

Managed Care Program Annual Report (MCPAR) for Louisiana: Dental Benefit Program (DBP)

Due date	Last edited	Edited by	Status
06/29/2026	06/25/2026	Brandon Bueche	Submitted

Indicator	Response
Exclusion of CHIP from MCPAR Enrollees in separate CHIP programs funded under Title XXI should not be reported in the MCPAR. Please check this box if the state is unable to remove information about Separate CHIP enrollees from its reporting on this program.	Not Selected
Did you submit or do you plan on submitting a Network Adequacy and Access Assurances (NAAAR) Report for this program for this reporting period through the MDCT online tool? If "No", please complete the following questions under each plan.	Yes, I plan on submitting it in MDCT

Section A: Program Information

Point of Contact

Number	Indicator	Response
A1	State name Auto-populated from your account profile.	Louisiana
A2a	Contact name First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	Cornelius Cole
A2b	Contact email address Enter email address. Department or program-wide email addresses ok.	Cornelius.Cole@la.gov
A3a	Submitter name CMS receives this data upon submission of this MCPAR report.	Brandon Bueche
A3b	Submitter email address CMS receives this data upon submission of this MCPAR report.	brandon.bueche@la.gov
A4	Date of report submission CMS receives this date upon submission of this MCPAR report.	06/25/2026

Reporting Period

Number	Indicator	Response
A5a	Reporting period start date Auto-populated from report dashboard.	01/01/2025
A5b	Reporting period end date Auto-populated from report dashboard.	12/31/2025
A6	Program name Auto-populated from report dashboard.	Dental Benefit Program (DBP)

Add plans (A.7)

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

Indicator	Response
Plan name	DentaQuest MCNA of Louisiana

Add BSS entities (A.8)

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

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

Indicator	Response
BSS entity name	Maximus Health Services

Add In Lieu of Services and Settings (A.9)

This section must be completed if any in lieu of services or settings (ILOSs) *other than short term stays in an Institution for Mental Diseases (IMD)* are authorized for this managed care program. **Enter the name of each ILOS offered as it is identified in the managed care plan contract(s).** (See 42 CFR 438.3(e)(2) and 438.16).

Indicator	Response
ILOS name	Not answered

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	<p data-bbox="310 100 586 174">Statewide Medicaid enrollment</p> <p data-bbox="310 195 727 520">Enter the average number of individuals enrolled in Medicaid per month during the reporting year (i.e., average member months). Include all FFS and managed care enrollees and count each person only once, regardless of the delivery system(s) in which they are enrolled.</p>	1,603,810
BI.2	<p data-bbox="310 562 656 678">Statewide Medicaid risk-based managed care enrollment</p> <p data-bbox="310 699 727 1087">Enter the average number of individuals enrolled in risk-based Medicaid managed care per month during the reporting year (i.e., average member months). Include all MCOs and at-risk PIHPs and PAHPs only, and count each person only once, even if they are enrolled in multiple managed care programs or plans.</p>	1,461,271

Topic III. Encounter Data Report

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

Topic X: Program Integrity

Number	Indicator	Response
BX.1	<p data-bbox="313 107 695 180">Payment risks between the state and plans</p> <p data-bbox="313 201 727 863">Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities. If no PI activities were performed, enter "No PI activities were performed during the reporting period" as your response. "N/A" is not an acceptable response.</p>	<p data-bbox="760 107 1382 1171">LDH PI section utilizes data mining runs/algorithms, risk scoring and alerts which focus on providers in both the Fee-For-Service (FFS) and Managed Care programs. Some of the algorithms and alerts include date of death runs, excluded provider runs, spike/surge runs, procedure code outlier runs, etc. Some of the audits resulting from the methods mentioned above are conducted by the UPIC contractors; other audits/leads are sent to the Plans to review; remaining audits are worked internally by our SURS team. In addition to data review, PI's SURS operates a complaint hotline. Both fee-for-service and managed care complaints are received via the hotline. The complaints are triaged and either is worked by the SURS or the complaints are referred to the Plans. The PI SURS and the MCO's SIUs also works closely with the Medicaid Fraud Control Unit (MFCU) in the Attorney General's office. Based on information discovered in audits and complaints, PI Internal SURS or the SIUs sends referrals to MFCU to investigate. MFCU works with SURS to initiate payment suspensions based on credible allegations of fraud. SURS, MFCU and the SIU have a monthly calls and quarterly meetings with the Plans.</p>
BX.2	<p data-bbox="313 1230 618 1304">Contract standard for overpayments</p> <p data-bbox="313 1325 727 1482">Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.</p>	<p data-bbox="760 1230 1247 1260">State has established a hybrid system</p>
BX.3	<p data-bbox="313 1535 634 1650">Location of contract provision stating overpayment standard</p> <p data-bbox="313 1671 727 1822">Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).</p>	<p data-bbox="760 1535 1333 1608">DBPM Contract, Attachment B: Statement of Work, Sections 2.12.6.4.2 - 2.12.6.4.3</p>
BX.4	<p data-bbox="313 1881 708 1955">Description of overpayment contract standard</p> <p data-bbox="313 1976 727 2060">Briefly describe the overpayment standard selected in indicator B.X.2.</p>	<p data-bbox="760 1881 1382 2070">All recoveries identified by the MCE are retained by the Plan. All recoveries identified by the State are retained by the State. If the MCE fails to collect at least a portion of the identified overpayment after 365 days the State may step</p>

in and recover from the MCE and said funds would be retained by the State. If the MCE's recovery efforts are deemed sufficient then the State will not step in and recover the overpayment.

BX.5	<p>State overpayment reporting monitoring</p> <p>Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting?</p> <p>The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment topics (whether annually or promptly). This indicator is asking the state how it monitors that reporting.</p>	All recoveries are reported by MCOs on two quarterly reports. The MCOs also report all identified overpayments and recovered overpayments on a monthly report. The PI MC Oversight unit conducts review seeking compliance with reporting requirements.
BX.6	<p>Changes in beneficiary circumstances</p> <p>Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).</p>	The State and the MCEs have a monthly and quarterly reconciliation 834 file.
BX.7a	<p>Changes in provider circumstances: Monitoring plans</p> <p>Does the state monitor whether plans report provider "for cause" terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.</p>	Yes
BX.7b	<p>Changes in provider circumstances: Metrics</p> <p>Does the state use a metric or indicator to assess plan reporting performance? Select one.</p>	No
BX.8a	<p>Federal database checks: Excluded person or entities</p> <p>During the state's federal database checks, did the state</p>	No

find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.

BX.9a **Website posting of 5 percent or more ownership control** No

Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to 42 CFR 438.602(g)(3) and 455.104.

BX.10 **Periodic audits**

If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, provide the link(s) to the audit results. Refer to 42 CFR 438.602(e). If no audits were conducted, please enter "No such audits were conducted during the reporting year" as your response. "N/A" is not an acceptable response.

Reviews conducted during CY2025 are published at <https://ldh.la.gov/resources?cat=&d=5&y=0&q=EQR>

Topic XIII. Prior Authorization



Beginning June 2026, Indicators B.XIII.1a-b-2a-b must be completed. Submission of this data before June 2026 is optional.

Number	Indicator	Response
N/A	Are you reporting data prior to June 2026?	Yes
BXIII.1a	<p>Timeframes for standard prior authorization decisions</p> <p>Plans must provide notice of their decisions on prior authorization requests as expeditiously as the enrollee's condition requires and within state-established timeframes. For rating periods that start before January 1, 2026, a state's time frame may not exceed 14 calendar days after receiving the request. For rating periods that start on or after January 1, 2026, a state's time frame may not exceed 7 calendar days after receiving the request. Does the state set timeframes shorter than these maximum timeframes for standard prior authorization requests?</p>	No
BXIII.2a	<p>Timeframes for expedited prior authorization decisions</p> <p>Plans must provide notice of their decisions on prior authorization requests as expeditiously as the enrollee's condition requires and no later than 72 hours after receipt of the request for service. Does the state set timeframes shorter than the maximum timeframe for expedited prior authorization requests?</p>	No

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C11.1	<p>Program contract</p> <p>Enter the title of the contract between the state and plans participating in the managed care program.</p>	Dental Benefit Program Management
N/A	<p>Enter the date of the contract between the state and plans participating in the managed care program.</p>	01/01/2021
C11.2	<p>Contract URL</p> <p>Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.</p>	<p>https://ldh.la.gov/resources?q=Dental%20Benefit%20Program%20Manager%20%28DBPM%29%20Procurement%20Documents%2C%20Contracts%2C%20and%20Related%20Materials%20for%20Contracting%20Period%20%202021%20to%20present</p>
C11.3	<p>Program type</p> <p>What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.</p>	Prepaid Ambulatory Health Plan (PAHP)
C11.4a	<p>Special program benefits</p> <p>Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more.</p> <p>Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.</p>	Dental
C11.4b	<p>Variation in special benefits</p> <p>What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable.</p>	<p>The benefits received by the EPSDT and Adult Waiver Programs are comprehensive. The Adult Denture Program receives only denture services. The ICF/IID Program also receives comprehensive dental care. But, some diagnostic services, such as exams and some radiographic images, are billed to the applicable ICF; these services include D0120, D0150, D0210, D0240, D0272 and D0330. The remainder of dental services for ICF/IDD</p>

C11.5	Program enrollment Enter the average number of individuals enrolled in this managed care program per month during the reporting year (i.e., average member months).	1,464,517
C11.6	Changes to enrollment or benefits Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year. If there were no major changes, please enter "There were no major changes to the population or benefits during the reporting year" as your response. "N/A" is not an acceptable response.	There were no major changes to the population or benefits during the reporting year.

Topic II: Medical Loss Ratio (MLR) Reporting

Number	Indicator	Response
C1II.1	<p data-bbox="313 107 708 180">Submission Date of Most Recent MLR Report</p> <p data-bbox="313 201 708 359">When is the last date the state submitted the MLR Summary Report in the Medicaid Data Collection Tool (MDCT) MLR Portal for this program?</p>	06/05/2025
C1II.2	<p data-bbox="313 411 708 485">Most Recent MLR Reporting Period</p> <p data-bbox="313 506 708 600">Please report the beginning date of that MLR reporting period.</p>	01/01/2023
N/A	<p data-bbox="313 653 708 716">Please report the end date of that MLR reporting period.</p>	06/30/2023
C1II.3	<p data-bbox="313 768 708 800">MLR Validation Completion</p> <p data-bbox="313 821 708 1041">Has the state completed the validation of plan MLR data for the current MCPAR reporting period by the submission date of this report for all plans? (See detailed reporting in Section D1.II by plan.)</p>	Yes

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	<p>Uses of encounter data</p> <p>For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more.</p> <p>Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).</p>	<p>Rate setting</p> <p>Quality/performance measurement</p> <p>Monitoring and reporting</p> <p>Contract oversight</p> <p>Program integrity</p> <p>Policy making and decision support</p>
C1III.2	<p>Criteria/measures to evaluate MCP performance</p> <p>What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more.</p> <p>Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).</p>	<p>Timeliness of initial data submissions</p> <p>Other, specify – An annual external review and validation of encounter data is conducted. The review includes encounter data completeness and accuracy, evaluated via optional EQR Protocol 5.</p>
C1III.3	<p>Encounter data performance criteria contract language</p> <p>Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.</p>	<p>DBPM Contract, Attachment B: Statement of Work Section 2.14.11</p>

C1III.4	Financial penalties contract language	DBPM Contract, Attachment B: Statement of Work Section 3.6.5, Table of Monetary Penalties
	Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.	
C1III.5	Incentives for encounter data quality	N/A
	Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with N/A if the program does not use incentives to reward encounter data quality.	
C1III.6	Barriers to collecting/validating encounter data	The state did not experience any barriers to collecting or validating encounter data during the reporting year.
	Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting year. If there were no barriers, please enter "The state did not experience any barriers to collecting or validating encounter data during the reporting year" as your response. "N/A" is not an acceptable response.	

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
C1IV.1	<p>State’s definition of “critical incident”, as used for reporting purposes in its MLTSS program</p> <p>If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for “critical incidents” within the managed care program? Respond with “N/A” if the managed care program does not cover LTSS.</p>	N/A
C1IV.2	<p>State definition of “timely” resolution for standard appeals</p> <p>Provide the state’s definition of timely resolution for standard appeals in the managed care program. Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.</p>	<p>For standard resolution of an appeal and notice to the affected parties, the timeframe is established as thirty (30) calendar days from the day the MCE receives the appeal. This timeframe may be extended.</p>
C1IV.3	<p>State definition of “timely” resolution for expedited appeals</p> <p>Provide the state’s definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal.</p>	<p>For expedited resolution of an appeal and notice to affected parties, the timeframe is established as seventy-two (72) hours after the MCE receives the appeal. This timeframe may be extended.</p>

C1IV.4

State definition of “timely” resolution for grievances

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

For standard disposition of a grievance and notice to the affected parties, the timeframe is established as ninety (90) days from the day the MCE receives the grievance.

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
C1IX.1	<p data-bbox="313 107 480 136">BSS website</p> <p data-bbox="313 161 721 317">List the website(s) and/or email address(es) that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.</p>	<p data-bbox="760 107 1317 220">Healthy Louisiana mobile app (available for download on Apple and Android), https://myplan.healthy.la.gov/en</p>
C1IX.2	<p data-bbox="313 369 618 441">BSS auxiliary aids and services</p> <p data-bbox="313 466 708 877">How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2)? CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.</p>	<p data-bbox="760 369 1377 525">All correspondence informs enrollees that they can request assistance or auxiliary aids. This information is also provided on the website and in the mobile app.</p>
C1IX.3	<p data-bbox="313 930 630 959">BSS LTSS program data</p> <p data-bbox="313 984 721 1299">How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4). If the program does not offer LTSS, enter "N/A".</p>	<p data-bbox="760 930 1284 959">LTSS is not coordinated through the BSS.</p>
C1IX.4	<p data-bbox="313 1352 721 1423">State evaluation of BSS entity performance</p> <p data-bbox="313 1449 721 1570">What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?</p>	<p data-bbox="760 1352 1338 1541">Every interaction includes a customer satisfaction survey. There is also a complaint process through which enrollees can provide feedback. All complaints come directly to the State.</p>

Topic X: Program Integrity

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

Topic XII. Mental Health and Substance Use Disorder Parity

Number	Indicator	Response
C1XII.4	Does this program include MCOs? If "Yes", please complete the following questions.	No

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D11.1	Plan enrollment Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).	DentaQuest 777,682
		MCNA of Louisiana 686,835
D11.2	Plan share of Medicaid What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? Numerator: Plan enrollment (D1.I.1)Denominator: Statewide Medicaid enrollment (B.I.1)	DentaQuest 48.5%
		MCNA of Louisiana 42.8%
D11.3	Plan share of risk-based Medicaid managed care What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in risk-based managed care?Numerator: Plan enrollment (D1.I.1)Denominator: Statewide Medicaid risk-based managed care enrollment (B.I.2)	DentaQuest 53.2%
		MCNA of Louisiana 47%
D11.4: Parent	Organization: The name of the parent entity that controls the Medicaid Managed Care Plan. If the managed care plan is owned or controlled by a separate entity (parent), report the name of that entity. If the managed care plan is not controlled by a separate entity, please report the managed care plan name in this field.	DentaQuest SunLife US
		MCNA of Louisiana MCNA

Topic II: Medical Loss Ratio (MLR) Reporting

Number	Indicator	Response
D1II.1	MLR Data Received Has the state received the MLR data specified at 42 CFR 438.8(k) from this plan for the current MCPAR reporting period as of the submission date of this MCPAR report?	DentaQuest Yes MCNA of Louisiana Yes
D1II.1a	MLR Data Validated Has the state validated the final MLR data specified at 42 CFR 438.8(k) from this plan for the current MCPAR reporting period as of the submission date of this MCPAR report?	DentaQuest Yes MCNA of Louisiana Yes

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	<p data-bbox="313 107 708 176">Definition of timely encounter data submissions</p> <p data-bbox="313 201 708 453">Describe the state’s standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.</p>	<p data-bbox="813 138 1360 579">DentaQuest</p> <p data-bbox="813 191 1360 579">The MCE is responsible for ensuring accurate and complete encounter reporting from their providers. The MCE must evaluate the adequacy of, and revise if necessary, the encounter data collection instruments and processes being used by its providers; and ensure that provider identification (NPI, taxonomy, and 9-digit zip code) is appropriate and submitted correctly in each transaction.</p> <p data-bbox="813 621 1360 1062">MCNA of Louisiana</p> <p data-bbox="813 674 1360 1062">The MCE is responsible for ensuring accurate and complete encounter reporting from their providers. The MCE must evaluate the adequacy of, and revise if necessary, the encounter data collection instruments and processes being used by its providers; and ensure that provider identification (NPI, taxonomy, and 9-digit zip code) is appropriate and submitted correctly in each transaction.</p>
D1III.2	<p data-bbox="313 1115 708 1272">Share of encounter data submissions that met state’s timely submission requirements</p> <p data-bbox="313 1293 708 1797">What percent of the plan’s encounter data file submissions (submitted during the reporting year) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract year when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting year.</p>	<p data-bbox="813 1146 1073 1230">DentaQuest</p> <p data-bbox="813 1199 870 1230">94%</p> <p data-bbox="813 1272 1073 1356">MCNA of Louisiana</p> <p data-bbox="813 1325 870 1356">96%</p>

D1III.3 Share of encounter data submissions that were HIPAA compliant

What percent of the plan's encounter data submissions (submitted during the reporting year) met state requirements for HIPAA compliance?

If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting year.

DentaQuest

100%

MCNA of Louisiana

99%

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Number	Indicator	Response
D1IV.1	<p>Appeals resolved (at the plan level)</p> <p>Enter the total number of appeals resolved during the reporting year. An appeal is “resolved” at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary’s representative) chooses to file a request for a State Fair Hearing or External Medical Review.</p>	<p>DentaQuest</p> <p>359</p> <p>MCNA of Louisiana</p> <p>78</p>
D1IV.1a	<p>Appeals denied</p> <p>Enter the total number of appeals resolved during the reporting period (D1.IV.1) that were denied (adverse) to the enrollee.</p>	<p>DentaQuest</p> <p>18</p> <p>MCNA of Louisiana</p> <p>12</p>
D1IV.1b	<p>Appeals resolved in partial favor of enrollee</p> <p>Enter the total number of appeals (D1.IV.1) resolved during the reporting period in partial favor of the enrollee.</p>	<p>DentaQuest</p> <p>18</p> <p>MCNA of Louisiana</p> <p>12</p>
D1IV.1c	<p>Appeals resolved in favor of enrollee</p> <p>Enter the total number of appeals (D1.IV.1) resolved during the reporting period in favor of the enrollee.</p>	<p>DentaQuest</p> <p>111</p> <p>MCNA of Louisiana</p> <p>3</p>
D1IV.2	<p>Active appeals</p> <p>Enter the total number of appeals still pending or in process (not yet resolved) as of the end of the reporting year.</p>	<p>DentaQuest</p> <p>270</p> <p>MCNA of Louisiana</p> <p>18</p>
D1IV.3	<p>Appeals filed on behalf of LTSS users</p> <p>Enter the total number of appeals filed during the reporting year by or on behalf</p>	<p>DentaQuest</p> <p>N/A</p> <p>MCNA of Louisiana</p>

of LTSS users. Enter "N/A" if not applicable. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the appeal was filed).

N/A

D1IV.4 **Number of critical incidents filed during the reporting year by (or on behalf of) an LTSS user who previously filed an appeal**

DentaQuest

N/A

MCNA of Louisiana

N/A

For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter "N/A". Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter "N/A". The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.

D1IV.5a **Standard appeals for which timely resolution was**

DentaQuest

provided

359

Enter the total number of standard appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.

MCNA of Louisiana

78

D1IV.5b

Expedited appeals for which timely resolution was provided

DentaQuest

0

Enter the total number of expedited appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.

MCNA of Louisiana

0

D1IV.6a

Resolved appeals related to denial of authorization or limited authorization of a service

DentaQuest

341

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service. (Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).

MCNA of Louisiana

73

D1IV.6b

Resolved appeals related to reduction, suspension, or termination of a previously authorized service

DentaQuest

0

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.

MCNA of Louisiana

0

D1IV.6c

Resolved appeals related to payment denial

DentaQuest

18

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of

MCNA of Louisiana

12

payment for a service that was already rendered.

D1IV.6d	Resolved appeals related to service timeliness	DentaQuest
	Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).	0
		MCNA of Louisiana
		0
<hr/>		
D1IV.6e	Resolved appeals related to lack of timely plan response to an appeal or grievance	DentaQuest
	Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	0
		MCNA of Louisiana
		0
<hr/>		
D1IV.6f	Resolved appeals related to plan denial of an enrollee's right to request out-of-network care	DentaQuest
	Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO). If not applicable, enter "N/A."	0
		MCNA of Louisiana
		3
<hr/>		
D1IV.6g	Resolved appeals related to denial of an enrollee's request to dispute financial liability	DentaQuest
	Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.	0
		MCNA of Louisiana
		0

Appeals by Service

Number of appeals resolved during the reporting period related to various services.

Note: A single appeal may be related to multiple service types and may therefore be counted in multiple categories.

Number	Indicator	Response
D1IV.7a	<p>Resolved appeals related to general inpatient services</p> <p>Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter “N/A”.</p>	<p>DentaQuest</p> <p>N/A</p> <p>MCNA of Louisiana</p> <p>N/A</p>
D1IV.7b	<p>Resolved appeals related to general outpatient services</p> <p>Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care not specifically listed in this section (e.g., primary and preventive services, specialist care, diagnostic and lab testing). Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter “N/A”.</p>	<p>DentaQuest</p> <p>N/A</p> <p>MCNA of Louisiana</p> <p>N/A</p>
D1IV.7c	<p>Resolved appeals related to inpatient behavioral health services</p> <p>Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter “N/A”.</p>	<p>DentaQuest</p> <p>N/A</p> <p>MCNA of Louisiana</p> <p>N/A</p>
D1IV.7d	<p>Resolved appeals related to outpatient behavioral health services</p> <p>Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or</p>	<p>DentaQuest</p> <p>N/A</p> <p>MCNA of Louisiana</p> <p>N/A</p>

substance use services. If the managed care plan does not cover outpatient behavioral health services, enter "N/A".

D1IV.7e	Resolved appeals related to covered outpatient prescription drugs	DentaQuest
	Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter "N/A".	N/A
		MCNA of Louisiana
		N/A
<hr/>		
D1IV.7f	Resolved appeals related to skilled nursing facility (SNF) services	DentaQuest
	Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter "N/A".	N/A
		MCNA of Louisiana
		N/A
<hr/>		
D1IV.7g	Resolved appeals related to long-term services and supports (LTSS)	DentaQuest
	Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter "N/A".(Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	N/A
		MCNA of Louisiana
		N/A
<hr/>		
D1IV.7h	Resolved appeals related to dental services	DentaQuest
	Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter "N/A".	359
		MCNA of Louisiana
		78

<p>D1IV.7i</p>	<p>Resolved appeals related to non-emergency medical transportation (NEMT)</p> <p>Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter "N/A".</p>	<p>DentaQuest</p> <p>N/A</p> <p>MCNA of Louisiana</p> <p>N/A</p>
<p>D1IV.7k:</p>	<p>Resolved appeals related to durable medical equipment (DME) & supplies</p> <p>Enter the total number of appeals resolved by the plan during the reporting year that were related to DME and/or supplies. If the managed care plan does not cover this type of service, enter "N/A".</p>	<p>DentaQuest</p> <p>N/A</p> <p>MCNA of Louisiana</p> <p>N/A</p>
<p>D1IV.7l:</p>	<p>Resolved appeals related to home health / hospice</p> <p>Enter the total number of appeals resolved by the plan during the reporting year that were related to home health and/or hospice. If the managed care plan does not cover this type of service, enter "N/A".</p>	<p>DentaQuest</p> <p>N/A</p> <p>MCNA of Louisiana</p> <p>N/A</p>
<p>D1IV.7m:</p>	<p>Resolved appeals related to emergency services / emergency department</p> <p>Enter the total number of appeals resolved by the plan during the reporting year that were related to emergency services and/or provided in the emergency department. Do not include appeals related to emergency outpatient behavioral health – those should be included in indicator D1.IV.7d. If the managed care plan does not cover this type of service, enter "N/A".</p>	<p>DentaQuest</p> <p>N/A</p> <p>MCNA of Louisiana</p> <p>N/A</p>
<p>D1IV.7n:</p>	<p>Resolved appeals related to therapies</p> <p>Enter the total number of appeals resolved by the plan during the reporting year that were related to speech language pathology services or occupational, physical, or respiratory therapy services. If</p>	<p>DentaQuest</p> <p>N/A</p> <p>MCNA of Louisiana</p> <p>N/A</p>

the managed care plan does not cover this type of service, enter "N/A".

D1IV.7o

Resolved appeals related to other service types

Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-n paid primarily by Medicaid, enter "N/A".

DentaQuest

N/A

MCNA of Louisiana

3

State Fair Hearings

Number	Indicator	Response
D1IV.8a	<p data-bbox="313 107 691 136">State Fair Hearing requests</p> <p data-bbox="313 161 721 317">Enter the total number of State Fair Hearing requests resolved during the reporting year with the plan that issued an adverse benefit determination.</p>	<p data-bbox="813 138 980 168">DentaQuest</p> <p data-bbox="813 193 829 222">2</p> <p data-bbox="813 262 1076 291">MCNA of Louisiana</p> <p data-bbox="813 317 829 346">2</p>
D1IV.8b	<p data-bbox="313 401 711 514">State Fair Hearings resulting in a favorable decision for the enrollee</p> <p data-bbox="313 539 721 695">Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.</p>	<p data-bbox="813 432 980 462">DentaQuest</p> <p data-bbox="813 487 829 516">0</p> <p data-bbox="813 556 1076 585">MCNA of Louisiana</p> <p data-bbox="813 611 829 640">3</p>
D1IV.8c	<p data-bbox="313 743 721 856">State Fair Hearings resulting in an adverse decision for the enrollee</p> <p data-bbox="313 882 721 1003">Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.</p>	<p data-bbox="813 777 980 806">DentaQuest</p> <p data-bbox="813 831 829 861">0</p> <p data-bbox="813 900 1076 930">MCNA of Louisiana</p> <p data-bbox="813 955 829 984">0</p>
D1IV.8d	<p data-bbox="313 1056 721 1129">State Fair Hearings retracted prior to reaching a decision</p> <p data-bbox="313 1155 721 1402">Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) during the reporting year prior to reaching a decision.</p>	<p data-bbox="813 1087 980 1117">DentaQuest</p> <p data-bbox="813 1142 829 1171">0</p> <p data-bbox="813 1211 1076 1241">MCNA of Louisiana</p> <p data-bbox="813 1266 829 1295">0</p>
D1IV.9a	<p data-bbox="313 1455 667 1568">External Medical Reviews resulting in a favorable decision for the enrollee</p> <p data-bbox="313 1593 721 2001">If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).</p>	<p data-bbox="813 1486 980 1516">DentaQuest</p> <p data-bbox="813 1541 829 1570">0</p> <p data-bbox="813 1610 1076 1640">MCNA of Louisiana</p> <p data-bbox="813 1665 829 1694">0</p>

D1IV.9b

**External Medical Reviews
resulting in an adverse
decision for the enrollee**

If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).

DentaQuest

0

MCNA of Louisiana

0

Grievances Overview

Number	Indicator	Response
D1IV.10	<p>Grievances resolved</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. A grievance is “resolved” when it has reached completion and been closed by the plan.</p>	<p>DentaQuest</p> <p>104</p> <p>MCNA of Louisiana</p> <p>51</p>
D1IV.11	<p>Active grievances</p> <p>Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.</p>	<p>DentaQuest</p> <p>53</p> <p>MCNA of Louisiana</p> <p>18</p>
D1IV.12	<p>Grievances filed on behalf of LTSS users</p> <p>Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.</p>	<p>DentaQuest</p> <p>N/A</p> <p>MCNA of Louisiana</p> <p>N/A</p>
D1IV.13	<p>Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance</p> <p>For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been “related” to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by</p>	<p>DentaQuest</p> <p>N/A</p> <p>MCNA of Louisiana</p> <p>N/A</p>

an LTSS user. If the managed care plan does not cover LTSS, the state should enter "N/A" in this field. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.

D1IV.14	Number of grievances for which timely resolution was provided	DentaQuest
	Enter the number of grievances for which timely resolution was provided by plan during the reporting year. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	104
		MCNA of Louisiana
		51

Grievances by Service

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

Number	Indicator	Response
D1IV.15a	<p>Resolved grievances related to general inpatient services</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter “N/A”.</p>	<p>DentaQuest</p> <p>N/A</p> <p>MCNA of Louisiana</p> <p>N/A</p>
D1IV.15b	<p>Resolved grievances related to general outpatient services</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care not specifically listed in this section (e.g., primary and preventive services, specialist care, diagnostic and lab testing). Do not include grievances related to outpatient behavioral health services - those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter “N/A”.</p>	<p>DentaQuest</p> <p>N/A</p> <p>MCNA of Louisiana</p> <p>N/A</p>
D1IV.15c	<p>Resolved grievances related to inpatient behavioral health services</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter “N/A”.</p>	<p>DentaQuest</p> <p>N/A</p> <p>MCNA of Louisiana</p> <p>N/A</p>
D1IV.15d	<p>Resolved grievances related to outpatient behavioral health services</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that</p>	<p>DentaQuest</p> <p>N/A</p> <p>MCNA of Louisiana</p>

were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".

D1IV.15e	Resolved grievances related to coverage of outpatient prescription drugs Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".	DentaQuest N/A MCNA of Louisiana N/A
D1IV.15f	Resolved grievances related to skilled nursing facility (SNF) services Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter "N/A".	DentaQuest N/A MCNA of Louisiana N/A
D1IV.15g	Resolved grievances related to long-term services and supports (LTSS) Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".	DentaQuest N/A MCNA of Louisiana N/A
D1IV.15h	Resolved grievances related to dental services Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter "N/A".	DentaQuest 104 MCNA of Louisiana 51

D1IV.15i	Resolved grievances related to non-emergency medical transportation (NEMT)	DentaQuest
	Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter "N/A".	N/A
		MCNA of Louisiana
		N/A
D1IV.15k	Resolved grievances related to durable medical equipment (DME) & supplies	DentaQuest
	Enter the total number of grievances resolved by the plan during the reporting year that were related to DME and/or supplies. If the managed care plan does not cover this type of service, enter "N/A".	N/A
		MCNA of Louisiana
		N/A
D1IV.15l	Resolved grievances related to home health / hospice	DentaQuest
	Enter the total number of grievances resolved by the plan during the reporting year that were related to home health and/or hospice. If the managed care plan does not cover this type of service, enter "N/A".	N/A
		MCNA of Louisiana
		N/A
D1IV.15m	Resolved grievances related to emergency services / emergency department	DentaQuest
	Enter the total number of grievances resolved by the plan during the reporting year that were related to emergency services and/or provided in the emergency department. Do not include grievances related to emergency outpatient behavioral health - those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	N/A
		MCNA of Louisiana
		N/A
D1IV.15n	Resolved grievances related to therapies	DentaQuest
	Enter the total number of grievances resolved by the plan during the reporting year that were related to speech language pathology services or occupational, physical, or	N/A
		MCNA of Louisiana
		N/A

respiratory therapy services. If the managed care plan does not cover this type of service, enter "N/A".

D1IV.15o**Resolved grievances related to other service types**

Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-n paid primarily by Medicaid, enter "N/A".

DentaQuest

0

MCNA of Louisiana0

Grievances by Reason

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

Number	Indicator	Response
D1IV.16a	<p>Resolved grievances related to plan or provider customer service</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.</p>	<p>DentaQuest</p> <p>18</p> <p>MCNA of Louisiana</p> <p>2</p>
D1IV.16b	<p>Resolved grievances related to plan or provider care management/case management</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management. Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.</p>	<p>DentaQuest</p> <p>0</p> <p>MCNA of Louisiana</p> <p>0</p>
D1IV.16c	<p>Resolved grievances related to network adequacy or access to care/services from plan or provider</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.</p>	<p>DentaQuest</p> <p>31</p> <p>MCNA of Louisiana</p> <p>2</p>
D1IV.16d	<p>Resolved grievances related to quality of care</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care. Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.</p>	<p>DentaQuest</p> <p>32</p> <p>MCNA of Louisiana</p> <p>22</p>
D1IV.16e	<p>Resolved grievances related to plan communications</p> <p>Enter the total number of grievances resolved by the plan during the</p>	<p>DentaQuest</p> <p>1</p>

reporting year that were related to plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.

MCNA of Louisiana

14

D1IV.16f Resolved grievances related to payment or billing issues

Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason related to payment or billing issues.

DentaQuest

18

MCNA of Louisiana

19

D1IV.16g Resolved grievances related to suspected fraud

Enter the total number of grievances resolved by the plan during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetrated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.

DentaQuest

0

MCNA of Louisiana

0

D1IV.16h Resolved grievances related to abuse, neglect or exploitation

Enter the total number of grievances resolved by the plan during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.

DentaQuest

0

MCNA of Louisiana

0

D1IV.16i Resolved grievances related to lack of timely plan response to a prior authorization/service authorization or appeal (including requests to expedite or extend appeals)

Enter the total number of grievances resolved by the plan during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).

DentaQuest

0

MCNA of Louisiana

0

D1IV.16j	<p>Resolved grievances related to plan denial of expedited appeal</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.</p>	<p>DentaQuest</p> <p>0</p> <p>MCNA of Louisiana</p> <p>0</p>
D1IV.16k	<p>Resolved grievances filed for other reasons</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason other than the reasons listed above.</p>	<p>DentaQuest</p> <p>0</p> <p>MCNA of Louisiana</p> <p>0</p>

Topic VII: Quality & Performance Measures

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



Complete

D2.VII.1 Measure Name: CMS 416

1 / 2

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

CMS 416

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

No, 10/01/2024 - 09/30/2025

D2.VII.8 Measure Description

Increase the percentage of EPSDT enrollees, age 1-20, receiving at least 1 preventative dental service. (Line 12b of CMS 416)

Measure results

DentaQuest

Plan-specific data is not available as of the date of submission of this report.

MCNA of Louisiana

Plan-specific data is not available as of the date of submission of this report.



Complete

D2.VII.1 Measure Name: HEDIS OED

2 / 2

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

Increase the percentage of members under 21 years of age receiving a comprehensive or periodic oral evaluation with a dental provider during the measurement year.

Measure results

DentaQuest

Plan-specific data is not available as of the date of submission of this report.

MCNA of Louisiana

Plan-specific data is not available as of the date of submission of this report.

Topic VIII. Sanctions

Describe sanctions that the state has issued for each plan. Report all known actions across the following domains: sanctions, administrative penalties, corrective action plans, other. The state should include all sanctions the state issued regardless of what entity identified the non-compliance (e.g. the state, an auditing body, the plan, a contracted entity like an external quality review organization).

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



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance)

1 / 10

D3.VIII.2 Plan performance issue

D3.VIII.3 Plan name
DentaQuest

Quality measure performance (e.g., failure to meet benchmarks or make progress on performance improvement projects)

D3.VIII.4 Reason for intervention

Failure to meet performance measures

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$84,000

D3.VIII.7 Date assessed

09/15/2025

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance)

2 / 10

D3.VIII.2 Plan performance issue

D3.VIII.3 Plan name
DentaQuest

Reporting (timeliness, completeness, accuracy)

D3.VIII.4 Reason for intervention

Failure to Submit Accurate Reports

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$90,000

D3.VIII.7 Date assessed

08/18/2025

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance)

3 / 10

D3.VIII.2 Plan performance issue

Quality measure performance (e.g., failure to meet benchmarks or make progress on performance improvement projects)

D3.VIII.3 Plan name

DentaQuest

D3.VIII.4 Reason for intervention

Meet Encounter Data Submission Requirements

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$50,000

D3.VIII.7 Date assessed

04/15/2025

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance)

4 / 10

D3.VIII.2 Plan performance issue **D3.VIII.3 Plan name**
DentaQuest

Quality measure performance (e.g., failure to meet benchmarks or make progress on performance improvement projects)

D3.VIII.4 Reason for intervention

Meet Encounter Data Submission Requirements

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$50,000

D3.VIII.7 Date assessed

07/31/2025

D3.VIII.8 Remediation date non-compliance was corrected

No, no remediation

D3.VIII.9 Corrective action plan

No



D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance)

5 / 10

D3.VIII.2 Plan performance issue **D3.VIII.3 Plan name**
DentaQuest

Quality measure performance (e.g., failure to meet benchmarks or make progress on performance improvement projects)

D3.VIII.4 Reason for intervention

Meet Encounter Data Submission Requirements

Sanction details

D3.VIII.5 Instances of non-compliance

D3.VIII.6 Sanction amount

1

\$50,000

D3.VIII.7 Date assessed

08/26/2025

D3.VIII.8 Remediation date non-compliance was corrected

No, no remediation

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance)

6 / 10

D3.VIII.2 Plan performance issue

Financial issues

D3.VIII.3 Plan name

DentaQuest

D3.VIII.4 Reason for intervention

Failure to Adjust or Void Encounters to Correct Claim Adjudication Errors
Timely

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

NA

D3.VIII.7 Date assessed

09/19/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 01/30/2026

D3.VIII.9 Corrective action plan

Yes



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance)

7 / 10

D3.VIII.2 Plan performance issue

Quality measure performance (e.g., failure to meet benchmarks or make progress on

D3.VIII.3 Plan name

MCNA of Louisiana

performance
improvement projects)

D3.VIII.4 Reason for intervention

Failure to meet performance measures

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$63,600

D3.VIII.7 Date assessed

09/15/2025

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance)

8 / 10

D3.VIII.2 Plan performance issue

Quality measure performance (e.g., failure to meet benchmarks or make progress on performance improvement projects)

D3.VIII.3 Plan name

MCNA of Louisiana

D3.VIII.4 Reason for intervention

Failure to Meet Encounter Data Submission Requirements

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$50,000

D3.VIII.7 Date assessed

04/15/2025

D3.VIII.8 Remediation date non-compliance was corrected

No, no remediation

D3.VIII.9 Corrective action plan

Yes



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance) 9 / 10

D3.VIII.2 Plan performance issue **D3.VIII.3 Plan name**
MCNA of Louisiana

Quality measure performance (e.g., failure to meet benchmarks or make progress on performance improvement projects)

D3.VIII.4 Reason for intervention

Failure to Meet Encounter Data Submission Requirements

Sanction details

D3.VIII.5 Instances of non-compliance **D3.VIII.6 Sanction amount**
1 \$50,000

D3.VIII.7 Date assessed **D3.VIII.8 Remediation date non-compliance was corrected**
07/31/2025 Remediation in progress

D3.VIII.9 Corrective action plan
No



Complete

D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance) 10 / 10

D3.VIII.2 Plan performance issue **D3.VIII.3 Plan name**
MCNA of Louisiana

Quality measure performance (e.g., failure to meet benchmarks or make progress on performance improvement projects)

D3.VIII.4 Reason for intervention

Failure to Meet Encounter Data Submission Requirements

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$50,000

D3.VIII.7 Date assessed

08/26/2025

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Topic X. Program Integrity

Number	Indicator	Response
D1X.1	<p>Dedicated program integrity staff</p> <p>Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).</p>	<p>DentaQuest</p> <p>1</p> <p>MCNA of Louisiana</p> <p>1</p>
D1X.2	<p>Count of opened program integrity investigations</p> <p>How many program integrity investigations were opened by the plan during the reporting year?</p>	<p>DentaQuest</p> <p>4</p> <p>MCNA of Louisiana</p> <p>11</p>
D1X.4	<p>Count of resolved program integrity investigations</p> <p>How many program integrity investigations were resolved by the plan during the reporting year?</p>	<p>DentaQuest</p> <p>5</p> <p>MCNA of Louisiana</p> <p>13</p>
D1X.6	<p>Referral path for program integrity referrals to the state</p> <p>What is the referral path that the plan uses to make program integrity referrals to the state? Select one.</p>	<p>DentaQuest</p> <p>Makes referrals to the SMA and MFCU concurrently</p> <p>MCNA of Louisiana</p> <p>Makes referrals to the SMA and MFCU concurrently</p>
D1X.7	<p>Count of program integrity referrals to the state</p> <p>Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of unduplicated referrals.</p>	<p>DentaQuest</p> <p>0</p> <p>MCNA of Louisiana</p> <p>4</p>
D1X.9a:	<p>Plan overpayment reporting to the state: Start Date</p> <p>What is the start date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?</p>	<p>DentaQuest</p> <p>03/01/2026</p> <p>MCNA of Louisiana</p> <p>03/01/2026</p>

D1X.9b:	Plan overpayment reporting to the state: End Date	DentaQuest
	What is the end date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	03/31/2026
		MCNA of Louisiana
		03/31/2026
D1X.9c:	Plan overpayment reporting to the state: Dollar amount	DentaQuest
	From the plan's latest annual overpayment recovery report, what is the total amount of overpayments recovered?	\$124,757
		MCNA of Louisiana
		\$140,548
D1X.9d:	Plan overpayment reporting to the state: Corresponding premium revenue	DentaQuest
	What is the total amount of premium revenue for the corresponding reporting period (D1.X.9a-b)? (Premium revenue as defined in MLR reporting under 438.8(f)(2))	\$0
		MCNA of Louisiana
		\$0
D1X.10	Changes in beneficiary circumstances	DentaQuest
	Select the frequency the plan reports changes in beneficiary circumstances to the state.	Daily
		MCNA of Louisiana
		Daily

Topic XI: ILOS

If ILOSs are authorized for this program, report for each plan: if the plan offered any ILOS; if "Yes", which ILOS the plan offered; and utilization data for each ILOS offered. If the plan offered an ILOS during the reporting period but there was no utilization, check that the ILOS was offered but enter "0" for utilization.

Number	Indicator	Response
D4XI.1	ILOSs offered by plan Indicate whether this plan offered any ILOS to their enrollees.	DentaQuest Not answered, optional Not answered
		MCNA of Louisiana Not answered, optional Not answered

Topic XIII. Prior Authorization



Beginning June 2026, Indicators D1.XIII.1-15 must be completed. Submission of this data including partial reporting on some but not all plans, before June 2026 is optional; if you choose not to respond prior to June 2026, select “Not reporting data”.

Number	Indicator	Response
N/A	Are you reporting data prior to June 2026? If “Yes”, please complete the following questions under each plan.	Yes

Topic XIV. Patient Access API Usage



Beginning June 2026, Indicators D1.XIV.1-2 must be completed. Submission of this data before June 2026 is optional; if you choose not to respond prior to June 2026, select “Not reporting data”.

Number	Indicator	Response
N/A	<p>Are you reporting data prior to June 2026?</p> <p>If “Yes”, please complete the following questions under each plan.</p>	Yes

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

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

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

Section F: Notes

Notes

Use this section to optionally add more context about your submission. If you choose not to respond, proceed to "Review & submit."

Number	Indicator	Response
F1	Notes (optional)	For D1.X.9d: Plan overpayment reporting to the state: Corresponding premium revenue we enter \$0 because LDH PI does not have information on the MCE's premium revenue as defined in MLR reporting under 438.8(f)(2).