be responsible for complying with the requirements outlined in Sections 6.14.10.1 through 6.14.10.3.5 of the RFP. All claim processing personnel at DentaQuest are audited each month by the Quality Assurance department with individual and department errors and performance results distributed across the organization for clear insight into the accuracy trends of our Claim operation. Errors are immediately corrected, and on-the-spot training is provided to avoid future errors. Processed claims are audited for header and detail level elements to ensure claim payments are accurate based on applicable fee schedules, claim edits and rules, benefit plans, claim history and COB calculations. Enrollee data is reviewed for eligibility for services, and provider data is audited to ensure eligibility for payment. Claims must be properly documented with substantive systematic or hand typed notes, when applicable, to explain processing. Auto adjudicated and manually processed claims, as well as new and adjusted claims are subject to audit.

For Louisiana, our Quality Assurance Claims Audit staff will conduct audits on a randomly selected sample of all processed and paid Louisiana claims with a minimum sample of 250 claims each year selected from both electronic and paper submissions. We will provide focused audits for Louisiana and these claims will also be included in our general population of claims eligible for monthly audit.

The Quality Assurance department will compile a monthly tracking and trending report including claims payment accuracy and timeliness percentages. We will use these reports to identify any salient trends that might need addressing or might lead to an individual or department corrective action plan. The monthly report details dollar and procedural accuracy rates, overall accuracy rate, and claims payment accuracy, and detail all RFP requirements outlined in Section 6.4.10. Operational review meetings are held regularly between Quality Assurance and the leadership of the audited operational areas to review findings and track completion of action items. Audit results are used as a critical performance measurement for all Claim employees.

6.14.11 ENCOUNTER DATA

SECTION 6.15 MAJOR SUBCONTRACTS

STRATEGIC OVERVIEW

FUNCTIONAL APPROACH AND MANNER OF PERFORMANCE

General subcontractor management and oversight falls under the purview of the DentaQuest Vendor Management Department. Our Vendor Management Program provides processes, tools, and resources to protect our enrollees, ensure contract compliance, and mitigate major risks. Our Compliance Department and business owners also play a key role in subcontractor oversight.

6.15.1 SUBCONTRACTOR OVERSIGHT

DentaQuest understands the importance of stringent and strong performance management of its subcontractors, and will comply with the requirements outlined in Sections 6.15.1.1 through 6.15.1.5 of the RFP. Strong subcontractor oversight begins with robust vetting and planning, followed by careful contract execution and close management and oversight. We use a five-stage sourcing process that includes the following components:

- **Analyze:** Build understanding, identify requirements, and align stakeholders
- **Strategize:** Define objectives and formulate strategies and techniques
- **Source:** Create competition and select the strongest subcontractor/vendor based on qualifications, cost, and ability to perform the activities being delegated
- **Execute:** Finalize the contract with established performance criteria, reporting responsibilities, and remedies up to and including contract termination in the event of inadequate performance
- **Manage:** Measure, improve, and monitor according to a formal schedule and industry standards

Business owners are responsible for day-to-day oversight and perfomance management of our subcontractors and vendors. In addition, the DentaQuest Vendor Management Department routinely reviews subcontractor operations to verify that they are consistent with the terms of written agreements and that risks are being controlled. Our Delegation Oversight Committee oversees the activities of all subcontracted and delegated entities according to NCQA standards. It reviews subcontractor performance against key metrics and determines whether corrective action is necessary. When subcontractors fail to meet performance standards or other contract requirements, the Delegation Oversight Committee discusses and agrees upon the appropriate action.

DentaQuest's Compliance Department ensures continuing compliance with applicable federal and state laws, rules, and regulations, as well as internal policies and procedures and applicable requirements of the underlying state Medicaid agency contract. In Louisiana, this will include compliance with program integrity requirements set forth in Section 6.12, frequent background and federal exclusion database checks, and annual reassessment of state and federal privacy law and

data security compliance. DentaQuest reserves the right to conduct periodic audits of all records related to services provided at any time.

DentaQuest requires its subcontractors to comply with general expectations, such as a code of ethical behavior detailed in DentaQuest's Employee Code of Conduct. We also require subcontractors to inform us of significant changes (mergers, acquisitions, or sales) that impact teams or operation of services under the contract. DentaQuest requires its subcontractors to supply written policies and procedures that provide protection for associates, subcontractors, and providers who report suspected fraud, waste, or abuse. DentaQuest and subcontractors must adhere to these expectations as part of the daily management of work.

6.15.2 LDH REVIEW AND APPROVAL

In compliance with Section 6.15.2 of the RFP, DentaQuest will submit all major subcontracts for the provision of any services under the Contract to LDH for prior review and approval.

6.15.3 NOTIFICATION OF CHANGES

In compliance with Section 6.15.3 of the RFP, DentaQuest will notify LDH of material amendments or changes to any subcontract prior to execution.

6.15.4 REMEDIES

In compliance with Section 6.15.4 of the RFP, in the event a subcontractor is not performing satisfactorily, DentaQuest acts swiftly to ensure that deficiencies are remedied. We increase our monitoring activities and implement a corrective action plan. Specifically, we notify the subcontractor of the corrective action with written communications and by scheduling a Performance Review Meeting. The subcontractor must attend the meeting and respond, within a pre-determined timeframe, with a "get well" action plan. We continue to meet frequently and monitor progress until all issues have been resolved satisfactorily.

Frequent reoccurence, failure to improve performance in required timeframes, and significant breachs may result in contract termination. In the event we terminate a subcontract, we follow a formal termination and transition process to ensure continuity of operations. This process includes but is not limited to advance notice to clients, identifying alternative subcontractors, thorough analysis of potential short term impact on business, communication to impacted areas and external parties, and knowledge transfer.

6.15.5 SUBCONTRACT TERMS AND CONDITIONS

If awarded the Contract, any subcontractor agreements supporting services under the Contract shall incorporate the Contract's terms and conditions, as applicable.

6.15.6 RECORDS AND AUDITS

DentaQuest will ensure its subcontractors understand and agree to meet the requirements of Sections 6.15.6.1 and 6.15.6.2 of the RFP. All DentaQuest subcontracts require subcontractors to maintain records for at least 10 years from the end date of the underlying state Medicaid agency contract. They also require timely compliance with audits, inspections, and other inquiries by state and federal authorities, as required by the underlying state Medicaid agency contract.

6.15.7 – 6.15.13 REQUIRED DISCLOSURES

DentaQuest will disclose the information outlined in Sections 6.15.7 through 6.15.13 of the RFP, as applicable, if awarded the Contract. This information will be disclosed in the timeframes and in the form and manner required by LDH.

SECTION 6.16 IMPLEMENTATION AND READINESS REVIEW

STRATEGIC OVERVIEW

As the industry leader in managing large and complex dental programs, DentaQuest has extensive program implementation and readiness review experience both directly with state agencies and MCOs across 30 states. We serve over 22 million government-sponsored program enrollees. This includes nine contracts with state Medicaid and CHIP agencies and 100 contracts with Medicaid MCOs, including for the past six years as a DBPM in Louisiana for Amerigroup and Aetna.

FUNCTIONAL APPROACH AND MANNER OF PERFORMANCE

Our Implementation and Readiness Review approach is led by our New Business Implementation (NBI) Department, to ensure we meet each state's requirements and timelines for dental benefits management. Together with an experienced

DentaQuest team leader, dedicated implementation staff, and Subject Matter Experts (SME) from each functional area, we implement professional project management practices to ensure all contractual requirements are met and systems testing completed to support successful implementation.

DentaQuest ensures there are time-tested processes in place to support continuity of care for enrollees and providers during transition. For example, we adhere to processes that offer enrollees flexibility during a transition to complete all existing courses of medically necessary services. If an enrollee is receiving care from an out-of-Network (OON) provider at the time they join DentaQuest, we offer multiple strategies to provide continuity of care for that enrollee, which include:

1. Identifying and honoring all existing courses of treatment.
2. Identifying and honoring all existing prior authorizations for covered services.
3. Inviting the Provider to join our network.
4. Establishing a single-case agreement with the provider.
5. Assisting the enrollee in identifying a new provider – with consideration of cultural and linguistic needs, other preferences, and enrollee choice.

Through the combination of dedicated and experienced staff and established processes, we will ensure we are ready to transition the Medicaid Dental Benefit Program to DentaQuest July 1, 2020, should we be awarded a Contract.

6.16.1 IMPLEMENTATION PLAN

6.16.2 READINESS REVIEW

Readiness Review is a standard component of DentaQuest's implementation project lifecycle and we are prepared to meet the requirements outlined in Sections 6.16.2.1 through 6.16.2.6.2 of the RFP. Each functional area will define its criteria for operational readiness based on review of the Contract and established DentaQuest standards. Shortly after implementation kick-off, we will begin weekly internal touch-point meetings for the entire cross-functional team to prepare for Readiness Review. During these meetings, we assess progress on the activities contained in the MCRD and identify and remediate any risks to meeting the operational Go-Live date. Every functional area reports on:

- Operational readiness
- Risks to project progress and readiness
- Rationale for the status and readiness reported

- Actions being taken to mitigate risks or impacts
- Any identified workarounds necessary to support operational readiness

During Readiness Review preparation we will produce the documentation specified by LDH or its designees to assist in conducting the review. This will include, for example, all policies and procedures, prepared for initial review and approval; a comprehensive written Cultural Competency Plan as specified in Section 6.1.3 of the RFP; and other relevant documents such as an Emergency Management Plan and Enrollee Education Plan. We will also ensure key staff are available on the dates and times specified by LDH to support Readiness Review, including the staff needed to provide a demonstration of systems readiness.

DentaQuest's history of successful implementations, combined with our expert resources, will support complete and timely implementation that meets the State's objectives and supports a smooth transition for enrollees and providers should we be awarded a Contract.

SECTION 2.15.4.5 MANDATORY NARRATIVES

SECTION 2.15.4.5.2.1 GOAL: IMPROVED COORDINATION OF CARE

2.15.4.5.2.2 GOAL: BETTER DENTAL HEALTH OUTCOMES

2.15.4.5.2.3 GOAL: INCREASED QUALITY OF DENTAL CARE

2.15.4.5.2.4 GOAL: IMPROVED ACCESS TO ESSENTIAL SPECIALTY DENTAL SERVICES

2.15.4.5.2.5 GOAL: OUTREACH & EDUCATION TO PROMOTE DENTAL HEALTH

2.15.4.5.2.6 GOAL: INCREASED ENROLLEE RESPONSIBILITY AND SELF- MANAGEMENT

SECTION 2.15.4.6 STAFFING REQUIREMENTS (SECTION 6.2)

DentaQuest has the organizational, operational, managerial, and administrative systems, the experience, and the policies needed to ensure that sufficient staffing and appropriate resources are in place to achieve compliance with all contract requirements of Sections 2.15.4.6 and 6.2 of the RFP.

STAFFING PLAN

6.2.4 Written Policies, Procedures, and Position Descriptions

In compliance with Sections 6.2.4.1 through 6.2.4.1.4 of the RFP, DentaQuest will maintain written policies, procedures and job descriptions for each functional area, review them annually, work with LDH to change policies and procedures as appropriate, and submit required organizational charts and staff listings to LDH annually.

6.2.5 Staff Training and Meeting Attendance

A knowledgeable workforce is a key component to our ensuring we provide best service to LDH, and our providers and enrollees. Our staff training program for this contract will comply with the requirements outlined in Sections 6.2.5.1 through 6.2.5.5.

Staff Training

DentaQuest offers training for all role levels across various work experience backgrounds. Upon hiring, all new employees are required to participate in a comprehensive new hire orientation program facilitated by HR. On their first day with the organization, employees are required to participate in New Hire Orientation, a day-long training session which focuses on the following areas: Mission, Vision & Values; DentaQuest's Culture; Our Environment; Development & Performance; Policy Overview; Employee Benefits & Compensation Overview; Employee Engagement; DentaQuest Learning Management System (DLMS) Overview. During the New Hire Orientation, employees also complete the following online compliance training modules: Privacy & Computer Information Security; Code of Conduct & Ethics; and Anti-Harassment Training.

DentaQuest also requires all employees, as well as subcontractors and independent consultants, to complete mandatory compliance training within 30 days of hire which includes the following compliance modules: Cultural Competency &

SECTION 2.15.4.7 REQUIRED ATTACHMENTS

2.15.4.7.1 PROPOSAL COMPLIANCE MATRIX (APPENDIX VI)

Please see **Attachment 1: Appendix VI Proposal Compliance Matrix**.

2.15.4.7.2 CERTIFICATION STATEMENT

Please see **Attachment 2: Appendix I Certification Statement.**

2.15.4.7.3 VETERAN HUDSON INITIATIVE

Please see **Attachment 3: Veteran Hudson Initiatives**.

2.15.4.7.4 DISCLOSURE OF OWNERSHIP, MANAGEMENT, & CONTROL OF MEDICAID PAHPS

Please see **Attachment 4: Appendix VII Medicaid Ownership and Disclosure Form.**

2.15.4.7.5 APPENDIX V: ELECTRONIC VENDOR PAYMENT SOLUTION

Please see **Attachment 5: Electronic Vendor Payment Solutions**.

2.15.4.7.6 AUDITED FINANCIAL STATEMENTS

Please see **Attachment 6: Audited Financial Statements**

OTHER ATTACHMENTS

We have included supplemental attachments that support our proposal. We understand these are included in our overall 150-page limit for the proposal. All totaled, the attachments noted below make up 27 pages. When added with this document, DentaQuest's total number of pages comes to 149.

Other Attachments		
Attachment	**RFP Cross Reference**	**Attachment Name**
Louisiana DOI Certificate of Authority	1.5.1.1.2	Attachment 7
Board Resolution	2.5	Attachment 8
Medicaid Related Litigation	2.15.4.3.5	Attachment 9
Organizational Chart	2.15.4.3.16	Attachment 10
Medicaid Dental Program Implementation Schedule	2.15.4.4.1	Attachment 11
Actuarial Value of Proposed Value-Added Services	6.4.3.9.1	Attachment 12
Subcontractor Commitment Letters	5.5	Attachment 13
Regulatory Actions	2.15.4.3.4	Attachment 14