MCNA Insurance Company

Response to RFP 3290: Dental Benefits Administrator

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

mcnadental

Foreword

About the Cover

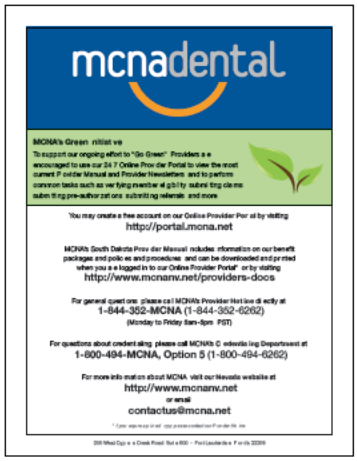
As a national enterprise, we at MCNA Insurance Company are privileged to experience the beauty and diversity of the states we serve. Our sense of pride as Americans is captured in the state specific artwork we incorporate into our RFP responses and member oriented materials. The hand-drawn cover of this RFP response reflects our appreciation of the Nevada landscape and the joy it must bring to the State's residents and visitors.

Going Green

MCNA shares Nevada's commitment to reduce solid waste and to further recycling efforts. Our response is printed double-sided on recycled paper, does not include pages of unnecessary advertising, and is presented in a reusable binder in accordance with Amendment 2 of the RFP.

Our corporate strategy focuses on using technology to reduce reliance on printed materials. MCNA's Provider and Member Portals provide downloadable content for key materials. We encourage our customers to only request printed materials as needed.

For example, our "Go Green" flyer for providers contains instructions on how to electronically access MCNA's Provider Portal, Provider Manual, forms, guides, and other pertinent information.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MCNA's Green nitiat ve

To support our ongoing effort to "Go Green" Providers a e encouraged to use our 24 7 Online Prov der Portal to view the most current P ovider Manual and Provider Newsletters and to perform common tasks such as ver fying member el gibil ty submi ting claims subm tting pre-author zat ons submitting referrals and more

You may create a free account on our Online Provider Por al by visiting
http://portal.mcna.net

MCNA's South Dakota Prov der Manual ncludes nformation on our benefit packages and polic es and procedures and can be downloaded and pr nted when you a e logged in to our Online Provider Portal* or by visiting
http://www.mcnanv.net/providers-docs

For general quest ons please ca l MCNA's Provider Hot line di ectly at
1-844-352-MCNA (1-844-352-6262)
(Monday to Friday 8am-6pm PST)

For questions about credent aling please call MCNA's C edentialing Department at
1-800-494-MCNA, Option 5 (1-800-494-6262)

For more info mat on about MCNA visit our Nevada website at
http://www.mcnanv.net
or email
contactus@mcna.net

* If you sign up or at any p ovider contact or P ovider Ph ne

300 West Cypr s Creek Road Suit e 600 – Fort Lauderdale F or da 33309

Section 1: State Documents [§9.2.1]

Title Page [§9.2.1.1(A)]

RFP Title:	Dental Benefits Administrator
RFP:	3290
Vendor Name:	MCNA Insurance Company
Address:	4400 NW Loop 410, Suite 250 San Antonio, TX 78229
Proposal Opening Date:	December 15, 2016
Proposal Opening Time:	2:00 PM

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Amendment Signature Pages [§9.2.1.1(C)(1)]

Amendment 1 Signature Page

Amend 1 quest 63.xlsx

ALL ELSE REMAINS THE SAME FOR RFP 3290.

Vendor must sign and return this amendment with proposal submitted.

Vendor Name: MCNA Insurance Company

Authorized Signature:

Title: Senior Vice President and General Counsel Date: November 30, 2016

This document must be submitted in the "State Documents" section/tab of vendors' technical proposal.

Amendment 1 *RFP 3290* *Page 11 of 11*

Amendment 2 Signature Page

ALL ELSE REMAINS THE SAME FOR RFP 3290.

Vendor must sign and return this amendment with proposal submitted.

Vendor Name: MCNA Insurance Company

Authorized Signature:

Title: Senior Vice President and General Counsel Date: December 2, 2016

This document must be submitted in the "State Documents" section/tab of vendors' technical proposal.

Amendment 3 Signature Page

State of Nevada
Department of Administration
Purchasing Division
515 E. Musser Street, Suite 300
Carson City, NV 89701

Brian Sandoval
Governor

Jeffrey Haag
Administrator

SUBJECT:	Amendment 3 to Request for Proposal 3290
RFP TITLE:	Dental Benefits Administrator
DATE OF AMENDMENT:	December 6, 2016
DATE OF RFP RELEASE:	November 7, 2016
OPENING DATE:	December 15, 2016
OPENING TIME:	2:00 PM
CONTACT:	Ronda Miller, Procurement Staff Member

The following shall be a part of RFP ***3290.*** If a vendor has already returned a proposal and any of the information provided below changes that proposal, please submit the changes along with this amendment. You need not re-submit an entire proposal prior to the opening date and time.

1. Can you provide more detail about the basis for the trend assumption in the cost of care build, in particular the 0% utilization trend assumption on the Expansion population?

   For the Expansion population, utilization trends were chosen to be generally lower than TANF and Check-Up. It is expected that the Expansion population cost trends will reflect larger management impacts relative to the base period data since the transition to managed care is relatively recent.

ALL ELSE REMAINS THE SAME FOR RFP 3290.

Vendor must sign and return this amendment with proposal submitted.

Vendor Name: MCNA Insurance Company

Authorized Signature:

Title: Senior Vice President and General Counsel Date: December 7, 2016

This document must be submitted in the "State Documents" section/tab of vendors' technical proposal.

Amendment 3 *RFP 3290* *Page 1 of 1*

Attachment A [§9.2.1.1(C)(2)]

Attachment A [Page 1 of 2]

ATTACHMENT A – CONFIDENTIALITY AND CERTIFICATION OF INDEMNIFICATION

Submitted proposals, which are marked "confidential" in their entirety, or those in which a significant portion of the submitted proposal is marked "confidential" **will not** be accepted by the State of Nevada. Pursuant to NRS 333.333, only specific parts of the proposal may be labeled a "trade secret" as defined in NRS 600A.030(5). All proposals are confidential until the contract is awarded; at which time, both successful and unsuccessful vendors' technical and cost proposals become public information.

In accordance with the Submittal Instructions of this RFP, vendors are requested to submit confidential information in separate binders marked "**Part I B Confidential Technical**" and "**Part III Confidential Financial**".

The State will not be responsible for any information contained within the proposal. Should vendors not comply with the labeling and packing requirements, proposals will be released as submitted. In the event a governing board acts as the final authority, there may be public discussion regarding the submitted proposals that will be in an open meeting format, the proposals will remain confidential.

By signing below, I understand it is my responsibility as the vendor to act in protection of the labeled information and agree to defend and indemnify the State of Nevada for honoring such designation. I duly realize failure to so act will constitute a complete waiver and all submitted information will become public information; additionally, failure to label any information that is released by the State shall constitute a complete waiver of any and all claims for damages caused by the release of the information.

This proposal contains Confidential Information, Trade Secrets and/or Proprietary information as defined in ***Section 2 "ACRONYMS/DEFINITIONS."***

Please initial the appropriate response in the boxes below and provide the justification for confidential status.

Part IB – Confidential Technical Information (Sections 1 through 5 of our RFP response, per instructions in Section 9 of this RFP.)			
YES		NO	
Justification for Confidential Status			
MCNA's response to this RFP contains proprietary trade secret information in the form of a compilation, pattern, method, technique, or process that derives economic value to the company and is not generally known or readily ascertainable by the general public. Accordingly, MCNA asserts Trade Secret protection over the content of this RFP response marked Trade Secret pursuant to NRS 333.333 and other applicable Nevada laws.			

A Public Records CD or Flash Drive has been included for the Technical and Cost Proposal			
YES		NO (See note below)	
Note: By marking "NO" for Public Record CD or Flash Drive included, you are authorizing the State to use the "Master CD or Flash Drive" for Public Records requests.			

Part III – Confidential Financial Information (Section 6 of our RFP response, per instructions in Section 9 of this RFP.)			
YES		NO	
Justification for Confidential Status			
MCNA's financial information is confidential and non-public and should be protected from competitors, pursuant to NRS 333.333 and other applicable Nevada laws.			

Dental Benefits Administrator *RFP 3290* *Page 176 of 196*

Attachment A [Page 2 of 2]

MCNA Insurance Company
Company Name

Signature

Carlos Lacasa
Print Name

November 30, 2016
Date

This document must be submitted in Tab IV of vendor's technical proposal
(Per the instructions in Section 9 of this RFP, this document is being submitted in Section 1 of our response.)

Attachment B [§9.2.1.1(C)(3, 4, 5, 6, 7)]

ATTACHMENT B – TECHNICAL PROPOSAL CERTIFICATION OF COMPLIANCE WITH TERMS AND CONDITIONS OF RFP

I have read, understand and agree to comply with ***all*** the terms and conditions specified in this Request for Proposal.

YES _____ I agree to comply with the terms and conditions specified in this RFP.

NO _____ I do not agree to comply with the terms and conditions specified in this RFP.

If the exception and/or assumption require a change in the terms in any section of the RFP, the contract, or any incorporated documents, vendors ***must*** provide the specific language that is being proposed in the tables below. If vendors do not specify in detail any exceptions and/or assumptions at time of proposal submission, the State will not consider any additional exceptions and/or assumptions during negotiations.

MCNA Insurance Company
Company Name

Signature

Carlos Lacasa
Print Name

November 30, 2016
Date

Vendors MUST use the following format. Attach additional sheets if necessary.

EXCEPTION SUMMARY FORM

EXCEPTION #	RFP SECTION NUMBER	RFP PAGE NUMBER	EXCEPTION (Complete detail regarding exceptions must be identified)
None			

ASSUMPTION SUMMARY FORM

ASSUMPTION #	RFP SECTION NUMBER	RFP PAGE NUMBER	ASSUMPTION (Complete detail regarding assumptions must be identified)
None			

This document must be submitted in Tab V of vendor's technical proposal
(Per the instructions in Section 9 of this RFP, this document is being submitted in Section 1 of our response.)

Dental Benefits Administrator *RFP 3290* *Page 178 of 196*

Attachment C [§9.2.1.1(D)]

ATTACHMENT C – VENDOR CERTIFICATIONS

Vendor agrees and will comply with the following:

(1) Any and all prices that may be charged under the terms of the contract do not and will not violate any existing federal, State or municipal laws or regulations concerning discrimination and/or price fixing. The vendor agrees to indemnify, exonerate and hold the State harmless from liability for any such violation now and throughout the term of the contract.

(2) All proposed capabilities can be demonstrated by the vendor.

(3) The price(s) and amount of this proposal have been arrived at independently and without consultation, communication, agreement or disclosure with or to any other contractor, vendor or potential vendor.

(4) All proposal terms, including prices, will remain in effect for a minimum of 180 days after the proposal due date. In the case of the awarded vendor, all proposal terms, including prices, will remain in effect throughout the contract negotiation process.

(5) No attempt has been made at any time to induce any firm or person to refrain from proposing or to submit a proposal higher than this proposal, or to submit any intentionally high or noncompetitive proposal. All proposals must be made in good faith and without collusion.

(6) All conditions and provisions of this RFP are deemed to be accepted by the vendor and incorporated by reference in the proposal, except such conditions and provisions that the vendor expressly excludes in the proposal. Any exclusion must be in writing and included in the proposal at the time of submission.

(7) Each vendor must disclose any existing or potential conflict of interest relative to the performance of the contractual services resulting from this RFP. Any such relationship that might be perceived or represented as a conflict should be disclosed. By submitting a proposal in response to this RFP, vendors affirm that they have not given, nor intend to give at any time hereafter, any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant or any employee or representative of same, in connection with this procurement. Any attempt to intentionally or unintentionally conceal or obfuscate a conflict of interest will automatically result in the disqualification of a vendor's proposal. An award will not be made where a conflict of interest exists. The State will determine whether a conflict of interest exists and whether it may reflect negatively on the State's selection of a vendor. The State reserves the right to disqualify any vendor on the grounds of actual or apparent conflict of interest.

(8) All employees assigned to the project are authorized to work in this country.

(9) The company has a written equal opportunity policy that does not discriminate in employment practices with regard to race, color, national origin, physical condition, creed, religion, age, sex, marital status, sexual orientation, developmental disability or handicap.

(10) The company has a written policy regarding compliance for maintaining a drug-free workplace.

(11) Vendor understands and acknowledges that the representations within their proposal are material and important, and will be relied on by the State in evaluation of the proposal. Any vendor misrepresentations shall be treated as fraudulent concealment from the State of the true facts relating to the proposal.

(12) Vendor must certify that any and all subcontractors comply with Sections 7, 8, 9, and 10, above.

(13) The proposal must be signed by the individual(s) legally authorized to bind the vendor per NRS 333.337.

MCNA Insurance Company
Vendor Company Name

Vendor Signature

Carlos Lacasa — **November 30, 2016**
Print Name — Date

This document must be submitted in Tab IV of vendor's technical proposal
(Per the instructions in Section 9 of this RFP, this document is being submitted in Section 1 of our response.)

Dental Benefits Administrator *RFP 3290* *Page 179 of 196*

Attachment J

ATTACHMENT J – CERTIFICATION REGARDING LOBBYING

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all sub awards at all tiers (including subcontracts, sub grants, and contracts under grants, loans, and cooperative agreements) and that all sub recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

By: _____ 11/30/2016
Signature of Official Authorized to Sign Application — Date

For: MCNA Insurance Company
Vendor Name

RFP # 3290 – Dental Benefits Administrator
Project Title

This document must be submitted in Tab IV of vendor's technical proposal
(This document is being submitted in Section 1 of our response, since no specific direction appeared in the RFP.)

Section 2: Company Information [§9.3]

Vendor Information [§9.3.1]

Vendor Information Sheet for RFP 3290 [$9.3.1]

VENDOR INFORMATION SHEET FOR RFP 3290

Vendor Must:

A) Provide all requested information in the space provided next to each numbered question. The information provided in Sections V1 through V6 will be used for development of the contract;

B) Type or print responses; and

C) Include this Vendor Information Sheet in Tab III of the Technical Proposal.

V1	Company Name	MCNA Insurance Company

V2	Street Address	4400 NW Loop 410, Suite 250

V3	City, State, ZIP	San Antonio, TX 78229

V4	Telephone Number		
	Area Code: 954	Number: 730-7131	Extension:

V5	Facsimile Number		
	Area Code: 954	Number: 628-3337	Extension:

V6	Toll Free Number		
	Area Code: 800	Number: 494-6262	Extension:

V7	***Contact Person for Questions / Contract Negotiations, including address if different than above***
	Name: Carlos A. Lacasa
	Title: Senior Vice President and General Counsel
	Address: 200 West Cypress Creek Road, Suite 500, Fort Lauderdale, FL 33309
	Email Address: clacasa@mcna.net

V8	Telephone Number for Contact Person		
	Area Code: 954	Number: 730-7131	Extension: 163

V9	Facsimile Number for Contact Person		
	Area Code: 954	Number: 628-3337	Extension:

V10	***Name of Individual Authorized to Bind the Organization***	
	Name: Carlos A. Lacasa	Title: Senior VP and General Counsel

V11	Signature ***(Individual must be legally authorized to bind the vendor per NRS 333.337)***	
	Signature:	Date: 11/30/2016

Dental Benefits Administrator *RFP 3290* *Page 2 of 196*

Company Profile [§4.1.1]

Question	Response
Company name:	MCNA Insurance Company
Ownership (sole proprietor, partnership, etc.):	Corporation
State of incorporation:	Texas
Date of incorporation:	May 4, 2011
# of years in business:	5
List of top officers:	Dr. Jeffrey P. Feingold, *Chairman of the Board and Chief Executive Officer* Albert Hawkins, *Vice Chairman of the Board* Governor Rick Perry, *Director* Glen Feingold, *Executive Vice President and Chief Operating Officer, Director* Carlos Lacasa, JD, *Senior Vice President and General Counsel, Director* Daniel Salama, BSE, *Chief Information and Security Officer* Edward Strongin, CPA, *Chief Financial Officer* Mayre Thompson, MHA, *Chief Compliance and Privacy Officer* Dr. Ronald Ruth, *Chief Dental Officer* Dr. Philip Hunke, *Plan President* [redacted] Shannon Turner, JD, *Vice President of Operations*
Location of company headquarters:	San Antonio, Texas
Location(s) of the company offices:	Fort Lauderdale, Florida; San Antonio, Texas; New Orleans, Louisiana; and Las Vegas, Nevada
Location(s) of the office that will provide the services described in this RFP:	Las Vegas, Nevada; San Antonio, Texas; and Fort Lauderdale, Florida

Number of employees locally with the expertise to support the requirements identified in this RFP:	15
Number of employees nationally with the expertise to support the requirements in this RFP:	356
Location(s) from which employees will be assigned for this project:	Las Vegas, Nevada; San Antonio, Texas; and Fort Lauderdale, Florida

Corporate Registration and License [§9.3.1.1 - §9.3.1.3, §4.1.2 - §4.1.4]

Question	Response
Nevada Business License Number:	Our Nevada Certificate of Authority (#134396) issued by the Nevada Department of Business & Industry, Division of Insurance, to transact the business of insurance satisfies the requirement for corporate registration as a foreign insurer. A copy of the license is included in the Response to Scope of Work in Section 3 of this response. MCNA Insurance Company is qualified by the Nevada Secretary of State to transact business in the State of Nevada (Certificate # C20161130-0744). Please see a copy of MCNA's Foreign Corporate Qualification on the following page.
Legal Entity Name:	MCNA Insurance Company

Is "Legal Entity Name" the same name as vendor is doing business as?

Yes	YES	No	

MCNA's Foreign Corporate Qualification

SECRETARY OF STATE

STATE OF NEVADA

FOREIGN CORPORATE QUALIFICATION

I, BARBARA K. CEGAVSKE, the duly elected and qualified Nevada Secretary of State, do hereby certify that **MCNA INSURANCE COMPANY** did on November 29, 2016 file in this office a Foreign Qualification in this State and is now on file and of record in the office of the Nevada Secretary of State, and that further, that said Corporation is at the date of this Certificate duly qualified to exercise therein all the powers recited in its Foreign Qualification and to transact business in the State of Nevada in accordance with the laws governing Corporations in said State.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the Great Seal of State, at my office on November 30, 2016.

Barbara K. Cegavske

BARBARA K. CEGAVSKE
Secretary of State

Certified By: G Ramos
Certificate Number: C20161130-0744
You may verify this certificate online at **http://www.nvsos.gov/**

Employee and Contract Disclosures [§9.3.1.4]

State of Nevada Contract Disclosure [§4.1.5]

Has the vendor ever been engaged under contract by any State of Nevada agency?

Yes		No	NO

State of Nevada Employee Disclosure [§4.1.6]

Are you now or have you been within the last two (2) years an employee of the State of Nevada, or any of its agencies, departments, or divisions?

Yes		No	NO

[redacted]

Contract Failures, Breaches, and Litigation Disclosure [§4.1.7]

Disclosure of any significant prior or ongoing contract failures, contract breaches, civil or criminal litigation in which the vendor has been alleged to be liable or held liable in a matter involving a contract with the State of Nevada or any other governmental entity. Any pending claim or litigation occurring within the past six (6) years which may adversely affect the vendor's ability to perform or fulfill its obligations if a contract is awarded as a result of this RFP must also be disclosed.

Does any of the above apply to your company?

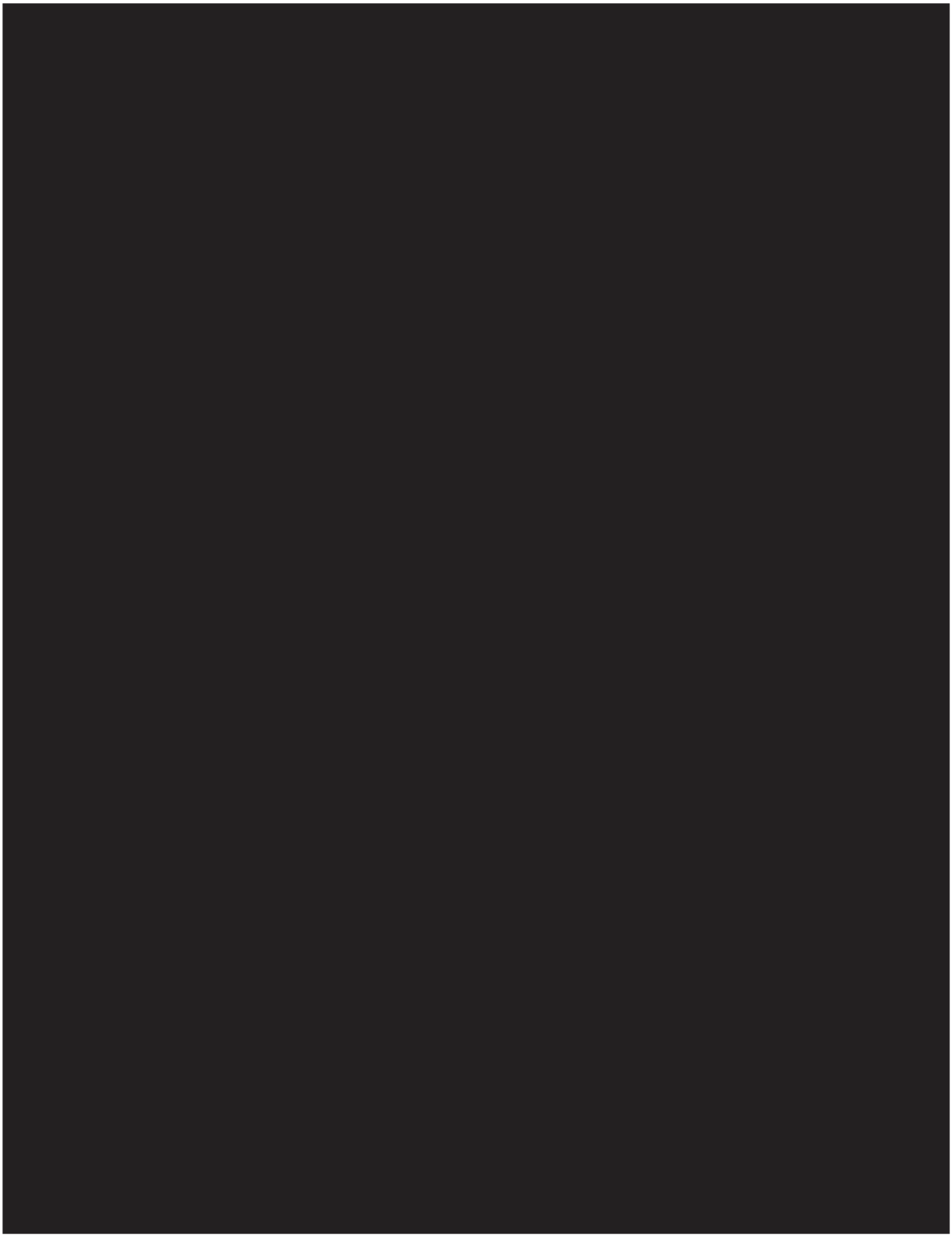
Yes		No	NO

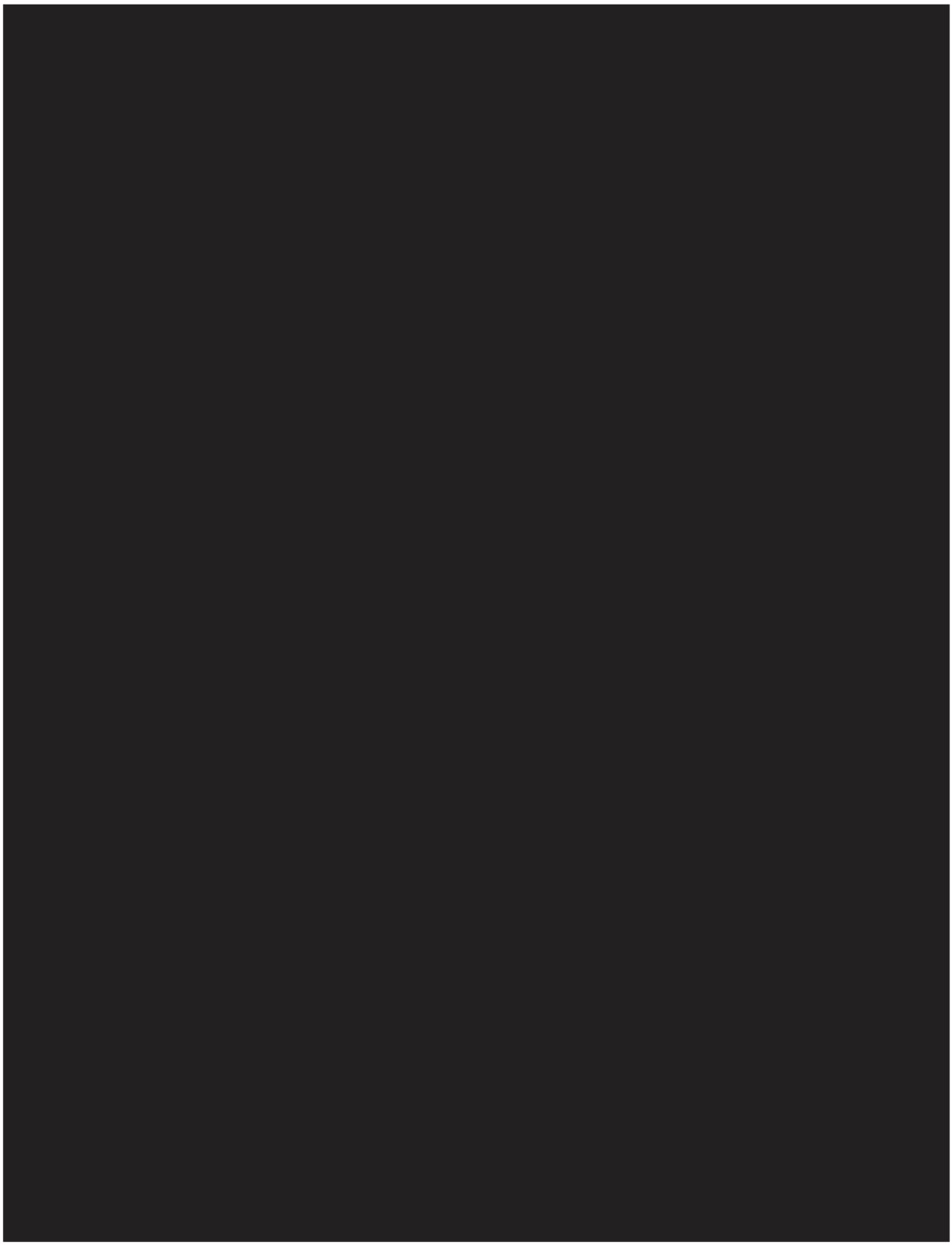
Insurance Requirements [§9.3.1.5, §4.1.8]

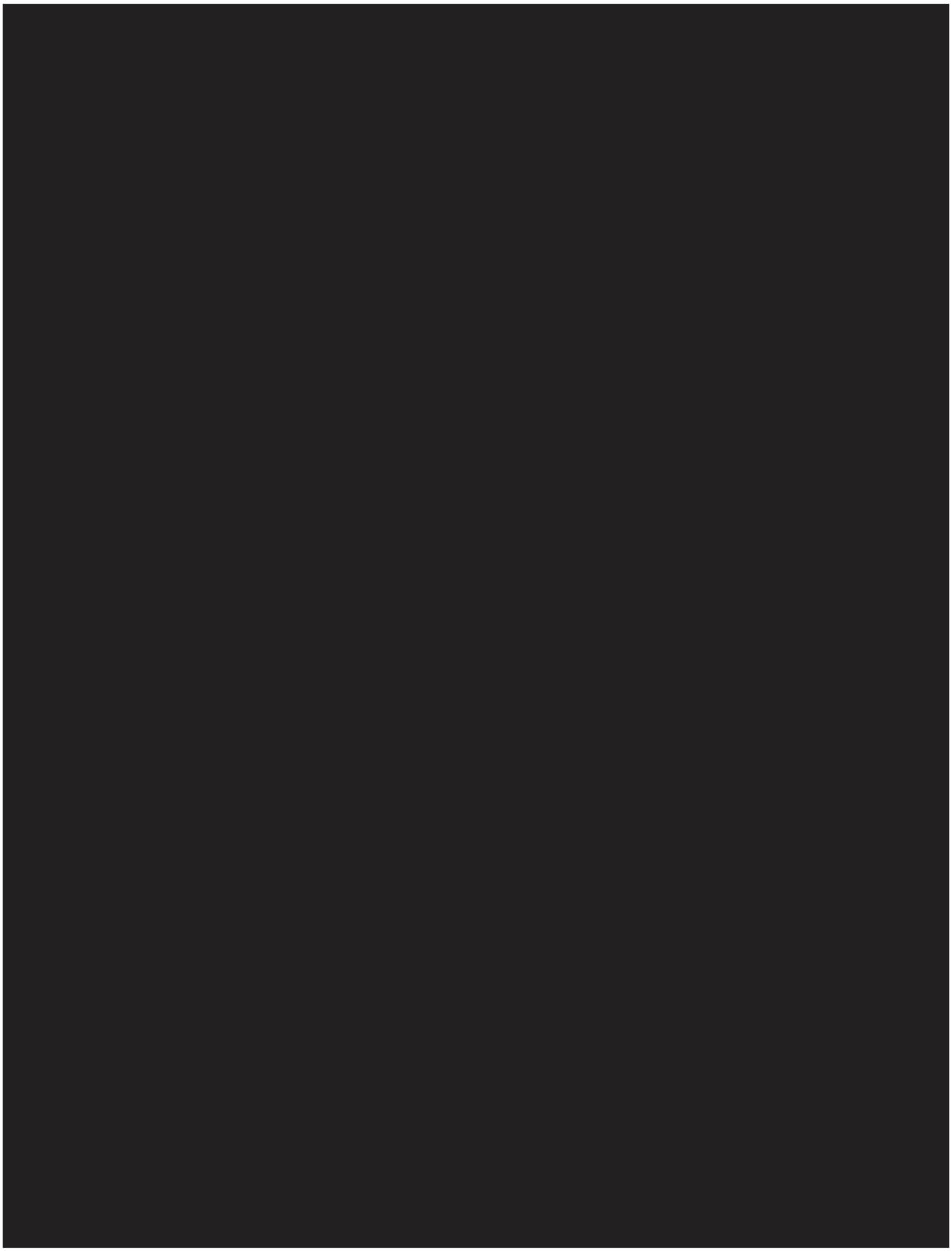
Vendors must review the insurance requirements specified in ***Attachment E, Insurance Schedule for RFP 3290.*** Does your organization currently have or will your organization be able to provide the insurance requirements as specified in ***Attachment E***?

Yes	YES	No	

MCNA's insurance policy meets or exceeds all insurance requirements specified in ***Attachment E, Insurance Schedule***. Please see the following Certificate of Liability Insurance and signed Attachment E.







Attachment E: Insurance Schedule [Page 1 of 4]

ATTACHMENT E
INSURANCE SCHEDULE

INDEMNIFICATION CLAUSE:

Contractor shall indemnify, hold harmless and, not excluding the State's right to participate, defend the State, its officers, officials, agents, and employees (hereinafter referred to as "Indemnitee") from and against all liabilities, claims, actions, damages, losses, and expenses including without limitation reasonable attorneys' fees and costs, (hereinafter referred to collectively as "claims") for bodily injury or personal injury including death, or loss or damage to tangible or intangible property caused, or alleged to be caused, in whole or in part, by the negligent or willful acts or omissions of Contractor or any of its owners, officers, directors, agents, employees or subcontractors. This indemnity includes any claim or amount arising out of or recovered under the Workers' Compensation Law or arising out of the failure of such contractor to conform to any federal, state or local law, statute, ordinance, rule, regulation or court decree. It is the specific intention of the parties that the Indemnitee shall, in all instances, except for claims arising solely from the negligent or willful acts or omissions of the Indemnitee, be indemnified by Contractor from and against any and all claims. It is agreed that Contractor will be responsible for primary loss investigation, defense and judgment costs where this indemnification is applicable. In consideration of the award of this contract, the Contractor agrees to waive all rights of subrogation against the State, its officers, officials, agents and employees for losses arising from the work performed by the Contractor for the State.

INSURANCE REQUIREMENTS:

Contractor and subcontractors shall procure and maintain until all of their obligations have been discharged, including any warranty periods under this Contract are satisfied, insurance against claims for injury to persons or damage to property which may arise from or in connection with the performance of the work hereunder by the Contractor, his agents, representatives, employees or subcontractors.

The insurance requirements herein are minimum requirements for this Contract and in no way limit the indemnity covenants contained in this Contract. The State in no way warrants that the minimum limits contained herein are sufficient to protect the Contractor from liabilities that might arise out of the performance of the work under this contract by the Contractor, his agents, representatives, employees or subcontractors and Contractor is free to purchase additional insurance as may be determined necessary.

A. **MINIMUM SCOPE AND LIMITS OF INSURANCE:** Contractor shall provide coverage with limits of liability not less than those stated below. An excess liability policy or umbrella liability policy may be used to meet the minimum liability requirements provided that the coverage is written on a "following form" basis.

1. **Commercial General Liability – Occurrence Form**
   Policy shall include bodily injury, property damage and broad form contractual liability coverage.
   - General Aggregate $5,000,000
   - Products – Completed Operations Aggregate Waived
   - Personal and Advertising Injury Waived
   - Each Occurrence $2,000,000

   a. The policy shall be endorsed to include the following additional insured language: "The State of Nevada shall be named as an additional insured with respect to liability arising out of the activities performed by, or on behalf of the Contractor".

2. **Automobile Liability - can be waived if contract does not involve use of motor vehicle.**

   Bodily Injury and Property Damage for any owned, hired, and non-owned vehicles used in the performance of this Contract.

   Combined Single Limit (CSL) Waived

Attachment E: Insurance Schedule [Page 2 of 4]

a. The policy shall be endorsed to include the following additional insured language: "The State of Nevada shall be named as an additional insured with respect to liability arising out of the activities performed by, or on behalf of the Contractor, including automobiles owned, leased, hired or borrowed by the Contractor".

3. **Worker's Compensation and Employers' Liability**

Workers' Compensation	Statutory
Employers' Liability	
Each Accident	$100,000
Disease – Each Employee	$100,000
Disease – Policy Limit	$500,000

a. Policy shall contain a waiver of subrogation against the State of Nevada.

b. This requirement shall not apply when a contractor or subcontractor is exempt under N.R.S., **AND** when such contractor or subcontractor executes the appropriate sole proprietor waiver form.

3. Professional Liability/Errors and Omissions

The policy shall cover professional misconduct or wrongful act for those positions defined in the Scope of Services of this contract.

Each Claim	$5,000,000
Annual Aggregate	$5,000,000

a. The retroactive coverage date shall be no later than the effective date of this contract.
b. Contractor shall maintain an extended reporting period for not less than two (2) years after termination of this contract.

4. **Network Security(Cyber) and Privacy Liability**

Each Claim	$5,000,000
Annual Aggregate	$5,000,000

This errors and omissions insurance shall include coverage for third party claims and losses including with respect to network risks (such as data breaches, transmission of virus/malicious code; unauthorized access or criminal use of third party, ID/data theft) and invasion of privacy regardless of the type of media involved in the loss of private information (such as computers, paper files and records, or voice recorded tapes), covering collection, use, access, etc. of personally identifiable information., direct liability, as well as contractual liability for violation of privacy policy, civil suits and sublimit for regulatory defense/indemnity for payment of fines and penalties.

a. The retroactive coverage date shall be no later than the effective date of this contract.
b. Contractor shall maintain an extended reporting period for not less than two (2) years after termination of this contract.

5. Fidelity Bond or Crime Insurance

Bond or Policy Limit $1 Million

a. The bond or policy shall include coverage for all directors, officers, agents and employees of the Contractor.

b. The bond or policy shall include coverage for third party fidelity and name the State of Nevada as loss payee.

c. The bond or policy shall include coverage for extended theft and mysterious disappearance.

Attachment E: Insurance Schedule [Page 3 of 4]

d. The bond or policy shall not contain a condition requiring an arrest and conviction.

e. Policies shall be endorsed to provide coverage for computer crime/fraud.

6. Performance Security

Amount required: **$4,000,000 in accordance with the requirements in Section 3.11.2 of RFP 3290.**

1) Security may be in the form of a certified check, cashier's check, Certificate of Deposit or Treasury Note or bond furnished by a surety company authorized to do business in this state. Note payable to the State of Nevada, only;
2) Vendors submitting performance security to the State of Nevada in the form a surety bond must utilize a company that meets the below listed requirements:
   - A.M. Best A-VII rated insurance company
   - Certified by the Department of Treasury, Financial Management Services for Nevada
   - Licensed by the Nevada Department of Business and Industry, Insurance Division.
3) The security shall be deposited with the contracting State agency no later than ten (10) working days following award of the Contract to Contractor.

Upon successful Contract completion, the security and all interest earned, if any, shall be returned to the Contractor

B. **ADDITIONAL INSURANCE REQUIREMENTS:** The policies shall include, or be endorsed to include, the following provisions:

1. On insurance policies where the State of Nevada is named as an additional insured, the State of Nevada shall be an additional insured to the full limits of liability purchased by the Contractor even if those limits of liability are in excess of those required by this Contract.
2 The Contractor's insurance coverage shall be primary insurance and non-contributory with respect to all other available sources.

C. **NOTICE OF CANCELLATION:** Each insurance policy required by the insurance provisions of this Contract shall provide the required coverage and shall not be suspended, voided or canceled except after thirty (30) days prior written notice has been given to the State, except when cancellation is for non-payment of premium, then ten (10) days prior notice may be given. Such notice shall be sent directly to **Division of Health Care Financing and Policy, Attn: Tammy Ritter, 1100 East William Street, Suite 101, Carson City, NV 89701.**

D. **ACCEPTABILITY OF INSURERS:** Insurance is to be placed with insurers duly licensed or authorized to do business in the state of Nevada and with an "A.M. Best" rating of not less than A- VII. The State in no way warrants that the above-required minimum insurer rating is sufficient to protect the Contractor from potential insurer insolvency.

E. **VERIFICATION OF COVERAGE:** Contractor shall furnish the State with certificates of insurance (ACORD form or equivalent approved by the State) as required by this Contract. The certificates for each insurance policy are to be signed by a person authorized by that insurer to bind coverage on its behalf.

All certificates and any required endorsements are to be received and approved by the State before work commences. Each insurance policy required by this Contract must be in effect at or prior to commencement of work under this Contract and remain in effect for the duration of the project. Failure to maintain the insurance policies as required by this Contract or to provide evidence of renewal is a material breach of contract.

All certificates required by this Contract shall be sent directly to **Division of Health Care Financing and Policy, Attn: Tammy Ritter, 1100 East William Street, Suite 101, Carson City, NV 89701.** The

Attachment E: Insurance Schedule [Page 4 of 4]

State project/contract number and project description shall be noted on the certificate of insurance. The State reserves the right to require complete, certified copies of all insurance policies required by this Contract at any time. **DO NOT SEND CERTIFICATES OF INSURANCE TO THE STATES RISK MANAGEMENT DIVISION.**

F. **SUBCONTRACTORS:** Contractors' certificate(s) shall include all subcontractors as additional insureds under its policies **or** Contractor shall furnish to the State separate certificates and endorsements for each subcontractor. All coverages for subcontractors shall be subject to the minimum requirements identified above.

G. **APPROVAL:** Any modification or variation from the insurance requirements in this Contract shall be made by the Attorney General's Office or the Risk Manager, whose decision shall be final. Such action will not require a formal Contract amendment, but may be made by administrative action.

MCNA Insurance Company

By: November 30, 2016 Senior Vice President and General Counsel

Independent Contractor's Signature Date Title

Signature – State of Nevada Date Title

Business References [§9.3.1.6, §4.3]

Business Reference 1: Texas Health and Human Services Commission

Reference #:	1		
Company Name:	MCNA Insurance Company		
Identify role company will have for this RFP project (Check appropriate role below):			
X	***VENDOR***		***SUBCONTRACTOR***
Project Name:	Texas Health and Human Services Commission (HHSC)		
Primary Contact Information			
Name:	[redacted]		
Street Address:	[redacted]		
City, State, Zip:	[redacted]		
Phone, including area code:	[redacted]		
Facsimile, including area code:	[redacted]		
Email address:	[redacted]		
Alternate Contact Information			
Name:	[redacted]		
Street Address:	[redacted]		
City, State, Zip:	[redacted]		
Phone, including area code:	[redacted]		
Facsimile, including area code:	[redacted]		
Email address:	[redacted]		
Project Information			
Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	In 2011, MCNA was awarded a contract with the Texas Health and Human Services Commission to administer a full spectrum of dental care, including diagnostic, preventive, restorative, endodontic, periodontic, orthodontic, and oral and maxillofacial surgery services to children statewide in the Texas Medicaid and CHIP programs on a full-risk basis. The operational phase of the contract commenced on March 1, 2012, and we currently serve approximately 1.5 million members.		
Original Project/Contract Start Date:	March 1, 2012		
Original Project/Contract End Date:	February 28, 2015 with up to five additional one-year extensions.		

Original Project/Contract Value:	Annual premium volume is approximately $625,000,000.
Final Project/Contract Date:	Through February 28, 2019 (an additional one-year extension option remains).
Was project/contract completed in time originally allotted, and if not, why not?	Yes, the contract began on-time and is still active.
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	Yes

Business Reference 2: Louisiana Department of Health

Reference #:	2		
Company Name:	MCNA Insurance Company		
Identify role company will have for this RFP project (Check appropriate role below):			
X	***VENDOR***		***SUBCONTRACTOR***
Project Name:	Louisiana Department of Health (LDH)		
Primary Contact Information			
Name:	[redacted]		
Street Address:	[redacted]		
City, State, Zip:	[redacted]		
Phone, including area code:	[redacted]		
Facsimile, including area code:	[redacted]		
Email address:	[redacted]		
Alternate Contact Information			
Name:	[redacted]		
Street Address:	[redacted]		
City, State, Zip:	[redacted]		
Phone, including area code:	[redacted]		
Facsimile, including area code:	[redacted]		
Email address:	[redacted]		
Project Information			

Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	MCNA was awarded the Dental Benefit Program Manager (DBPM) contract for Louisiana Medicaid and CHIP as the sole vendor. Under the program, MCNA administers on a full-risk basis dental benefits for approximately 1.45 million children and adults. The operational phase of the contract commenced on July 1, 2014.
Original Project/Contract Start Date:	July 1, 2014
Original Project/Contract End Date:	June 30, 2017 with up to two additional one-year extensions.
Original Project/Contract Value:	Annual premium volume is approximately $168,000,000.
Final Project/Contract Date:	Through June 30, 2017 (two one-year extension options remain).
Was project/contract completed in time originally allotted, and if not, why not?	Yes, the contract began on-time and is still active.
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	Yes

Business Reference 3: Iowa Medicaid Enterprise

Reference #:	3		
Company Name:	MCNA Insurance Company		
Identify role company will have for this RFP project (Check appropriate role below):			
X	***VENDOR***		***SUBCONTRACTOR***
Project Name:	Iowa Medicaid Enterprise (IME)		
Primary Contact Information			
Name:	[redacted]		
Street Address:	[redacted]		
City, State, Zip:	[redacted]		
Phone, including area code:	[redacted]		
Facsimile, including area code:	[redacted]		
Email address:	[redacted]		
Alternate Contact Information			
Name:	[redacted]		

Street Address:	[redacted]
City, State, Zip:	[redacted]
Phone, including area code:	[redacted]
Facsimile, including area code:	[redacted]
Email address:	[redacted]
Project Information	
Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	MCNA administers a full spectrum of dental care, including diagnostic, preventive, restorative, endodontic, periodontic, and oral and maxillofacial surgery services statewide to approximately 13,000 Iowa Dental Wellness Plan members on a full-risk basis. This program is an adult Medicaid expansion plan utilizing a tiered benefit approach that allows members to earn additional benefits through timely receipt of preventive care.
Original Project/Contract Start Date:	July 1, 2016
Original Project/Contract End Date:	June 30, 2017 with up to one additional two-year extension.
Original Project/Contract Value:	Annual premium volume is approximately $4,000,000.
Final Project/Contract Date:	Through June 30, 2017 (an additional two-year extension option remains).
Was project/contract completed in time originally allotted, and if not, why not?	Yes, the contract began on-time and is still active.
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	Yes

Vendor Staff Resumes [§9.3.1.7, §4.4]

Nevada is a priority to our organization, and as such, our most valuable resources will be dedicated to the success of this contract. Please find below a list of key management, customer service, and other personnel.

Name and Title	Contact Information
Jeffrey P. Feingold, DDS, MSD *Chairman and Chief Executive Officer*	**Phone:** 1-800-494-6262 x110 **Email:** DrFeingold@MCNA.net
Glen S. Feingold *Executive Vice President and Chief Operating Officer*	**Phone:** 1-800-494-6262 x111 **Email:** GFeingold@MCNA.net
Philip H. Hunke, DDS, MSD *Plan President*	**Phone:** 1-800-494-6262 x195 **Email:** DrHunke@MCNA.net
[redacted]	[redacted]
[redacted]	[redacted]
Carlos A. Lacasa, JD *Senior Vice President and General Counsel*	**Phone:** 1-800-494-6262 x163 **Email:** CLacasa@MCNA.net
Edward A. Strongin, CPA *Chief Financial Officer*	**Phone:** 1-800-494-6262 x189 **Email:** EStrongin@MCNA.net
Daniel Salama, BSE *Chief Information and Security Officer*	**Phone:** 1-800-494-6262 x180 **Email:** DSalama@MCNA.net
Mayre Thompson, MHA *Chief Compliance and Privacy Officer*	**Phone:** 1-800-494-6262 x164 **Email:** MHerring@MCNA.net
Shannon Turner, JD *Vice President of Operations*	**Phone:** 1-800-494-6262 x252 **Email:** STurner@MCNA.net
DeDe Davis *Vice President of Dental Management and Quality Improvement*	**Phone:** 1-800-494-6262 x361 **Email:** DeDavis@MCNA.net
Martha Abadilla *Associate Vice President of Administration and Operations*	**Phone:** 1-800-494-6262 x225 **Email:** MBailey@MCNA.net
Oteasa Townsend-Hardy, BHSA *Director of Quality Improvement and Risk Management*	**Phone:** 1-800-494-6262 x192 **Email:** OTownsendH@MCNA.net
Meghan Henkel, LPN *Director of Utilization Management and Case Management*	**Phone:** 1-800-494-6262 x125 **Email:** MHenkel@MCNA.net

Carol Raspa *Director of Claims Management*	**Phone:** 1-800-494-6262 x198 **Email:** CRaspa@MCNA.net
Diana Davis *Director of Grievances and Appeals*	**Phone:** 1-800-494-6262 x179 **Email:** DDavis@MCNA.net
René Canales *Director of Network Development*	**Phone:** 1-800-494-6262 x591 **Email:** RCanales@MCNA.net
Aldwin Gomez *Director of Call Center Operations*	**Phone:** 1-800-494-6262 x127 **Email:** AGomez@MCNA.net
Sophia Wallen *Director of Credentialing*	**Phone:** 1-800-494-6262 x103 **Email:** SWallen@MCNA.net
Jeanette Logan, MBA *Senior Manager of Client Services*	**Phone:** 1-800-494-6262 x544 **Email:** JLogan@MCNA.net

Please see **Attachment 2-1** for key staff resumes.

Subcontractor Information [§9.3.1.8, §4.2]

Does this proposal include the use of subcontractors?

Yes	YES	No	

MCNA Insurance Company is a Texas licensed and domiciled Accident and Health Insurance Company and has been authorized by the Nevada Department of Business and Industry, Division of Insurance, to transact the business of health insurance in the State as of September 23, 2016. The MCNA Organization was founded in Florida and is headquartered in Fort Lauderdale, with regional headquarters in San Antonio, Texas, and New Orleans, Louisiana. Our core business is delivering the **highest quality dental care** to traditionally underserved populations enrolled in Medicaid, CHIP, and Medicare programs. We manage dental benefits on a full-risk basis for **nearly 3,500,000 children and adults** throughout the nation.

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

The ultimate parent of **MCNA Insurance Company** (the bidder) is MCNA Health Care Holdings, LLC ("MCNA Holdings"), a Florida limited liability company. MCNA Holdings is also the parent company of our affiliate subcontractor, **Managed Care of North America, Inc., d/b/a MCNA Dental Plans**, a Florida corporation licensed as a pre-paid limited health services organization ("MCNA Dental Plans"). MCNA Dental Plans has operated as a multi-state dental insurance administrator since January 30, 1992.

Description of Subcontractor Relationship [§9.3.1.8(A,B)]

MCNA Insurance Company (MCNA) will comply with the requirements of the DHCFP contract by underwriting the cost of the dental benefits, ensuring all Provider Relations and Outreach responsibilities are fulfilled, engaging a team of general and specialty dentists to provide clinical review services, managing a robust network of general dentists and specialists, and overseeing our affiliated subcontractor who will provide additional administrative services.

Our affiliate, **Managed Care of North America, Inc.**, d/b/a MCNA Dental Plans, is contracted to provide administrative services to MCNA Insurance Company, including:

MCNA Insurance Company (the bidder) utilizes our affiliate subcontractor, MCNA Dental Plans, as our third party administrator for all current and planned business operations.

Subcontractor Oversight [§9.3.1.8(B,C,F)]

MCNA's subcontract contains rigorous performance standards designed to ensure compliance with DHCFP requirements. These performance standards will be monitored on a day-to-day basis by:

- Shannon Turner, Vice President of Operations.

MCNA Insurance Company's Plan President, Dr. Philip Hunke, and Vice President of Operations, Shannon Turner, are ultimately responsible for ensuring all performance standards are met. MCNA also oversees the subcontractor's performance through our Quality Improvement Committee process. The Quality Improvement Committee evaluates the subcontractor's ability to perform the activities to be delegated; monitors the subcontractor's performance on an ongoing basis; subjects the subcontractor to formal review on an annual basis; identifies deficiencies or areas for improvement; and takes corrective action as necessary.

MCNA's Nevada Quality Improvement Committee (QIC) is chartered by the Board of Directors. MCNA's executive leadership team, participating network providers, and department directors and managers are all active members of the QIC.

MCNA's Quality Improvement (QI) Department continuously monitors plan operations. Each of our plans has a dedicated Key Performance Indicator dashboard that tracks contract performance across a spectrum of measures including identified performance standards from this RFP:

- Network Access and Availability
- Call Center
- Grievances, Appeals, and State Fair Hearings
- Claims Processing
- Encounter Data
- Reporting
- Key Persons
- Prior Authorizations

- Quality Measures

This dashboard approach ensures rapid identification and escalation by our supervisory staff of any performance standard issues affecting our plans.

MCNA will not allow any subcontractor to commence work until all required insurance information is provided. Additionally, we will provide proof of payment to any subcontractors used for this contract upon request by the State, and we agree to notify the State via their choice of mail, email, or fax within five (5) business days of receipt of the request. MCNA will remain fully responsible for the obligations, services, and functions performed by our subcontractor to the same extent as if such obligations, services, and functions were performed by MCNA Insurance Company.

[redacted]

Subcontractor References [§4.3, §9.3.1.8(D,E)]

Business Reference 1: Florida Healthy Kids Corporation

Reference #:	1		
Company Name:	Managed Care of North America, Inc.		
Identify role company will have for this RFP project (Check appropriate role below):			
	VENDOR	X	***SUBCONTRACTOR***
Project Name:	Florida Healthy Kids Corporation (FHKC)		
Primary Contact Information			
Name:	[redacted]		
Street Address:	[redacted]		
City, State, Zip:	[redacted]		
Phone, including area code:	[redacted]		
Facsimile, including area code:	[redacted]		
Email address:	[redacted]		
Alternate Contact Information			
Name:	[redacted]		
Street Address:	[redacted]		
City, State, Zip:	[redacted]		
Phone, including area code:	[redacted]		
Facsimile, including area code:	[redacted]		
Email address:	[redacted]		
Project Information			
Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	MCNA Dental Plans is a full-risk contractor with the Florida Healthy Kids Corporation under a capitation arrangement. We currently serve approximately 70,000 Florida CHIP children statewide. We provide comprehensive dental benefits, including diagnostic, preventive, restorative, endodontic, periodontic, orthodontic, and oral and maxillofacial surgery services. Our initial contract began January 1, 2005, and has been continuously renewed through multiple procurements.		
Original Project/Contract Start Date:	January 1, 2005		
Original Project/Contract End Date:	June 30, 2018 with up to two additional one-year extensions.		

Original Project/Contract Value:	Annual premium volume is approximately $12,000,000.
Final Project/Contract Date:	Through June 30, 2018 (two one-year extension options remain)
Was project/contract completed in time originally allotted, and if not, why not?	Yes, the contract began on-time and is still active.
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	Yes

Business Reference 2: Aetna

Reference #:	2		
Company Name:	Managed Care of North America, Inc.		
Identify role company will have for this RFP project (Check appropriate role below):			
	VENDOR	X	***SUBCONTRACTOR***
Project Name:	Aetna		
Primary Contact Information			
Name:	[redacted]		
Street Address:	[redacted]		
City, State, Zip:	[redacted]		
Phone, including area code:	[redacted]		
Facsimile, including area code:	[redacted]		
Email address:	[redacted]		
Alternate Contact Information			
Name:	[redacted]		
Street Address:	[redacted]		
City, State, Zip:	[redacted]		
Phone, including area code:	[redacted]		
Facsimile, including area code:	[redacted]		
Email address:	[redacted]		
Project Information			

Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	[redacted]
Original Project/Contract Start Date:	[redacted]
Original Project/Contract End Date:	[redacted]
Original Project/Contract Value:	[redacted]
Final Project/Contract Date:	[redacted]
Was project/contract completed in time originally allotted, and if not, why not?	[redacted]
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	[redacted]

Business Reference 3: Community Care Plan (CCP)

Reference #:	3		
Company Name:	Managed Care of North America, Inc.		
Identify role company will have for this RFP project (Check appropriate role below):			
	VENDOR	X	***SUBCONTRACTOR***
Project Name:	Community Care Plan (CCP)		
Primary Contact Information			
Name:	[redacted]		
Street Address:	[redacted]		
City, State, Zip:	[redacted]		
Phone, including area code:	[redacted]		
Facsimile, including area code:	[redacted]		
Email address:	[redacted]		
Alternate Contact Information			
Name:	[redacted]		
Street Address:	[redacted]		
City, State, Zip:	[redacted]		
Phone, including area code:	[redacted]		

Facsimile, including area code:	[redacted]
Email address:	[redacted]
Project Information	
Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	[redacted]
Original Project/Contract Start Date:	[redacted]
Original Project/Contract End Date:	[redacted]
Original Project/Contract Value:	[redacted]
Final Project/Contract Date:	[redacted]
Was project/contract completed in time originally allotted, and if not, why not?	[redacted]
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	[redacted]

Subcontractor Company Profile [§4.2, §9.3.1.8(D)]

Question	Response
Company name:	Managed Care of North America, Inc.
Ownership (sole proprietor, partnership, etc.):	Corporation
State of incorporation:	Florida
Date of incorporation:	May 3, 1991
# of years in business:	25
List of top officers:	Dr. Jeffrey P. Feingold, *Chairman of the Board and Chief Executive Officer* Glen Feingold, *Executive Vice President and Chief Operating Officer, Director* Carlos Lacasa, JD, *Senior Vice President and General Counsel* Daniel Salama, BSE, *Chief Information and Security Officer* Edward Strongin, CPA, *Chief Financial Officer* Mayre Thompson, MHA, *Chief Compliance and Privacy Officer* Dr. Ronald Ruth, *Chief Dental Officer* DeDe Davis, *Vice President of Dental Management and Quality Improvement*
Location of company headquarters:	Fort Lauderdale, Florida
Location(s) of the company offices:	Fort Lauderdale, Florida
Location(s) of the office that will provide the services described in this RFP:	Fort Lauderdale, Florida
Number of employees locally with the expertise to support the requirements identified in this RFP:	0
Number of employees nationally with the expertise to support the requirements in this RFP:	198
Location(s) from which employees will be assigned for this project:	Fort Lauderdale, Florida

Section 3: Technical Proposal [§9.4]

Response to Scope of Work [§9.4.1]

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General [§3.1]

Corporate Structure

MCNA is the exclusive dental benefits administrator for the Louisiana and Idaho Medicaid and CHIP dental programs.

MCNA Insurance Company is a Texas licensed and domiciled Accident and Health Insurance Company and has been authorized by the Nevada Department of Business and Industry, Division of Insurance, to transact the business of health insurance in the State as of September 23, 2016. The MCNA Organization was founded in Florida and is headquartered in Fort Lauderdale, with regional headquarters in San Antonio, Texas, and New Orleans, Louisiana. Our core business is delivering the **highest quality dental care** to traditionally underserved populations enrolled in Medicaid, CHIP, and Medicare programs. We manage dental benefits on a full-risk basis for **nearly 3,500,000 children and adults** throughout the nation.

We hold the only statewide, full-risk, single-plan Medicaid and CHIP dental benefits administration contracts in the nation. MCNA was selected through competitive procurement processes to serve as the sole dental vendor for the Louisiana Medicaid and CHIP Dental program in 2014, and the Idaho Medicaid and CHIP Dental program in 2016. Nationally, MCNA has the largest number of **full-risk, statewide** Medicaid and CHIP dental contracts with state agencies:

- **Florida Healthy Kids Corporation** (CHIP) since 2005
- **Texas Health and Human Services Commission** (Medicaid and CHIP) since 2012
- **Louisiana Department of Health** (Medicaid and CHIP) since 2014
- **Iowa Medicaid Enterprise** (Medicaid) since 2016
- **Idaho Department of Health and Welfare** (Medicaid and CHIP) since 2016

In addition to the contracts above, MCNA provides dental benefit management services as a subcontractor to various health plans and offers limited commercial coverage in Florida. We serve some of the most vulnerable members of society, with the mission of improving overall health through the provision of quality dental care. We also offer commercial dental plans for private employers, individuals, and families. Our commitment to ensuring our members have access to care in urban and rural areas through our statewide provider networks has allowed us to become the premier dental plan throughout the nation. We approach our work of developing and implementing dental service programs with dedication and commitment to excellence. We are eager to assist the **Nevada Division of Health Care Financing and Policy (DHCFP)** in reaching its goal to provide quality dental care to the targeted populations.

The ultimate parent of MCNA Insurance Company is MCNA Health Care Holdings, LLC ("MCNA Holdings"), a Florida limited liability company. MCNA Holdings is also the parent company of Managed Care of North America, Inc., d/b/a MCNA Dental Plans, a Florida corporation licensed as a pre-paid limited health services organization ("MCNA Dental Plans"). MCNA Dental Plans has operated as a dental insurance administrator since January 30, 1992, and is licensed in Nevada as a third party administrator (license number 567602).

Mission and Goal

Our proposal combines the financial strength of MCNA Insurance Company and the unparalleled dental managed care experience of its affiliate, Managed Care of North America, Inc., to deliver to the DHCFP a turnkey solution and seamless transition for the new contract term. MCNA was founded by Jeffrey P. Feingold, DDS, MSD, a Florida-licensed Periodontist and Diplomate of the American Board of Periodontology. With a staff of over 550, MCNA has the infrastructure and experience to deliver **best-in-class** dental benefits management to our clients.

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

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

Our Commitment to Quality Dental Care

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

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

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

For a copy of our SOC 2 Type 2 Report, please see **Attachment 3-1** of this response.

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

Licensed Nevada Insurance Company [§3.1.2]

[redacted]

MCNA is pleased to provide a copy of our Certificate of Authority to transact the business of health insurance issued by the Nevada Department of Business and Industry, Division of Insurance, on September 23, 2016. MCNA will adhere to all requirements necessary to maintain our Certificate of Authority in good standing at all times, including during the term of any contract entered into by MCNA pursuant to this RFP.

Certificate of Authority

Certificate of Authority

STATE OF NEVADA
DEPARTMENT OF BUSINESS & INDUSTRY
DIVISION OF INSURANCE
Carson City, Nevada

Nevada ID:	**134396**
THE	**MCNA INSURANCE COMPANY**
Incorporated in the State of	**TEXAS**
Home office at	**AUSTIN, TEXAS**

having duly qualified, is hereby licensed to transact:

**** HEALTH ****

insurance business within the State of Nevada. This Certificate shall remain in force unless terminated or voluntarily surrendered. This Certificate shall at all times remain the property of the State of Nevada. Upon any termination the holder shall promptly deliver or surrender this Certificate to the Commissioner of Insurance, pursuant to NRS 680A.160.

Dated at Carson City, Nevada

This 23rd day of Sept, 2016

Barbara D. Richardson

Commissioner of Insurance

An Experienced Partner [§3.1.1, §3.1.3 - §3.1.5]

MCNA has provided dental managed care services for individuals and state programs for over 20 years. The following lists our **active full-risk contracts with state Medicaid and CHIP agencies:**

- **Florida** – MCNA has been providing **full-risk, statewide** dental managed care services for Florida's CHIP Program, **since January 1, 2005**. We currently serve approximately 70,000 enrollees. In early 2016, MCNA was awarded its fourth consecutive contract by the Florida Healthy Kids Corporation (FHKC) to continue managing this program. MCNA scored first in FHKC's most recent dental HEDIS results.

- **Texas** – MCNA has been providing **full-risk, statewide** dental managed care services for the Texas Health and Human Services Commission Medicaid and CHIP dental programs **since March 1, 2012**. We currently serve approximately 1,500,000 enrollees, and the State of Texas has extended MCNA's contract beyond the initial term.

- **Louisiana** – MCNA was **ranked first** in the Louisiana procurement to serve as the **full-risk, statewide** dental benefits program manager with a go-live date of July 1, 2014. We currently serve the State's 1,450,000 Medicaid and CHIP members as the **sole vendor** under a contract with the Louisiana Department of Health.

- **Iowa** – MCNA was awarded a **full-risk, statewide** contract by the Iowa Medicaid Enterprise to serve adult members enrolled in the State's Dental Wellness Plan. We commenced operations on August 1, 2016, and have a current enrollment of approximately 13,000 members.

- **Idaho** – MCNA was recently **ranked first** in the Idaho Smiles procurement and awarded a **full-risk, statewide** contract to serve as the **sole vendor** for the Idaho Department of Health and Welfare to provide dental managed care services to the State's 280,000 Medicaid and CHIP enrollees with a go-live date of February 1, 2017.

We maintain a commercial plan in the State of Florida, and we serve Medicaid, ACA, and long term care members under various subcontracts with Medicaid managed care plans in Florida, Indiana, and West Virginia.

From 2009 to 2014, MCNA served Florida's Medicaid enrollees under a direct contract with the Florida Agency for Health Care Administration. The program began as a demonstration project in Miami-Dade County that was so successful the Legislature expanded it to a statewide program in 2012. Throughout the life of the contract, MCNA's enrollment for both programs peaked at over 600,000 members.

Additionally, MCNA was subcontracted by Centene Corporation's Florida affiliate, Sunshine Health, to provide all dental benefits administration services for its Florida Medicaid and Long Term Care members from 2008 through 2014. Over the life of this contract, enrollment increased from 100,000 to approximately 400,000 members.

MCNA is a fiscally-responsible state partner. In 2014, Louisiana's rates included a **13.9% managed care savings** by moving their Medicaid and CHIP program to full-risk dental managed care. The Texas

Association of Health Plans estimates that by fiscal year 2018, dental managed care will have **saved the state $3 billion.**

MCNA will fully comply with all State and federal laws and regulations including Title XIX, Title XXI state plans and amendments, Code of Federal Regulations, and the Medicaid Services Manual. We understand and acknowledge that the DHCFP intends to procure dental services for eligible individuals in urban Clark and Washoe Counties, and that other services, populations and/or geographic areas may be included in the DBA plan during the course of this contract and are to be considered as covered for this Request for Proposal. MCNA also understands that out-of-state treatment for a recipient is required when a provider in Nevada is not available to provide services to the recipient, and that the Medicaid catchment areas in California, Arizona, Idaho, and Utah are treated the same as in state for the purposes of service delivery.

Vendor Duties and Responsibilities [§3.2]

Key Staff Identification and Meeting Participation

MCNA is committed to working closely with DHCFP to achieve all program objectives. Our senior staff and other identified key staff shall participate in all designated key meetings scheduled by the DHCFP. MCNA acknowledges and understands that the meetings will include, at a minimum, monthly teleconferences and/or videoconferences in addition to quarterly on-site meetings. The location of the on-site meetings will be at either the DHCFP administrative offices in Carson City or a site in Las Vegas, and the DHCFP will provide reasonable advanced notice of such meetings, including location, time, date, and agenda items for discussion.

Our CEO, Dr. Jeffrey Feingold, understands the importance of maintaining strong relationships with the local dental community.

Dental Services [§3.3]

Amount, Duration, and Scope of Covered Services [§3.3, §3.3.1.1, §3.3.1.8, §3.3.2]

MCNA's Nevada members will have access to the full spectrum of dental care services required in this RFP. MCNA understands and shares the desire of DHCFP to increase access to appropriate, quality dental care and improve oral health outcomes for its Medicaid population. **We have extensive experience delivering the quality dental care services required by the DHCFP for its members.**

Nevada dental benefits include covered diagnostic, preventive or corrective services and procedures that include treatment of the teeth and associated structures of the oral cavity due to disease, injury or impairment that may affect the oral or general health of eligible Medicaid members (up to 21 years of age) and Nevada Check Up members (up to 19 years of age). Members are also provided emergent and urgent dental care. Orthodontic services for eligible members are covered under fee-for-service (FFS) pursuant to MSM Chapter 1000. MCNA will ensure the referral and the coordination of care for orthodontic services, pursuant to this RFP.

Individuals age 21 and over who qualify for full Medicaid benefits receive emergency extractions, palliative care, and may also be eligible to receive prosthetic care (dentures/partials) under certain guidelines and limitations. Nevada Medicaid offers expanded dental services in addition to the adult dental services for Medicaid-eligible pregnant women for periodontal scaling and root planing, to reduce the risk of pregnancy related gingivitis, as well as treatment of inflamed gums around third molars during the pregnancy as defined in MSM Chapter 1000 Dental.

MCNA maintains a robust network of general dentists, pediatric dentists, oral and maxillofacial surgeons, endodontists, periodontists, prosthodontists, and dental hygienists to ensure that our members have access to all medically necessary covered services. We will coordinate with the member's managed care organization (MCO) for access to facilities and physician services necessary to support dental providers serving Nevada Medicaid and CHIP members under general anesthesia or intravenous (IV) sedation. We will also coordinate with the non-emergency transportation (NET) broker to secure transportation for members, and to verify dental appointments upon request by DHCFP or the NET broker.

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

MCNA will **ensure** that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope than those covered services specified in the respective State Plans for Title XIX and XXI programs and the Nevada Medicaid Service Manual Chapter 1000. MCNA also provides for second opinions at the request of our members to ensure that the services and treatment proposed are appropriate for their condition. We will arrange for a second opinion from a qualified dental professional

within our network, or, if unavailable, allow the member to obtain one outside of the network, at no cost to the member.

By tailoring our Utilization Management (UM) program to meet the needs of Nevada, MCNA ensures that the provision of dental care services is high quality, cost-effective and provided in the most appropriate setting consistent with 42 CFR §456. Designed and guided by dentists, MCNA's UM program follows generally accepted dental standards of care and review criteria developed in conjunction with dental guidelines from the American Academy of Pediatric Dentistry, the American Dental Association, the American Association of Oral and Maxillofacial Surgeons, the American Association of Endodontists, the American Academy of Periodontology, and the American College of Prosthodontists. The goal of the UM program is to monitor the appropriateness, quality and necessity of dental services provided to our members.

Medical Necessity [§3.3.1.2 - §3.3.1.3]

As a provider owned organization, MCNA recognizes the importance of cooperation and agreement between providers and our Clinical Reviewers. The criteria and clinical guidelines used by MCNA ensure that all clinical terminology is clearly defined. We educate our Clinical Reviewers and providers on both the benefits and limitations of the plans we administer, as well as qualifying criteria related to the amount, duration and scope of general and specialty treatment. MCNA understands that we may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. All Utilization Management **decisions regarding covered benefits will be made by licensed dental professionals** reviewing relevant clinical information and in consultation with the treating providers as appropriate. Requests for services are reviewed to determine that the service is medically necessary (as defined in the Nevada Medicaid Service Manual Chapter 100 section 103.1), and that the service is being delivered consistent with MCNA's approved Utilization Review Criteria and Guidelines.

MCNA's utilization management protocols ensure that appropriate limits are placed on services only on the basis of certain criteria, such as medical necessity, periodicity, or for the purpose of utilization control, provided the services furnished can be reasonably expected to achieve their purpose. For example, our utilization review and referral management policies ensure that eligibility criteria for oral and maxillofacial surgery services and treatment in a facility setting must be met in order for those specialty services to be covered. MCNA will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.

Additionally, our providers understand that members cannot be charged copayments for covered services, and each participating provider agreement contains a provision prohibiting balance billing. MCNA will comply with all DHCFP requirements with respect to provider reimbursement and timely claims payment.

MCNA defines medically necessary services as services provided in accordance with 42 CFR §438.210(a)(4), and will adhere to the Nevada definition found in the Medicaid Service Manual Chapter 100 section 103.1 which states that Medical Necessity is defined as:

A health care service or product that is provided for under the Medicaid State Plan and is necessary and consistent with generally accepted professional standards to: diagnose, treat or prevent illness or disease; regain functional capacity; or reduce or ameliorate effects of an illness, injury or disability.

The determination of medical necessity is made on the basis of the individual case and takes into account:

- Type, frequency, extent, body site and duration of treatment with scientifically based guidelines of national medical or health care coverage organizations or governmental agencies.
- Level of service that can be safely and effectively furnished, and for which no equally effective and more conservative or less costly treatment is available.
- Services are delivered in the setting that is clinically appropriate to the specific physical and mental/behavioral health care needs of the member.
- Services are provided for medical or mental/behavioral reasons rather than for the convenience of the member, the member's caregiver, or the health care provider.

Medical Necessity shall take into account the ability of the service to allow members to remain in a community based setting, when such a setting is safe, and there is no less costly, more conservative or more effective setting.

Service Authorization [§3.3.1.3 - §3.3.1.4]

All types of care are reviewed for dental necessity, appropriateness of services, level of care, location of care, and quality of care as well as benefit and coverage determinations. [redacted] Our UM program generates operational data and integrates captured information into the UM and Quality Improvement processes. Reports generated by our Quality Improvement Department are used to continuously monitor the efficacy of the UM program and the appropriateness of the dental care received by our members.

MCNA understands that we may use different authorization requirements than the State so long as they are not more restrictive. We follow written policies and procedures for the processing of requests for initial and continuing authorizations of services. MCNA ensures consistent application of review criteria for authorization decisions through the use of inter-rater reliability audits. Our clinical reviewers consult with the requesting provider via our peer-to-peer program as needed.

We monitor all prior authorization requests, and understand that the DHCFP, at its sole discretion, may require removal of the prior authorization requirement based on reported approval percentage rates, to align prior authorization procedures across delivery entities, and if determined necessary for the proper administration of the Medicaid program. We will coordinate prior authorizations and edit patterns with those used in the FFS program.

MCNA accepts prior authorization requests submitted by providers **electronically**, via our free, easy to use online **Provider Portal**, or on **paper**. Paper requests are scanned and entered into our DentalTrac™ system and electronic requests are received in either HIPAA compliant 837D files or real-

time through our online Provider Portal submission process. MCNA's Provider Portal allows dentists to attach x-rays, narrative, and other supporting documentation electronically. Providers using a clearinghouse to submit prior authorizations electronically can use **NEA FastAttach®**. Members may also submit a service authorization request for the provision of services either via mail or by contacting our Member Hotline.

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

Key Facts About MCNA

- MCNA utilizes the expertise of **licensed general and specialty care dentists** to review all utilization management cases that require medical necessity review.
- 2015 processing time for UM cases in Texas: **1.44 business days**
- 2015 processing time for UM cases in Louisiana: **0.99 business days**
- 2015 processing time for UM cases in Florida: **1.26 business days**

Upon receipt of an authorization request, the Utilization Management Coordinator (UMC) verifies the member's eligibility and benefits as well as the requesting provider's network affiliation. All prior authorizations requiring medical necessity determinations are routed to a Clinical Reviewer through our MIS, DentalTrac™.

MCNA maintains a staff of active licensed primary and specialty care dentists who serve as Clinical Reviewers and review all requests for authorization. Requests for services are reviewed to determine that the service is a medically necessary covered benefit and that the service is being delivered consistent with established criteria and guidelines. Our Clinical Reviewers examine each prior authorization and relate the existing conditions to the qualifying criteria to determine approval. They use criteria to evaluate information submitted by dentists such as x-rays, models, narratives, and chart notes to determine the medical necessity of requested procedures. Additional information will be sought as needed from the requesting dentist.

Any clinical decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a licensed dentist with the appropriate clinical expertise.

MCNA provides all covered counseling and referral services included in the Nevada Medicaid and CHIP dental program. However, we understand that if MCNA elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, we must furnish information about the services that will not be covered to the DHCFP with our application for a Medicaid contract and whenever such a policy is adopted during the term of the contract.

Commitment to AAPD Periodicity Schedule and EPSDT Requirements [§3.3.3]

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

Our stated mission is the improvement of oral health outcomes in state sponsored Medicaid programs by continuously stressing prevention, diagnosis, and early treatment intervention. Our network dentists utilize the entire spectrum of diagnostic services available so early problems can be detected and addressed promptly. **All eligible members under 21 will receive medically necessary services in accordance with EPSDT requirements.** MCNA will adhere to the AAPD Periodicity Schedule to ensure all children served have access to timely preventive care as well as other medically necessary restorative and therapeutic services. EPSDT screens for Nevada Medicaid members and Well Baby / Well Child screens for Nevada Check Up members are billed with standard ADA CDT codes and will reimburse at no less than the current Nevada Medicaid fee schedule.

Tracking EPSDT

We believe that early treatment is better for both our members and the program. We fully integrate all member data to create a unique member eligibility record for each individual we serve to ensure a comprehensive, coordinated approach to quality dental treatment. Participating providers can view past treatment history via MCNA's online Provider Portal to ensure all EPSDT services are being rendered timely and to avoid duplication of services.

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

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

Outreach, Health Promotion, and Education Programs [§3.3.4]

MCNA understands that we must conduct regularly scheduled and targeted outreach and education activities for all covered members. We identify relevant community issues and health promotion and education needs of our members, and implement plans that are culturally appropriate to meet those identified needs.

We utilize community-based needs assessments and other relevant information available from State and local governmental agencies and community groups to identify target population groups and behaviors. MCNA's outreach and education efforts comply with all applicable State and federal requirements. We will submit a written description of all planned health promotion and education activities and targeted implementation dates to the Nevada Division of Public and Behavioral Health, Chronic Disease Prevention and Health Promotion for approval, prior to implementation, including culturally and linguistically appropriate materials developed to accommodate each of the enrolled target populations.

Throughout the life of the contract, MCNA will conduct outreach activities across the State of Nevada to improve oral health literacy and inform members about the availability of dental services. We measure the impact of our outreach activities to ensure that we achieve the overall goal of increasing the use of preventive services. **Please see Attachment 3-2 for our draft Nevada Outreach Program.**

MCNA's Member Advocate Outreach Specialists (MAOS)

In Texas and Louisiana, MCNA employs experienced Member Advocate Outreach Specialists (MAOS) to ensure members receive appointment reminders, assistance with scheduling dental appointments, transportation coordination, oral health education, understanding plan benefits, and one-on-one assistance with submitting grievances and appeals. MAOS also participate in community outreach events where they focus on educating members, their parents, and members of the public about the benefits of adhering to the AAPD Periodicity Schedule and improving overall oral health outcomes. To facilitate continuity of care, network providers can inform MAOS of members who continuously break appointments so that MAOS can conduct outreach to these members and ensure they receive dental care in an appropriate and timely manner. MAOS also work closely with underserved populations such as migrant and seasonal farmworkers to ensure that services are obtained and to reduce health care disparities.

Given MCNA's success with our MAOS approach, we will employ Nevada-based MAOS to work with our Nevada members and their families. The MAOS will be located regionally throughout the State in order to be close to the populations they serve. Upon approval from DHCFP, MAOS will implement outreach programs, attend health fairs, and work with community partners such as faith-based groups, community action agencies, and other organizations who are devoted to improving the health and lives of our members.

MCNA's MAOS are available to provide a variety of services to members across the State, by:

- Working with DHCFP and community partners such as the Ronald McDonald House Charities across the State.

- Organizing visits with our members and providing education about good oral health.
- Attending health fairs and events.
- Giving oral health presentations at schools and organizations for children and adults.

MAOS are trained to help members, by:

- Teaching them about how to take care of their teeth at home to achieve a healthy smile.
- Educating them about their dental benefits with MCNA.
- Reminding them to go to the dentist for a checkup.
- Assisting them with the Grievances and Appeals processes.
- Locating and connecting them with organizations in the community that provide free or low cost resources (child care, heating, transportation, housing) to low-income families.

Health Fairs

Since 2015, our MAOS Teams have actively participated in **over 1,300 health fairs and outreach events** in Texas, Louisiana, and Florida. These health fairs are organized in coordination with faith-based organizations, county health departments, Head Start programs, public school systems, civic organizations, dental centers, and health plans. In Nevada, MCNA is committed to providing health fairs and outreach across the state, including underserved rural areas. Our goal is to educate parents and children throughout Nevada about the importance of good oral health.

MCNA has organized and sponsored health fairs across the states we serve to provide community members with vital healthcare information and services. At MCNA, we not only focus on dental, but also on total body wellness. The health fairs we participate in and sponsor include free services such as:

- Screenings (Vision, Dental, and Hearing)
- Vouchers for Free Exams (Mammograms, Well-Woman Checkups, and Colonoscopies)
- Educational Information About Community Supports (Food and Diaper Banks)

During outreach events, MCNA's MAOS team members:

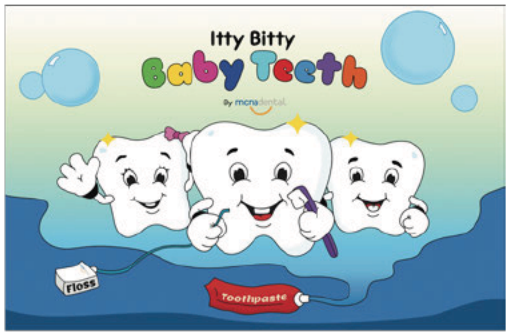
- Discuss techniques to help maintain good oral hygiene and encourage members to follow the periodicity schedule for continuity of care.
- Discuss the importance of preventive services such as dental sealants and fluoride.
- Discuss the importance of having a primary care dentist to provide treatment and services at an early age, and encourage attendees and parents to visit the dentist regularly for a check-up.
- Engage participants by utilizing age appropriate "hands-on" activities to teach children the proper way to brush and floss their teeth.
- Provide participants with dental kits that include a toothbrush, toothpaste and dental floss as well as informational flyers, water bottles, backpacks, hand sanitizer, and pencils.

- Provide information about non-emergency transportation (NET) for Medicaid members.
- Share information with participants about other organizations that provide services for little or no cost.

Presentations and Meetings

MCNA's Member Advocate Outreach Specialists (MAOS) partner with local school districts and Head Start programs to not only organize and participate in health fairs, but also provide oral health presentations for students, faculty, staff and parents. MAOS utilize age appropriate interactive activities to engage children in learning about proper oral health. These activities include playing games and reading books including a children's book written and published by MCNA, *Itty Bitty Baby Teeth*. This book was created to ease children's fears about losing their baby teeth and to encourage healthy oral hygiene habits. The book is easy to read and is designed for pre-school through first grade. The book is available in both English and Spanish. The MAOS also attend various parent meetings to provide parents with important oral hygiene information as well as information about MCNA, the services available to members, and how to access those services.

Elementary School Reading Session



MCNA's Itty Bitty Baby Teeth Book

Improving Oral Health

MCNA's Nevada outreach campaign is designed to address dental health issues that are most likely to have an impact on our membership. EPSDT adherence and promoting preventive dental health services are critical elements of our initiatives.

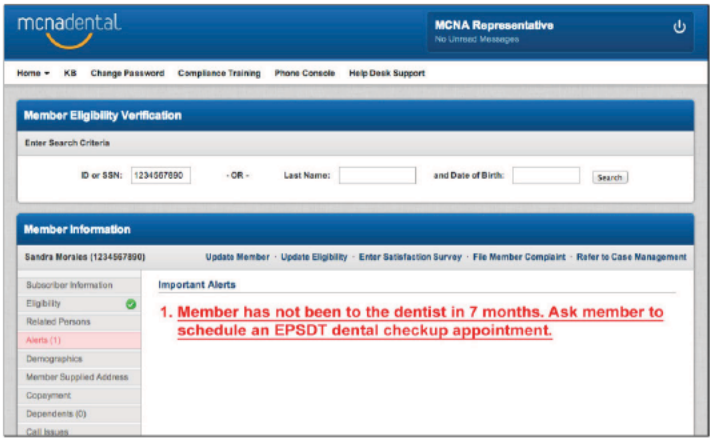
MCNA focuses primarily on prevention to lessen the occurrence of specific dental conditions or diseases. Through our experience, we know that educating our members and their parents or guardians is essential to making sure families understand the importance of achieving and maintaining good oral health. In addition to education via our Member Handbook, interactive website, and reminder postcards, MCNA also uses our internal staff, network providers, and community partners to reach out to our members and educate them about the importance of oral hygiene and timely dental care.

MCNA is committed to maintaining or increasing the preventive service measures for our members in the Nevada program. We have **extensive expertise** in reporting the metrics required by the Form CMS-416: Annual EPSDT Participation Report, the HEDIS Annual Dental Visit (ADV) measure, and measures developed by the American Dental Association's Dental Quality Alliance. Our multi-faceted approach to improving or maintaining current Nevada CMS-416 metrics includes driving increases in preventive services and appropriate sealant utilization. MCNA's continuous quality improvement

activities include the use of timely and meaningful data, multi-disciplinary team analysis, and active engagement of members, providers, and plan staff in intervention strategies.

Care Gap Alerts and Consistent Outreach

MCNA's management information system, DentalTrac™, **continuously analyzes** member eligibility data and claims data to identify members who are not receiving care in accordance with the periodicity schedule. Our business intelligence functionality uses this data to generate actionable "Care Gap Alerts."



MCNA's experienced Quality Improvement staff, Member Advocate Outreach Specialists (MAOS), and our skilled Call Center Operations Team use this data to identify and coordinate education and outreach opportunities. Real-time Care Gap Alerts are used by our Member Services Representatives (MSRs) during incoming calls. The MSRs educate the member on the importance of preventive care and assist the member in scheduling an appointment. During 2015, MCNA's Member Hotline **assisted over 235,000 Florida, Texas, and Louisiana Medicaid and CHIP members in scheduling a dental appointment**. Please see a screenshot of a Care Gap Alert generated by DentalTrac™ above.

MCNA Care Connections and Outreach to Non-Compliant Members

MCNA's Care Connections Team (CCT) is a dedicated unit within the Call Center Operations Department. Care Connections Representatives are skilled in outbound call campaign processes and procedures. Our sophisticated suite of telephony software allows thousands of phone numbers to be dialed automatically over the length of the campaign. Each answered call is routed immediately to the next available Care Connections Representative.

The CCT provides targeted outreach to MCNA members to increase appropriate utilization of preventive services. For example, MCNA's skilled Care Connections staff conducts outbound calls to members under 21 who are overdue for a regular dental checkup according to the American Academy of Pediatric Dentistry (AAPD) Periodicity Schedule. We provide education and offer assistance scheduling an appointment.

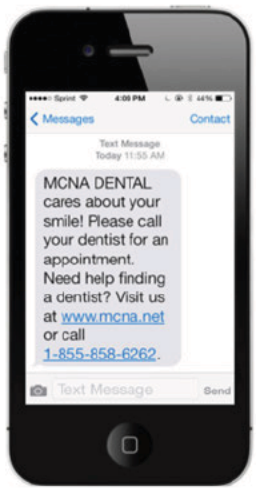
Other CCT preventive service campaigns include contacting members who are eligible for sealants but have not yet received them and targeted teen outreach calls to encourage receipt of routine dental care. The CCT also conducts service receipt confirmation calls to a random sample of members to verify the members actually received services submitted by their providers for reimbursement.

Text Messaging

Our Quality Improvement Department uses text messaging to increase the Annual Dental Visit (ADV) rate and the number of members receiving preventive services. MCNA encourages our members, and their parents and guardians, to schedule dental appointments in accordance with the AAPD Periodicity Schedule.

This approach is also used to follow up with members who have not visited a dentist within the previous 6 months of enrollment. This continuous outbound text messaging initiative has improved the screening rates for the members we currently serve.

Since 2015, MCNA has sent over 470,000 targeted text messages to our members in need of care. [redacted]



Example Text Message

Robust Provider Network [§3.3.1.5 - §3.3.1.7, §3.3.1.10 - §3.3.1.12]

MCNA has over 20 years of experience building extensive networks and credentialing providers. Unlike many of our competitors who limit the size of the provider network by closing their dental panels, **MCNA maintains an open network policy**. Our network policy prevents situations where access is arbitrarily limited by plans who exclude quality dental providers. For example, DentaQuest, the prior plan in Idaho, closed their network and arbitrarily excluded over one hundred providers. Idaho's Governor, Butch Otter, had to intervene and ensure the providers were reinstated to serve Medicaid members[2]. A similar scenario occurred in Tennessee, where a large provider group, Snodgrass-King Pediatric Dental Associates, recently received a $22.2 million judgment against DentaQuest for arbitrarily keeping them out of the DentaQuest network[3].

We welcome all providers who meet our quality and credentialing standards, especially those dentists who have a history of serving the Medicaid population.

Our Director of Network Development will continually monitor geoaccess reports to verify that we have a sufficient number of specialists, pediatric dentists, general dentists, and dental hygienists to care for our members. **MCNA pays providers on a fee-for-service basis at the State's Medicaid fee schedule or above.**

Our providers are contracted and credentialed in accordance with State and federal requirements, and NCQA and URAC accreditation standards. We evaluate multiple factors in our approach to network development including the anticipated number of enrolled members and their geographic location,

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[1] [redacted]
[2] http:// dahobus nessrev ew.com/2010/10/20/dentaquest restores daho dent sts cut rom program/
[3] http://www.nashv epost.com/bus ness/hea th care/art c e/20845054/snodgrassk ng awarded 222m n dentaquest case

anticipated utilization of services based on the needs of the member population, and the numbers and types of providers available in each geographic area, including whether they currently accept new Medicaid and Check Up members and if the provider treats members with special needs.

MCNA allows members freedom of choice among dental providers. Members can select a general dentist, pediatric dentist, or a federally qualified health center (FQHC) to serve as their primary dental provider (PDP). To facilitate continuity of care, MCNA allows for continued use of a member's current provider until the member can be transferred to an appropriate MCNA network provider. We understand and acknowledge that the member's assigned PDP may not be more than 25 miles from the member's place of residence, unless the member has submitted a written request to utilize a PDP that does not meet this standard.

All network providers shall enter into a written contract with MCNA, and our Provider Manual is incorporated into that agreement by reference. We require participating providers to offer hours of operation that are no less than the hours of operation offered to their commercial members or those in Medicaid FFS, if the provider services only Medicaid members pursuant to 42 CFR §438.206. MCNA ensures that our providers meet State standards for timely access to care and services, taking into account the urgency of the need for services. Participating providers must ensure emergency coverage twenty-four (24) hours per day, seven (7) days per week.

MCNA has written policies and procedures describing how members can obtain urgent coverage and emergency services after business hours and on weekend, including the provision of direct contact with qualified dental professionals. Members can speak with a qualified dental professional during an emergency to advise and direct members to the correct service location including local emergency departments or dental offices. Members are educated about access to care through the MCNA Member Handbook. Urgent care may be provided directly by a member's PDP or as directed by MCNA through other arrangements. We monitor member utilization of emergency dental services to ensure members have properly addressed their chief complaint. Our Quality Improvement Department and Case Management Department will facilitate this level of care coordination, and provide metrics and required reporting to the DHCFP.

Out-of-Network Services [§3.3.1.7, §3.3.1.9, §3.3.5]

MCNA recognizes that sometimes members may need to seek care from an out-of-network (OON) provider. We will adequately and timely cover these services OON for the member for as long as MCNA is unable to provide them through a network provider. If the network is unable to provide necessary services covered under the contract to a particular member, we will negotiate a Letter of Agreement (single member contract) with a reimbursement rate that does not exceed the FFS rate. Additionally, MCNA will offer the provider the opportunity to become part of our network. We will attempt to contract with all OON providers located within 25 miles of the member's address before contracting with an OON provider located over 25 miles from member's address.

The Nevada Medicaid and Check Up dental program includes covered medically necessary dental services that require MCNA to reimburse providers who do not have formal contracts with MCNA. We must coordinate with out of network providers with respect to payment.

If it is necessary for a member to obtain services from an out-of-state (OOS) provider, MCNA will negotiate a contract to determine the rate prior to services being rendered. MCNA must inform the provider that MCNA's reimbursement shall be considered payment in full. The only exception to this requirement is in the case of third party liability (TPL). The OOS provider must not bill, accept or retain payments from Nevada Medicaid or Nevada Check Up members.

Emergency Dental and Post Stabilization Services [§3.3.6, §3.3.6.1 - §3.3.6.9]

MCNA ensures that our members have access to emergency dental care services for issues such as trauma or acute infection without any delay or hindrance. Our members have access to emergency care without the need to obtain prior authorization and can receive services through any emergency facility or provider, regardless of whether the facility is in or out-of-network. We reimburse emergency service providers at 100% of the Medicaid rate in effect on the date of service in order to comply with Section 6085 of the Deficit Reduction Act of 2005.

We do not indicate that emergencies are covered only if care is secured within a certain period of time or use terms such as "life threatening" or "bona fide" to qualify the type of emergency that is covered. MCNA will not deny payment for emergency services when an MCNA representative instructs the member to seek emergency care. Members are not required to notify MCNA in advance or within a certain period of time after the emergency care is given.

MCNA does not deny payment for treatment obtained when a member had an emergency dental condition and stabilization of the condition, including cases in which the absence of immediate dental attention would not have had the outcomes specified in 42 CFR §438.114(a) of the definition of an emergency dental condition. However, MCNA is not responsible for emergency dental coverage provided on an emergency basis in a hospital, emergency room or ambulatory surgery center under the medical benefit which may include dislocated jaw, traumatic damage to teeth and supporting structures, and removal of cysts; treatment of oral abscess of tooth or gum origin; treatment and devices for correction of craniofacial anomalies; and drugs.

MCNA will not deny emergency dental services claims submitted by an out-of-network provider solely based on the period between the date-of-service and the date of clean claim submission unless that period exceeds 365 days. We acknowledge that non-emergent services provided in an emergency room are a covered service. Providers are expected to follow national coding guidelines by billing at the most appropriate level for any services provided in an emergency room setting.

MCNA shall provide post-stabilization services obtained within or outside the network that are pre-approved by MCNA. Payment will also be made for post-stabilization services (including out-of-network care) that were not pre-approved, but administered to maintain the member's stabilized condition within one (1) hour of a request to MCNA for pre-approval of further post-stabilization care services or in instances where MCNA cannot be reached.

In situations where MCNA and the treating provider cannot reach an agreement concerning the member's care, and another MCNA clinical reviewer is not available for consultation, MCNA allows the

treating provider to continue with care of the member until a network provider is reached or one of the criteria in 42 CFR §438.114(e) and 42 CFR §422.113 is met.

Pursuant to 42 CFR §438.114(e) and 42 CFR §422.113, MCNA's financial responsibility for post-stabilization care that was not pre-approved ends when a network provider with privileges at the treating hospital assumes responsibility for the member's care, or a network provider assumes responsibility for the member's care through transfer, or MCNA and the treating provider reach an agreement concerning the member's care or the member is discharged. Charges for post stabilization care services provided by an out-of-network provider to a member may be no greater than the amount MCNA would pay if the services had been obtained in network as specified in CFR §438.114(e).

Coordination with Other Vendors and Other Services [§3.3.6.10]

MCNA's Case Management Department provides care coordination for our members with special needs including physical or mental disabilities, pregnant women, individuals with chronic conditions, and those who are receiving services that require care coordination with other providers. Our Case Managers also refer orthodontic members to their PDP for periodic examinations and cleanings. Upon request or notification of the need for care coordination services, our experienced Case Managers will communicate with the member's medical plan (MCO) or other vendors serving the member, our assessment of any special health care needs to ensure that services are not duplicated. Our Case Managers ensure continuity of care and services for members with special needs.

MCNA protects the privacy of our members during all care coordination efforts in accordance with the confidentiality requirements of 45 CFR Parts 160 and 164, the Health Insurance Portability and Accountability Act (HIPAA). We will coordinate services with other appropriate Nevada Medicaid and non-Medicaid programs, including appropriate electronic data sharing for integrated health care. MCNA ensures continuity of care for members with special needs and other covered circumstances.

Federally Qualified Health Center (FQHC) [§3.3.6.11]

MCNA will seek out and engage all FQHCs, IHCs, and outpatient health programs or facilities operated by Tribes or Tribal organizations as defined under 42 U.S.C §1396(d)(l)(2)(b) that provide dental services in Nevada and states contiguous to Nevada to ensure that they have an opportunity to participate in the Nevada Medicaid and CHIP dental program. MCNA has a rich history of partnering with FQHCs, Rural Health Clinics, Indian Health Service Providers, and County Health Departments in the markets we serve. Collaborating with these entities is a significant benefit to our members.

We will pay for services provided by a Federally Qualified Health Center (FQHC). MCNA understands that we may contract with FQHCs provided that payments are at least equal to the amount paid to other providers for similar services. If MCNA does not have a contract with an FQHC, we will pay at a rate equivalent to the FFS rate. This does not apply to out-of-network providers of emergency services. MCNA will demonstrate a good faith effort to negotiate a contract with FQHCs and include all licensed and qualified FQHC providers in our network. We acknowledge that contracting with just one provider at each FQHC does not constitute a good faith effort to include the FQHC in our network. MCNA will report to the DHCFP payments and visits made to FQHCs on a quarterly basis. The DHCFP is

responsible for FQHC wrap payments. **Every effort will be made to partner with these critical community providers as part of our network development strategy.**

Enrollment Requirements and Limitations [§3.4]

Eligibility Verification System – Summary [§3.4.1 - §3.4.2]

MCNA has been managing HIPAA and other industry standard and proprietary file format transmissions for over a decade and exchanging data with over seventy-five trading partners. The Electronic Data Interchange (EDI) subsystem of our DentalTrac™ management information system exchanges data involving encounters, enrollment updates, eligibility inquiries, provider data, claims, and payment acknowledgments. Currently, our MIS and EDI subsystem is **fully developed** and interfaces with all major clearinghouses, state Medicaid agencies' secure systems, health plan subsystems, Health Level Seven, and third-party administrators nationwide.

Our extensive experience working with industry standard organizations such as DISA and ACORD provides us with the expertise to **maintain an up-to-date MIS** that interfaces with different systems, MMIS vendors, trading partners, clearinghouses, and other state vendors. **MCNA utilizes the DentalTrac™ system to accept and process daily eligibility files and full replacement files from DHCFP MMIS.**

Complete coverage of all EDI file formats is possible because MCNA has developed in-house a universal EDI translator that works off EDI Standard Exchange Format (SEF) machine-readable format descriptions. We have extended this capability to allow encoding of exceptions specified in companion guides and to support automatic mapping of EDI format data to the DentalTrac™ database schema. By working from SEF specifications, the translator is better able to validate EDI transmissions for correct format and even content accuracy, preventing contamination of the core DentalTrac™ database.

The eligibility and enrollment functions are the responsibility of the DHCFP and the Division of Welfare and Supportive Services (DWSS). MCNA will establish and implement enrollment procedures and maintain applicable enrolled member data. We will accept each member who is enrolled in or assigned by the DHCFP and/or its enrollment sections and/or for whom a capitation payment has been made or will be made by the DHCFP. We understand that the first date a Medicaid or Nevada Check Up-eligible member will be enrolled is not earlier than the applicable date in MCNA's specified contract.

MCNA will accept recipients eligible for enrollment in the order in which they apply without restriction, up to the limits set under the contract 42 CFR §438.6(d)(1). We acknowledge that enrollment is mandatory except in the case of voluntary enrollment programs that meet the conditions set forth in 42 CFR §438.50(a). Per 42 CFR §438.6(d)(3)(4), MCNA does not discriminate against eligible individuals on the basis of health status. Further, MCNA will not deny the enrollment nor discriminate against any Medicaid or Nevada Check Up eligible members to enroll on the basis of race, color or national origin, and will not use any policy or practice that has the effect of discrimination on the basis of race, color or national origin. MCNA has in place written policies and procedures for enrolling all eligible populations and receiving monthly and other enrollment updates from the DHCFP. MCNA will accept as enrolled all members appearing on monthly enrollment reports.

All incoming EDI transmissions from DHCFP will go through **multiple levels of validation** including but not limited to:

- Preliminary ASC X12 validation of file structure to ensure compliance with standards
- Validation of content at the data element level
- Mapping and verifying data to our schema, but in a staging area before committing the data to our production systems

We operate our own Secure File Transmission Protocol (SFTP) servers, which are used by trading partners to send or receive electronic files. Additionally, DentalTrac™ connects to external FTP servers, SFTP servers (directly or by Virtual Private Network), and secure web (HTTP/HTTPS) portals in order to exchange data.

MCNA's systems and network engineers monitor the continuous operation of all data interfaces, review and address any transmission or data communication errors, and maintain complete audit trails of activities in our data interface communications infrastructure. Our EDI team is responsible for verifying the successful transmission and receipt of electronic file exchanges. They review and audit the results of processing EDI files and immediately react to exceptions as required by this RFP.

Eligibility and Enrollment [§3.4.3]

DentalTrac™'s comprehensive eligibility and enrollment module uses a sophisticated **business rules engine to process benefit and enrollment data transmissions** and to determine eligibility and benefits of members. Our system accepts HIPAA-format and proprietary member enrollment files transmitted daily by trading partners. DentalTrac™'s sophisticated EDI subsystem also allows us to accept eligibility and enrollment data in virtually any data format provided. We are able to process data files with fixed or varying layouts, file formats, and delivery methods.

*In 2015, the MCNA EDI module processed **over 85 million enrollment transactions** for almost 4 million member records with an average turnaround time of 19.7 hours from the time the transaction file was received.*

Currently, we receive and process eligibility and enrollment data files from twelve different trading partners, most using HIPAA ASC X12N 834 file format and the rest using proprietary file formats. Our EDI subsystem and our Automated Communications Module (ACM) are responsible for automatically retrieving data files from our trading partners, applying all validation and business rules applicable to each trading partner and program administration. Scheduling the retrieval of data files from our trading partners can be configured with granularity down to a one-minute interval.

For Nevada, enrollment files will be received and processed monthly or more frequently if desired by DHCFP.

Upon processing eligibility and enrollment files, DentalTrac™ follows business rules that trigger multiple validation checks during the process and executes those steps necessary to satisfy contractual compliance. During the validation points, DentalTrac™ generates integrity checksums and reports that

confirm the electronically transmitted data file was not altered in any way during processing. The execution of additional steps throughout the loading of eligibility and enrollment files include:

- Normalizing and validating member addresses
- Reconciling members to households
- Assigning members to Primary Dental Providers (PDPs), if applicable
- Generating ID cards
- Producing member handbooks
- Preparing provider directories
- Reconsidering claims data
- Providing processing results and reports to internal staff and meeting plan-required notifications

Our Enrollment Coordinator works with the Member Services Department to ensure the accuracy and timeliness of member enrollment information. MCNA understands and agrees that it must use the data contained in the files received from the State to replace MCNA's existing eligibility files. All plan-approved changes to a member's eligibility record will be made when the daily file is processed such that, in real-time, the record reflects the most recent eligibility detail **ensuring members always obtain the services to which they are entitled**.

DentalTrac™'s extensive logging capabilities maintain an audit trail for all current and retroactive changes to enrollment data, whether those changes arise from manual updates or from processing an electronic transmission. **MCNA will accept and manually process changes from the DHCFP such as adding additional beneficiaries in the system.**

Our Member Services Representatives also have functionality available to them to capture additional information from our members, which may not always be available in the eligibility and enrollment files. This additional information may be critical to the successful delivery of services to our members. **Additionally, MCNA will submit a daily report of beneficiary eligibility daily update statistics to DHCFP in a method and format as approved by DHCFP.**

All member-related materials are also tracked within DentalTrac™, either automatically during the loading and processing of enrollment files or via manual updates done by our Member Services Representatives or Enrollment Coordinators. Changes to member records may trigger the **automatic mailing of member handbooks or welcome packets**. These materials will be automatically produced and mailed to new members within five (5) business days of receipt of eligibility and enrollment files from DHCFP.

DentalTrac™ leverages its uniform data dictionary to enforce referential integrity checks when loading and processing eligibility and enrollment files. Members are assigned a unique member number that persists across changes in demographics and changes in eligibility benefits and categories. Member eligibility is managed through non-overlapping dated eligibility spans which are linked to the member's record. All information in the eligibility and enrollment files provided by the Nevada MMIS will be stored within DentalTrac™ and linked to the member's profile for referential and reporting purposes.

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

The EM will be responsible for:

- Ensuring that enrollment files received are processed within the DHCFP-specified timeframe
- Reconciling the enrollment data
- Reviewing enrollments and disenrollments to identify potential issues, and ensuring each member's eligibility status is accurate
- Notifying the State if any issues are identified during processing of the file

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

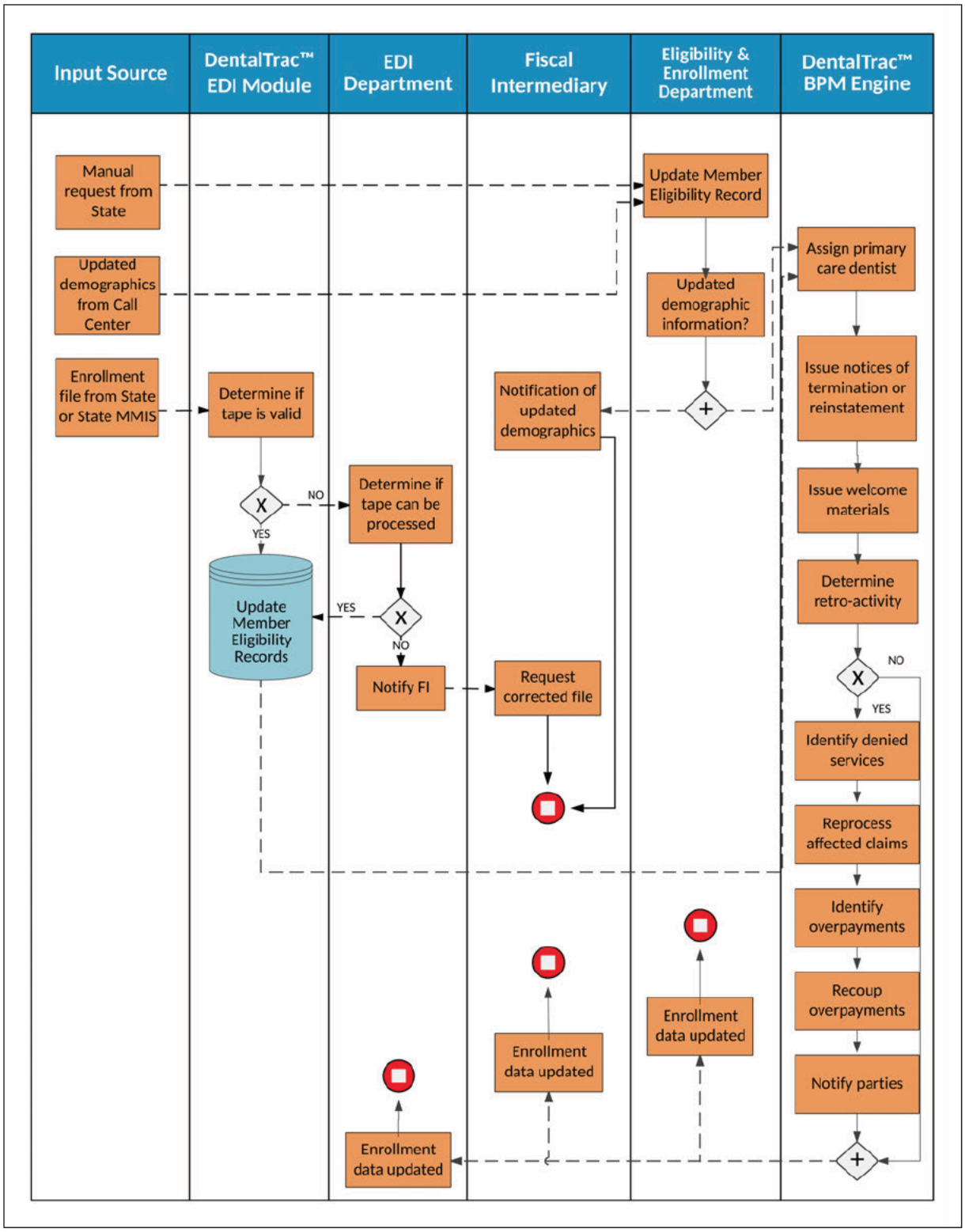
Our Eligibility and Enrollment module is **completely interoperable** with all other aspects of DentalTrac™. This allows for members to be identified uniquely across multiple populations housed in our system. Duplicate records for a single member can be identified and resolved to where enrollment, claims,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

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

MCNA is responsible for services rendered during a period of retroactive enrollment in situations where eligibility errors have caused an individual to not be properly and timely enrolled. In such cases, we will pay for such services that would have been authorized by MCNA had the individual been enrolled at the time of such services. For in-state providers in these circumstances, MCNA shall pay the providers for such services only in the amounts that would have been paid to a contracted provider in the applicable specialty. Out-of-state providers in these circumstances will be paid according to a negotiated rate between MCNA and the out-of-state provider. The timeframe to make such corrections will be limited to 180 days from the incorrect enrollment date. We understand that DHCFP is responsible for payment of applicable capitation for the retroactive coverage period.

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

Enrollment and Eligibility Process Flowchart



Provider Assignment and Transitioning of Members [§3.4.4 - §3.4.6]

Upon initiation of the transition phase for MCNA, we will provide the technical means by which our Enrollment team (Enrollment Sections) can:

- Determine the number of recipients each enrolled PDP will accept as new patients; and
- Transmit recipient elections regarding PDP assignment for the forthcoming month.

MCNA currently monitors PDP assignment for the millions of members we serve. Providers are asked to let MCNA know if they wish to limit or close their panels to new members. Upon receipt of such notification, MCNA adds the limitation to the provider and facility profile in the DentalTrac™ system. This prevents assignment of the provider as a PDP for new members. Each individual member's record in DentalTrac™ is updated to reflect their PDP assignment. Reports are routinely generated from this data and will be provided to DHCFP on a monthly basis.

MCNA notifies providers of the members who select them as their PDP via our online Provider Portal. All newly assigned members will be identified during their initial month of assignment. Providers can see the member's assignment history throughout the life of the assignment. This information is made available to each PCP within five (5) business days of MCNA receiving the Membership File. The DHCFP's Enrollment Sections will pass the Membership File through the system for verification of eligibility prior to distribution to MCNA, who will in turn be responsible for keeping individual participating providers informed. MCNA understands that we may elect to update our Membership File more frequently to keep PDPs informed of the enrollment activity.

MCNA acknowledges and understands that it may be necessary to transfer a member from one vendor to another or to FFS for a variety of reasons. When notified that a member has been transferred to another plan or to FFS, MCNA's written policies and procedures for transferring/receiving relevant patient information, dental records and other pertinent materials to the other plan or current FFS provider will be followed. This will be done in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and other privacy laws.

Recipient Services [§3.5]

Member Communication [§3.5.1]

MCNA knows the importance of consistent (and persistent) communication with our members and potential members because of our extensive experience with the Medicaid and CHIP programs in Texas, Louisiana, Florida, Kentucky, and Iowa. Our outstanding clinical outcomes coupled with high rates of member and provider satisfaction illustrate the effectiveness of our approach.

MCNA's goal is to ensure all member materials are consistent in style, language, and format, and are written using plain language that is focused on the essential information members need to understand. All member written materials are composed for ease of understanding, at or below an 8th grade reading level based on the **Flesch-Kincaid grade level calculation formula**.

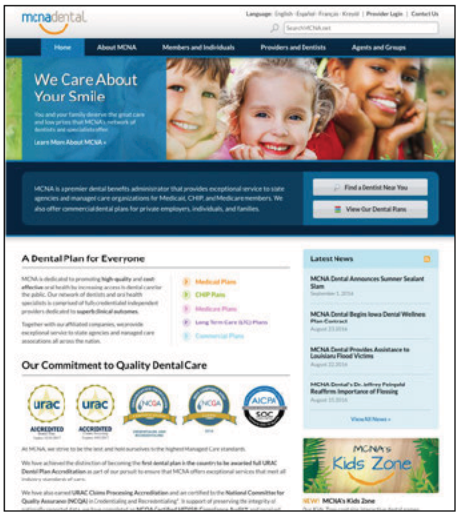
When creating member materials, our staff utilizes the following techniques to promote member comprehension:

- Use a positive tone and active voice
- Use bulleted lists to help pinpoint specific topics
- Use short sentences for ease of reading
- Provide specific, need-to-know information
- Avoid using acronyms, jargon, or figures of speech
- Use simple graphics or icons to communicate ideas
- Use a minimum font size of 12 point

MCNA translates member materials needed to communicate to each member their benefits, rights and responsibilities, and how to access and utilize dental services. We understand that all written materials must be available in English and Spanish, and that all educational and other materials must also be made available in any other language deemed necessary by the State of Nevada and in its particular geographic service area. MCNA will ensure that materials are translated, submitted for DHCFP approval, and made available to our members. **We understand that materials must be made available at no charge** to the member in that specific language to ensure a reasonable chance for all members to understand how to access the dental program and use services appropriately as specified in 42 CFR §438.10(c) (4) and (5). Large print, Braille, and audio recordings are also available to members who are visually impaired in accordance with the requirements of the Americans with Disabilities Act of 1990. MCNA uses Teneo Linguistics Company, a Texas minority owned business, for written translation services.

Teneo Linguistics Company®

Accuracy, ease of understanding, and readability are critical to ensuring compliance with the Social Security Act §1932 (d), 42 CFR §438.104, and the Federal Plain Language Guidelines. To ensure that these requirements are met, we have developed a Communications Committee to provide interdepartmental oversight of the quality, accuracy, and appropriateness of all communications we develop and publish for our members and providers. MCNA's Communications Committee membership is comprised of leadership from Call Center Operations, Grievances and Appeals, Utilization Management, Provider Services, Quality Improvement, and Compliance.



The Communications Committee reviews and approves all member materials prior to submission to the Compliance Department. Upon receipt, the Compliance Department reviews the accuracy and readability of the content to ensure compliance with state and federal requirements. The Compliance Department will then ensure that all member education materials, in all mediums, are submitted for review and written approval by DHCFP or its designee in accordance with Social Security Act §1932 (d)(2)(A), 42 CFR §438.104, and the terms of this RFP.

MCNA distributes member materials in a variety of ways. We provide educational materials at outreach events and as part of targeted, population-specific initiatives. Our member newsletter, the *Tooth Tribune*, is published via social media sites. Our dedicated Nevada website (http://www.mcnanv.net), Member Portal, and App also allow members to view and download educational flyers, games, videos, and our Nevada Member Handbook.

Availability of Bilingual Staff and Translation Services

MCNA satisfies the linguistic preferences of members whose primary language is not English by maintaining staff members who are culturally competent and fluent in Spanish, Creole, French, Vietnamese, and other predominant regional languages. If a caller has limited English proficiency, the call is transferred to a representative who conducts the call in the member's preferred language. MCNA has over 200 MSRs and over half are bilingual or multi-lingual.

If there are no representatives who speak the member's preferred language, MCNA can access the translation and interpretive services of our vendor, LanguageLine, the largest interpretation service company in the industry. LanguageLine provides translation services for over 200 languages not directly available from MCNA staff. A TTY/TDD line is also available for members who are deaf, hard of hearing, or speech impaired. Members who are unable to push telephone buttons are prompted to remain on the line while the call is routed to an MSR. **All translation services are provided free of charge to our members and providers.**

A description of how to access materials in alternative formats and the availability of oral/written interpretation will be featured on MCNA's Member Handbook and on MCNA's Nevada Website. MCNA's Member Hotline will be available to answer any questions a member or potential member may have about materials and oral interpretation services.

MCNA's Member Handbook [§3.5.2]

MCNA's Member Handbook will be sent to the head of every member household within five (5) business days of receiving notice of the recipient's enrollment. MCNA will submit the Member Handbook to the DHCFP before it is published and/or distributed and will make any changes requested

by DHCFP in order to comply with State and CMS requirements. MCNA acknowledges that the handbook must be updated at least annually.

Our Member Handbook is written at an 8th grade reading level, as determined by the Flesch-Kincaid index, and will be made available in alternate languages and formats. Members will be notified of their right to obtain information at least once per year upon request and how to access the most current Member Handbook on MCNA's dedicated Nevada website. The following statement is conspicuously displayed on the first page:

"THIS HANDBOOK IS NOT A CERTIFICATE OF INSURANCE AND SHALL NOT BE CONSTRUED OR INTERPRETED AS EVIDENCE OF INSURANCE COVERAGE BETWEEN THE VENDOR AND THE RECIPIENT."

Topics addressed in MCNA's Member Handbook include the following:

- How to Contact MCNA and the days/hours of operations
- Member Rights and Responsibilities, including the right to refuse treatment, and to express preferences about future treatment decisions
- Eligibility and Nature of the Relationship Between MCNA and the Member
- Enrollment and Disenrollment
- The Role of the Primary Dental Provider
- How to find a Primary Dental Provider by calling MCNA's Member Hotline or accessing MCNA's dedicated Nevada website, which is updated in real-time
- An insert listing current network PDPs, whether they are accepting new patients, and languages spoken in the office
- How to Change Primary Dental Providers
- Covered Services
- A list of all services available to EPSDT program members and a statement that services are provided to the recipient at no costs and a telephone number to call for assistance in scheduling an appointment
- How to Obtain Pre-Authorization for Dental Services
- Cost-sharing for non-covered services
- Referrals to specialists or other medically necessary dental services
- How to access Non-Emergency Transportation
- The right to request information on the structure and operation of MCNA and information about provider incentive plans as set forth in 42 CFR §438.6 (h)
- The Importance of Good Oral Hygiene
- Accessing Dental Care
- Obtaining a Replacement ID Card (if applicable)
- What to Do in an Emergency Situation (including natural disasters)
- Benefit Exclusions and Limitations
- Information needed to decide among relevant treatment plans
- The risks, benefits, and consequences of treatment and non-treatment
- Notice of Privacy Practices

- Filing a Complaint, Grievance, or Appeal
- Requesting a State Fair Hearing
- Reporting Suspected Fraud and Abuse
- Coordination and Continuity of Care
- How to Access Out of Network Care
- How to Obtain Prevention and Wellness Information
- Third Party Dental Coverage
- Other DHCFP Requirements

MCNA will provide written notice to members when there are significant changes to the Member Handbook within thirty (30) days of the intended effective date. We also provide notice to members when their dental provider who has delivered primary care or has seen the member on a regular basis is no longer participating in MCNA's network. This notice is provided within fifteen (15) business days after receipt or issuance of a provider termination. MCNA will also notify members of any changes to the Member Handbook no less that semi-annually via member newsletters. All changes will be documented and tracked to verify handbook updates.

A complete copy of the draft Nevada Member Handbook is included with this submission as **Attachment 3-4**.

Customer Service System [§3.5.3]

MCNA offers a comprehensive Customer Service System that provides courteous, prompt, and responsive support to all customers in a professional manner, ensuring that each Nevada Medicaid recipient, recipient's family member, provider, and DHCFP staff member will have an exceptional experience.

Toll-Free Member and Provider Hotlines [§3.5.3.1 - §3.5.3.2]

MCNA's Nevada Customer Service System provides a toll-free Member Hotline (1-844-350-MCNA) for program recipients, and a separate toll-free Provider Hotline (1-844-352-MCNA) for dental providers and their staff. Our Hotlines are staffed from 5am to 5pm PST, Monday through Friday, excluding state approved holidays. MCNA's interactive voice response (IVR) system is available 24x7x365 and provides a voice message system that informs callers of our business hours and what to do in cases of a dental emergency or natural disaster. It also offers an opportunity to leave a message after business hours, and all messages are returned within one (1) business day.

Call Center teams will address customer inquiries and provide information in a professional, prompt, and courteous manner.

Robust Call Center Capabilities [§3.5.3.3]

MCNA's Interactive Voice Response (IVR) system answers calls within one ring and offers a series of prompts in the essential languages of the markets we serve to ensure calls are routed correctly. After

authentication, callers can discuss any of their concerns with an experienced Call Center team member. Our Call Center Representative can provide a variety of services, including:

- Explanation of MCNA's role as Dental Benefits Administrator for DHCFP.
- Explanation of covered services.
- Verification of recipient eligibility.
- Member ID card replacement.
- Respond to all member inquiries including questions about claims, pre-authorizations, or referrals.
- Resolve and document verbal complaints.
- Submit formal member and provider complaints, grievances, or appeals to MCNA's Grievances and Appeals department.
- Concierge services to locate a provider (including an out-of-area or non-network provider if a contracted provider is not available within the access standards).
    - Assistance in changing or selecting a primary care dentist.
    - Assistance with appointment scheduling via a three party call with the provider office (including arrangement of non-emergency medical transportation, if necessary).

MCNA has over 200 Member and Provider Service Representatives who will be cross-trained to serve our Nevada dental plan members. This minimizes wait times for our customers, provides overflow capacity, and offers redundancy in the event of a system or power outage, or natural disaster.

Our Member and Provider Service Representatives will address customer inquiries accurately and provide information in a professional, prompt, and courteous manner.

After-Hours Procedures

MCNA's call center operates Monday through Friday 5am to 5pm PST, excluding state-approved holidays. For after-hours calls, including weekends and state-approved holidays, our members can access MCNA's toll-free IVR system. The voice-activated menu is available in the essential languages of the markets we serve, and can be easily modified to accommodate the language of any additional population group. The IVR informs callers of our operating hours and what to do in cases of a dental emergency or natural disaster. Members who have a dental emergency are given the option to speak with a qualified dental professional who will advise and direct members to the correct service location, including local emergency departments or dental offices. MCNA's toll-free IVR system also provides an opportunity for callers to leave messages. Our staff monitors the message queues and returns all calls within one (1) business day of receipt. All after-hours calls are logged, and response times are monitored.

MCNA's Compliance Department routinely audits MCNA's after-hours call handling process by remotely contacting the call center outside of normal business hours and validating the functionality of the system and the timeliness of the response from the call center staff.

Logging, Tracking and Monitoring Member Grievances

MCNA maintains well-defined procedures for logging, tracking, and monitoring grievances from the initial receipt to the decision time frame. Our proprietary management information system, DentalTrac™, time stamps each grievance enabling the creation of a complete audit trail to ensure compliance with all timeliness requirements. Our tracking system supports our grievance process and has the capability to track cases when they are received and resolved, as well as those that are in the process of resolution. The system allows the Call Center Operations Department to store all details of a grievance/complaint.

DentalTrac™ generates thorough reports used daily by MCNA's management team to track grievances and ensure timely resolution. DentalTrac™'s reporting capabilities allow for the generation of customized reports, and reports in formats that fully comply with DHCFP reporting requirements. MCNA is committed to meeting all DHCFP performance standards and reporting requirements.

Proven Call Center Performance

Our Member Services Representatives (MSRs) are our **"key link"** to the nearly **3,500,000 members** we serve. Our MSRs are at the forefront of our commitment to ensuring that all of our members receive accurate and timely information needed to access dental care, and are responsible for answering all inbound calls from MCNA's members.

Each MSR is **extensively trained** to provide accurate and timely resolution of all inquiries and issues using quality-driven customer service skills. This training has enabled MCNA to consistently meet and exceed all performance measures; both in our current service areas and those set forth for the State of Nevada. Please see below a table outlining MCNA's 2015 performance with respect to our Texas contractual standards.

2015 MCNA Annual Call Center Performance Measures			
Performance Measure	**Texas Target**	**MCNA's Performance**	**Target Achieved**
Service Level	80% within 30 seconds	**98.6% within 30 seconds**	✔
Average Speed of Answer	30 seconds	**1.42 seconds**	✔
Abandoned Call Rate (%)	Less than 7%	**Less than 1%**	✔

Training to Ensure Performance

MCNA understands the critical nature of each incoming call we receive from our members and providers. Our intensively trained call center staff is the heart of our business operation. MCNA's corporate philosophy recognizes that each caller is unique and special, and we treat him or her with the same courtesy and respect we would want our family members to receive. We strive continuously to ensure that our call center representatives are thoroughly trained and know how to handle the various situations that may arise. Our representatives present themselves with skill and professionalism at all times. We start by using the GROW model to acquire stellar talent. MCNA recruits a diverse workforce that mirrors the populations we serve. The GROW model uses a collaborative approach to determine if candidates are a good fit for our call center.

Goal	Recruit	Options	Welcome
Leadersh p d scusses recru t ng goa s and how to ach eve them.	Proact ve y seek out qua f ed cand dates to ensure the r ght ta ent s h red to meet bus ness needs.	Ut ze exper enced ca center eadersh p to nterv ew and conduct "round-tab e" d scuss on to determ ne wh ch cand dates are a good f t.	Onboard ng processes nc ude emp oyment ver f cat on, background checks, reference checks, and new-h re or entat on.

Martha Abadilla, MCNA's Associate Vice President of Administration and Operations, is responsible for educating, monitoring, and ensuring ongoing staff training as needed to maintain professional competency and the highest standards of customer service.

MCNA has a skilled training team led by Shawn Zielinske. Our training team continuously updates a library of training materials, desk reference materials, and our online knowledge database to ensure all MSRs have the most up-to-date program, benefit, and operational information. Each MSR receives formal training during the initial 90 days of employment with MCNA and is required to attend four additional supplemental training sessions per year.

Our MSRs attend a four-week training program that prepares them to provide exceptional customer service to our members. The program includes a comprehensive training schedule that covers:

- Customer Service Skills and System Navigation
- Fraud, Waste, and Abuse
- HIPAA and Regulatory Compliance
- Plan Specific Requirements and Covered Services
- Member Rights and Responsibilities
- Policies and Procedures
- Member Eligibility
- Provider Selection
- Special Health Care Needs
- Coordination of Care (including assistance with transportation services)
- Claims, Pre-Authorizations, and Referrals
- Complaints, Grievances, Appeals, and State Fair Hearings
- MCNA's FORCE Factors Quality Monitoring Program

MCNA's Customer Service Leaders

Martha Abadilla

AVP of Administration and Operations

Martha Abadilla is an accomplished operations leader with more than 15 years of experience driving organizational change in call center and customer care environments.

Shawn Zielinske

Director of Training and Quality Assurance

Shawn Zielinske is a 21-year veteran of the United States Air Force with 20 years of experience creating, developing, and implementing training programs and training personnel.

Aldwin Gomez

Director of Call Center Operations

Aldwin Gomez has over 17 years of experience in call center operations. He is a highly skilled, results-driven leader with a keen ability to unite teams and build relationships.

Dental Home Program and ESPDT Outreach [§3.5.4]

MCNA is committed to recruiting providers from across the State of Nevada to serve our Nevada Medicaid and CHIP members. Our network will include a sufficient number of general and pediatric dentists to ensure all Nevada members will have access to a primary care dentist who will serve as their Dental Home provider. For additional information about MCNA's network recruitment approach, please see the **Network [§3.6]** section of this response.

In keeping with the AAPD policy on Dental Home, MCNA supports and encourages the establishment of a dental home for all of its members. We understand that young children assigned and active with a dental home are more likely to maintain good oral health practices throughout the remainder of their childhood years. The AAPD adopted their policy because children having a dental home will have higher quality outcomes through receipt of early examinations and preventive care, and will result in lower cost due to fewer emergency room visits.

MCNA will send a letter to the member informing them of their assigned PDP's contact information and their ability to change their PDP at any time by calling MCNA's Member Hotline. MCNA will track the number of requests to change PDPs and the reason for such requests for quality assurance purposes.

We allow members the freedom of choice among participating providers and permit them to change Primary Care Dentists or Primary Care Dental Sites for any reason, without limitation. In cases where the PDP has been terminated, MCNA will notify members in writing and allow recipients to select another PDP, or make a re-assignment within fifteen (15) business days of the termination effective date and allow urgent care for members until a new provider has been assigned.

Within the Dental Home, dental care experts work together as a team with a member's family to ensure that each child receives the services he or she needs. The Dental Home provides culturally competent, individualized care to patients based upon their needs as assessed through a dental examination. The dental examination specifically evaluates the patient to identify any decay or gum disease. The Dental Home/PDP is responsible for providing comprehensive preventive, acute, and corrective care, and refers members to specialists as needed for services outside of the PDP's scope of practice.

In accordance with standards of practice and policy guidelines set forth by the American Academy of Pediatric Dentistry and the American Dental Association**, the PDP must also educate the member about the importance of receiving timely preventive care, how to properly care for the member's teeth and gums, and the benefits of a healthy diet (avoidance of sugar and acidic foods such as soda).**

Our participating dentists have the responsibility to develop a dentist/patient relationship based on trust and cooperation. Coordination of care strengthens the positive relationship between the member, the member's parent or guardian, and the provider. This coordination is a critical tool for achieving positive oral health outcomes.

For our pediatric members, it is important for the dental home provider to educate parents and guardians about their child's growth and development with respect to tooth eruption, exfoliation, and jaw growth. This anticipatory guidance helps families and caregivers fully understand the need for ongoing, routine dental care, and proper oral hygiene.

Commitment to AAPD Periodicity Schedule and EPSDT Requirements

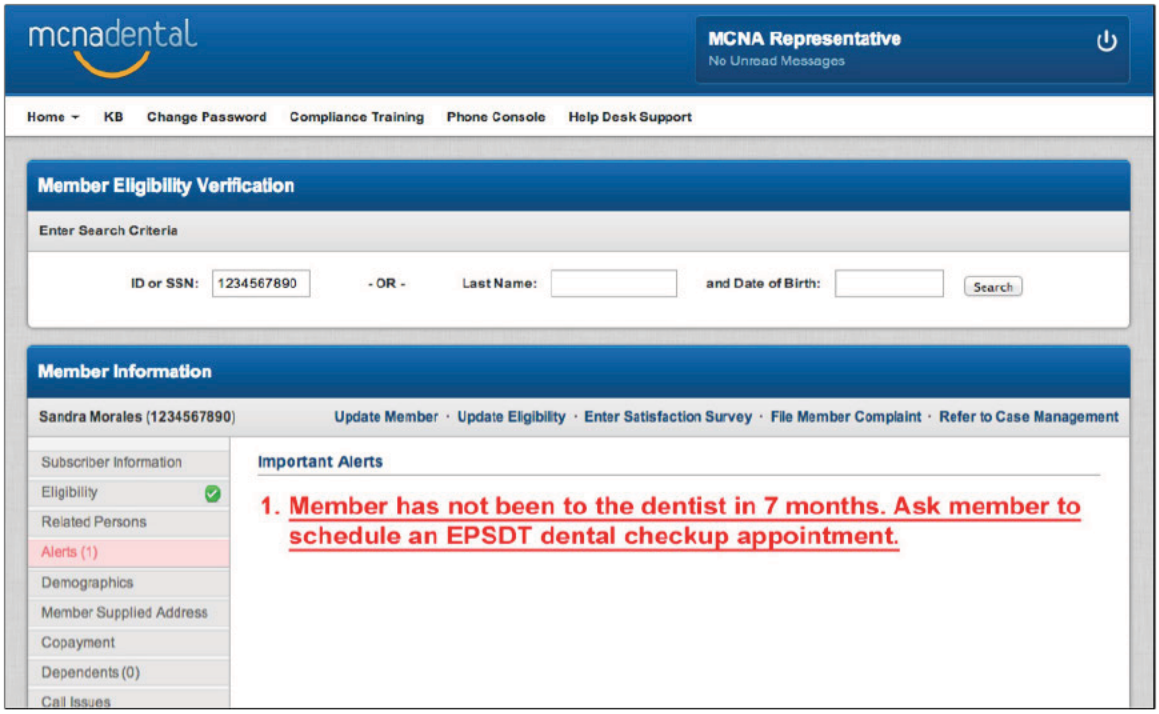
MCNA's stated mission is the improvement of oral health outcomes for children enrolled in Medicaid and CHIP programs by continuously stressing prevention, diagnosis, and early treatment intervention. The American Academy of Pediatric Dentistry's (AAPD) recommended Periodicity Schedule of diagnostic and preventive services forms the foundation of MCNA's approach to the provision of EPSDT services for children in all of the states we serve. For our adult members, we will monitor claims data to ensure the member has received an annual dental visit.

DentalTrac™ continuously mines member eligibility data received from DHCFP and current and historic claims data to identify children who are not receiving care in accordance with the AAPD Periodicity Schedule, and those adult members who have not received an annual dental visit. Our business intelligence functionality uses this data to generate actionable **Care Gap Alerts** for non-compliant members.

Care Gap Alerts are used by MCNA's experienced Quality Improvement (QI) Department, MAOS, and Call Center Operations to identify and coordinate education and outreach opportunities to both

members and providers. QI is responsible for overseeing quality initiatives throughout MCNA. Here are some examples of periodicity compliance focused activities:

- **Member Hotline:** Real-time information about AAPD and EPSDT compliance is used by our Member Services Representatives (MSRs) to identify members who are past due for a screening. MSRs assist the member in scheduling an appointment. Please see below a screen shot of a Care Gap Alert generated by DentalTrac™.



- **Provider Involvement**: Our providers are educated about the importance of member adherence to the periodicity schedule. MCNA's Provider Portal notifies dentists when any of their patients are out of compliance with the periodicity schedule so that the provider can attempt to make contact and schedule an appointment.

Providers are key to MCNA's multi-faceted EPSDT strategy. By educating our providers about the importance of periodicity compliance and monitoring their performance, we have been able to increase the number of members who receive an annual dental visit. Feedback is shared with dentists and offices that are not compliant with periodicity requirements, and we learn from providers how best to improve our process to support their efforts.

Case Management for Children with Special Health Care Needs [§3.5.5]

MCNA takes pride in the quality of care and attention we give to recipients who require additional assistance. For this reason, we are pleased to offer our Case Management program to our Nevada members. Individuals with developmental disabilities and those with special needs sometimes require a helping hand to navigate the dental care delivery system. We also work to identify providers to see adults and children with special needs and provide continuous follow-up to make sure these especially vulnerable recipients are getting covered dental services in a timely manner.

MCNA identifies those recipients eligible for case management through a variety of sources. Our Member Service Representatives (MSRs) and the enrollment file are the primary sources of this information. The MSRs are trained to ask whether a recipient is eligible for any of the Case Management categories. This information is then entered into the recipient's file in DentalTrac™ for use by Case Management Coordinators (CMC). Our Provider Relations Representatives also receive referrals to Case Management from participating providers.

MCNA integrates our dental disease management programs into our Case Management program. Any recipient identified as having a chronic dental condition or disease is eligible for Case Management. We have a holistic approach to dental care that creates the opportunity for more focused care delivery and increases the likelihood of better health outcomes.

Once identified, recipients are contacted telephonically by a CMC. The CMC explains the program to the recipient, and the recipient is encouraged to participate. Typically, most recipients welcome the opportunity to participate and receive assistance from our CMCs. MCNA makes no less than three (3) attempts to contact recipients in Case Management to remind them to seek routine or follow-up care.

MCNA's case managers provide a variety of services based on the needs of the individual recipient. A CMC may provide "one-time" assistance with transportation or locating a provider that treats patients with special health care needs. Some patients may require longer term support and assistance from Case Management, such as obtaining prior authorizations based on the recipient's treatment plan, conducting routine follow up calls ensuring the recipient is maintaining compliance with a given treatment plan, scheduling hospital based dentistry, or coordinating additional services (most commonly sedation services through an anesthesiologist).

A treatment development plan is created for all members with special health care needs. The treatment plan is developed by the PDP with member participation and in consultation with any specialists caring for the member. All treatment plans are approved in a timely manner and in accordance with any applicable State quality assurance and utilization review standards. Members with special health care needs have direct access to specialists through a standing referral or an approved number of visits as deemed appropriate for the member's condition and identified needs.

Please see the following flyer that describes the activities of MCNA's Case Management Program.

Case Management Program Flyer

MCNA Dental

Case Management Program

MCNA's Case Management Program assists:

- Members with special health care needs.
- Members with catastrophic dental conditions.

We assist members in the Program by:

- Finding dentists that speak the member's language.
- Identifying offices that can meet a member's special health care needs.
- Assisting members with scheduling appointments.
- Facilitating referrals and pre-authorizations as requested by the member's treating dentist.
- Coordinating dental care covered by the member's health plan.
- Obtaining a translator for dental office visits.
- Aiding members with obtaining transportation.
- Assisting members with obtaining all medically necessary treatment ordered by their dentist.

If you have questions or would like to refer a member to the Case Management Program, please call us (Toll-Free) at **1-855-702-6262**. Our hours are 7am to 7pm (CST), Monday through Friday.

Network [§3.6]

Robust Provider Network [§3.6.2, §3.6.11]

MCNA is an industry leader in building robust network solutions for state partners. We provide solutions that recognize and support the needs of some of the most vulnerable citizens while offering geographic accessibility. Our provider network development and management approach is based on the experience we gain by being on the ground; collaborating with providers, community leaders, and advocacy groups; and listening to our members and their families describe the challenges they face as they maneuver the dental care system. Building our network strategies around this feedback creates a strong foundation for the repeatable and sustainable success of our networks.

MCNA will recruit, credential, contract with, and maintain a statewide network of licensed dental care providers to deliver covered dental services to eligible Nevada Medicaid and CHIP beneficiaries as outlined in the RFP. MCNA will maintain a binding written agreement approved by DHCFP with all contracted providers performing duties covered by this contract. **MCNA will reimburse network providers on a fee-for-service basis; we do not capitate providers.** Network maintenance includes credentialing, contracting, provider education, performance monitoring, and corrective action/discipline, as needed. These are integral components of our approach to ensure a network that complies with the requirements set forth in the RFP and resulting contract.

In Nevada, we will deliver a statewide provider network that meets or exceeds all network adequacy standards. Equally important, we will focus on addressing underlying member access to care issues that may not currently be fully addressed. Our network will include providers who traditionally serve the population covered by the Nevada Medicaid and CHIP dental program, including Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and Indian Health Clinic (IHC) providers.

MCNA has assembled a strong leadership team in Nevada comprised of well-respected dental providers from the State. These dentists have spent their entire careers caring for Medicaid and CHIP populations and know these members deserve the same access to care as any other individual with commercial coverage. Our network providers share this philosophy and as part of their contract with MCNA agree to provide timely care to our members in accordance with the waiting times and office hour requirements of this RFP.

Network Management [§3.6.3]

MCNA is committed to recruiting providers from across the State of Nevada to serve our Medicaid and CHIP members. Our network will include a sufficient number of general and pediatric dentists to ensure all Nevada members will have access to a primary dental provider (PDP). [redacted] **In Nevada, the core of MCNA's Dental Home is the primary dental provider (PDP).** MCNA PDPs must adhere to all RFP requirements including the prompt delivery of medically necessary covered services, care coordination, and maintenance of a complete and current dental record for all members treated.

Within the Dental Home, dental care experts work together as a team with a member's family to ensure that each child receives the services he or she needs. The Dental Home provides culturally competent, individualized care to patients based upon their needs as assessed through a dental examination. The dental examination specifically evaluates the patient to identify any decay or gum disease. The Dental Home/PDP is responsible for providing comprehensive preventive, acute, and corrective care, and refers members to specialists as needed for services outside of the PDP's scope of practice.

In order to maximize the amount of time we have to build a robust network prior to the go-live date, we have already begun the recruitment process with an initial focus on the state's urban areas, such as Las Vegas and Reno. We have established relationships with several dentists and specialists throughout Nevada, and met with key leaders in the dental community through the Nevada Dental Association (NDA) and the Nevada Oral Health Advisory Board to gain insight into the issues facing Nevada's dental community. [redacted]

MCNA does not limit our networks. We welcome all providers who meet our quality and credentialing standards. MCNA continually recruits new providers into our network.

MCNA has a long history of partnering with essential community providers who serve our members. We will make a good faith effort to negotiate with all providers designated by the DHCFP as an essential community provider.

[redacted]

Our Director of Network Development will continually monitor geoaccess reports to verify that we have a sufficient number of specialists, pediatric dentists, and general dentists to care for our members. We repeat the RECRUIT process throughout the life of the contract to ensure that all new dentists in Nevada will be given an opportunity to join our network.

The mission of our Provider Relations Department is to ensure access for members to all medically necessary covered dental services. MCNA understands that ensuring patient access to care requires a stable and geographically distributed network of providers who are committed to maximizing their appointment availability for our members.

MCNA routinely monitors member complaints, enrollment data, and changes in the existing provider network in order to maintain network compliance with an emphasis on "lagging counties." Lagging counties include counties in which there is a shortage of dental care providers. We will ensure that all members, including those with special health care needs, have access to both general and specialty dental care.

Louisiana Success Story

MCNA was awarded the contract to serve as the sole Dental Benefits Program Manager on a full-risk basis for Louisiana's Medicaid and CHIP programs on March 21, 2014, with a program start date of July 1, 2014.

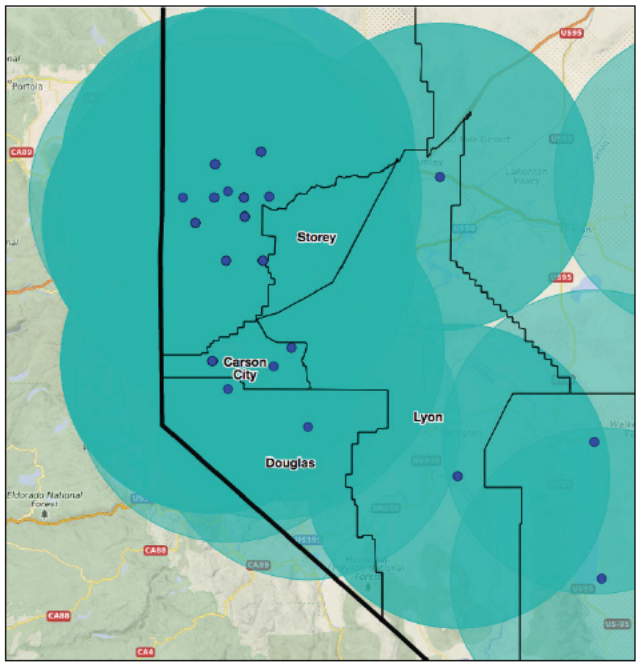
DEPARTMENT OF HEALTH

Prior to partnering with MCNA, Louisiana had approximately 600 providers who routinely treated participants in the Medicaid and CHIP programs. MCNA was able to recruit over 800 providers by the go-live date, of which over 200 were new providers who had previously chosen not to participate in the Medicaid and CHIP programs because of administrative hassles. Today, we have a network of nearly 950 providers in rural and urban areas to provide high quality dental care to our approximately 1,450,000 Louisiana Medicaid and CHIP members.

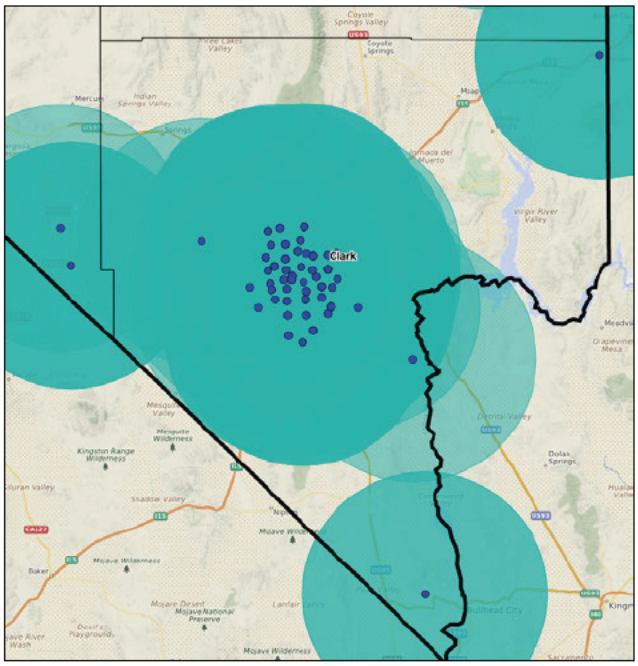
Current Nevada Network Analysis

MCNA has analyzed access to specialty care in Nevada and the following maps illustrated the geographic coverage of available dental specialists in relation to geographic regions in the State. The provider locations plotted in the sample maps below were obtained from the following website: https://www.insurekidsnow.gov. Each provider location is represented by a blue dot. The shaded circles indicate areas where coverage is available by a provider based on the provider's location, since member addresses are unavailable.

Sample Geoaccess Maps for Nevada Medicaid and CHIP



Urban Washoe County



Clark County

Access to Care [§3.6.5.1 - §3.6.5.7]

MCNA has a strong history of delivering access to care and will adhere to all DHCFP provider access requirements. MCNA actively communicates with dental program stakeholders to address issues and identify opportunities to improve the delivery of care to our members. All new members are welcomed to the plan via an outbound call campaign designed to encourage receipt of timely preventive care. This approach has yielded positive results in our other markets served. Since program inception, MCNA has made over 740,000 welcome calls to members in our Louisiana Medicaid and CHIP plans, advising them of the need to visit a dentist, offering assistance with scheduling an appointment, and informing them of their ability to select the PDP of their choice.

Our geoaccess mapping software enables MCNA to ascertain the travel time and distance from each member's residence to our participating network of providers. MCNA continually analyzes our network

for gaps and identifies available dental providers. We will monitor access using our geoaccess mapping software on a least a quarterly basis to ensure the following standards are met:

- The PDP network should maintain a ratio of one full time equivalent (FTE) dental provider to 1500 members (1:1500) per geographic service area. In no case may a single provider accept more recipients than allowed by the FTE requirement.
    - MCNA must also ensure the availability of pediatric dentists, dental hygienists, and oral surgeons in each geographic in a sufficient number to provide access to care.
    - Dental residents who have a temporary permit from the Nevada State Board of Dental Examiners may have their capacity increased to a ratio of 1:1000 members upon approval by DHCFP.
    - At least 50% of all network PDPs must contractually agree to accept eligible recipients.
- Members should have access to a Primary Care Dentist within 25 miles of the member's residence.
- MCNA shall provide at least two specialists in our service areas.
    - The specialist ratio is also one full time equivalent (FTE) dental provider to 1500 members (1:1500) per geographic service area.
    - We understand that the ratio of specialists to members may be adjusted by the DHCFP based upon availability of the specialty within the service area.

Appointment Availability [§3.6.5.8 - §3.6.5.10]

The ability of our members to access care from our network providers is greatly affected by the level of provider compliance with our prescribed appointment and wait times. MCNA's providers are contractually required to meet the appointment availability and wait time standards set forth in our contract with DHCFP. Our participating provider contract also prohibits hours of operation that are less than the hours of operation offered to fee-for-service patients. MCNA ensures our Nevada Medicaid and CHIP members are able to receive dental services on a timely basis as follows:

- **PDP Appointments:**
    - Urgent care, including urgent specialty care – 24 hours
    - Therapeutic and diagnostic care – 14 days
    - Routine or preventive dental care – six (6) weeks
    - Referrals for specialty care from a PDP – no later than 30 days
- **Specialist Appointments:**
    - Same day, emergency appointments – within 24 hours of referral
    - Urgent appointments – within three (3) calendar days of referral
    - Routine appointments – within 30 calendar days of referral
    - MCNA does not restrict access to pediatric dentists, and no referral is required for care from a pediatric dentist

We understand that access exceptions may be requested from DHCFP in compliance with section 3.6.5.10 of the RFP. We successfully meet similar access requirements for all of our existing state Medicaid and CHIP programs, and look forward to serving Nevada members.

MCNA also maintains written guidelines for member wait times at the dental provider's office. Should wait time exceed one (1) hour from the scheduled appointment time, the member is to be offered a new appointment time. We encourage members via the Member Handbook to let MCNA know if a provider's office fails to comply with wait time requirements. Trends in member complaints will result in corrective action for the non-compliant provider.

Our Provider Relations staff ensures accountability with these contract requirements by conducting unannounced site visits on a quarterly basis to at least 10% of the total provider network. A statistically valid random sample of dentists are selected in order to test their compliance with MCNA appointment and access standards, after-hours availability, and to verify that the provider offers the same hours of operation for Medicaid members as private fee-for-service patients. All results are maintained in the provider's record within DentalTrac™, our proprietary management information system. Should MCNA fail to meet the access standard requirements, we will implement a plan of correction (POC).

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

MCNA's Member Handbook and Provider Manual outline our appointment availability standards, including the requirements regarding after-hours coverage and how to obtain urgent dental care. Providers must have an answering service or voicemail message instructing members how to seek care, and this communication must be comprehensive in nature without simply directing the member to the nearest emergency room.

Our Provider Relations (PR) Department conducts audits to monitor after-hours access and telephone coverage standards. These audits are conducted by PR staff during onsite visits by viewing the office appointment book, and by calling provider offices after normal business hours to evaluate compliance with MCNA requirements.

In addition to provider site audits, our QI Department ensures provider compliance with appointment availability standards by engaging in **"secret shopper" calls**, and evaluating feedback from member satisfaction surveys and complaints. Secret shopper calls are made by QI staff on a routine basis and the results are tabulated and tracked for quality improvement and compliance purposes. Member complaints about appointment access are also monitored on a daily basis to identify and address provider non-compliance.

The POC will be reviewed and agreed to with the provider to ensure "buy in" and increase the likelihood that it will be successfully completed. The Provider Relations Department will audit the provider's performance of the POC within 30 days of execution. Provider Relations staff will share the results of the reviews with the provider and address any further or continuing compliance issues. If the provider is non-compliant, the provider will be reviewed again in 30 days. If the provider passes the initial 30-day review, a final review will occur in six (6) months to ensure ongoing compliance. A provider's continued failure to adhere to appointment and wait time standards may result in suspension or termination from the network.

Provider Terminations and Significant Network Changes [§3.6.5.11 - §3.6.5.12]

MCNA is proud to provide our members with access to highly qualified, fully credentialed networks of participating general dentists and specialists. MCNA has a proven track record of establishing and maintaining networks of qualified dental providers across every state in which we operate. MCNA's Network Development and Management policies and procedures comply with 42 CFR §438.214(a) and (b). MCNA will address material changes in the network that may negatively affect the ability of members to access services from specialty providers.

Our Network Development Department proactively assesses our network to ensure members have access to the care they need. **To date, MCNA has never experienced a significant, material change in our network in any of our existing markets.**

Should MCNA lose significant providers, our Network Development Department will conduct an analysis of the network to **identify any gaps, and develop interventions** to bring the network into compliance with contractual requirements as appropriate. MCNA will notify the DHCFP within one (1) business day of any significant network change. When MCNA has advance knowledge that a significant network change will occur, our Director of Network Development will notify the DHCFP as soon as the change is known, or not less than 15 calendar days prior to the change. In the event of an emergency material change where advance knowledge is unavailable, MCNA will work with DHCFP to provide expedited notice to affected members.

We will communicate any providers who are terminated, decredentialed, or disenrolled to the DHCFP Provider Enrollment Unit within five (5) business days. MCNA will provide all reasons or causes for the action, and we will provide the DHCFP with supporting documentation including patient files, audit findings, and medical necessity reviews as applicable.

MCNA will give notice to our members within 15 calendar days after receipt or issuance of a termination notice to or from a provider, and ensure that the terminating provider completes treatment for members in active care. We understand the impact that contract terminations can have on our members. To ease the transition, MCNA's DHCFP-approved notification to affected members will contain a list of alternate network providers available within their surrounding area. The notice will also include information on how to contact MCNA's Member Hotline for assistance with selecting a new provider. Members with special health care needs or those who may be undergoing active treatment plans are assured of our commitment to continuity of their care.

Our Subcontracts and Provider Contracts [§3.6.4, §3.6.5.13 - §3.6.5.14, §3.6.6]

MCNA understands that all subcontracts, including delegation agreements, must be in writing, must be prior approved by the DHCFP, and must contain all applicable items and requirements as set forth in the DHCFP DBA Contract, as amended. MCNA shall not delegate any item or requirement in the DHCFP DBA Contract to any subcontractor without the express, written approval of the DHCFP. Without limitation, MCNA will make all subcontracts available within five (5) business days of a request by the DHCFP. This includes but is not limited to administrative and technical services, and sub-contracted dental providers.

Any subcontract entered into by MCNA and approved by the DHCFP will include a full indemnification of the State of Nevada, the DHFCP, and all of its officials, representatives, and employees. MCNA shall fully comply with the procedures set forth in ***Attachment D, Contract Form***.

Our written provider contract details our requirements for participation and incorporates our Provider Manual. The contract and any necessary amendments are reviewed by MCNA's General Counsel and the Compliance Department to ensure compliance with all regulatory standards. All provider contracts, subcontracts, and addenda are subject to review and approval by the DHCFP, and will be submitted for

review and approval during the Readiness Review period. Any revisions to the agreement will also be submitted for DHCFP review and approval. MCNA will submit all provider contracts to the DHCFP or MFCU within five (5) business days of request. Key contract provisions include a prohibition against balance billing, fraud and abuse prevention standards, and dental record keeping requirements. Our provider contracts do not contain “gag” clauses, and are not structured to provide financial or other incentives for reducing or limiting medically necessary services. For additional information about MCNA’s provider contract requirements, please see our response to the **Program Integrity [§3.15]** section of this RFP. We will comply fully with all requirements outlined in the RFP with respect to provider contracts and prohibited practices.

Our **network development** methods are designed to ensure that our network includes a diverse array of providers to care for the population served. MCNA recruits providers that **value diversity** and are committed to serving people of racial and ethnic minorities and those with disabilities. We strive to achieve the best match possible in each community. MCNA captures information from providers regarding their own and their staff’s language abilities. This information is maintained on our online Provider Directory so that members can choose providers who speak **their preferred language**.

Our provider agreement **requires compliance with the Affordable Care Act (ACA) and the Americans with Disabilities Act (ADA)**, including **non-discrimination** provisions that we monitor and enforce. Member complaints are monitored for any allegation of discrimination by a network provider.

MCNA employs a **diverse workforce** that represents the spectrum of cultural diversity of our membership. Our Member and Provider Hotlines can easily meet the linguistic needs of our population. MCNA hires staff that is committed to their community, represents a variety of cultural backgrounds, and is capable of communicating in cross-cultural situations. **Discrimination is not tolerated** and we require employees and network providers to conduct business in a manner that recognizes the values, and affirms and respects the worth of the individual, and protects and preserves the dignity of each. Providers cannot create barriers or use methods designed to "steer" members to certain providers.

We provide diligent oversight of our contracted providers and maintain and implement policies and procedures for monitoring performance and providing corrective action. MCNA will submit these policies to DHCFP within 5 business days of any changes or upon request.

Initial and Ongoing Provider Education and Training [§3.6.10.3]

Our past experience in successful transitions allows us to proactively address the concerns of our providers, specifically with respect to provider claims processing, reimbursements, filing grievances and appeals, periodicity schedules for preventive care, and our clinical practice guidelines.

MCNA believes the key to our previous successes can be attributed to extensive training of our staff on transitioning providers to our plans, and the strong relationships we build with our provider communities during and after transitions. With **over 20 years of experience**, we have learned that the most effective way to build relationships is by establishing trust. MCNA establishes trust with our provider communities with early and earnest communication and then by training our staff on the following five guiding principles:

- **Mutual Concern:** MCNA demonstrates shared concern with our providers about the oral health of our members and the challenges of participation in a Medicaid plan
- **Keeping Commitments:** MCNA values integrity, competence, and consistency in keeping commitments to our providers and members
- **Open Communication:** MCNA fosters an open communication environment with customers, employees, providers and members
- **Active Collaboration:** MCNA actively collaborates with community partners, providers, and members to promote good oral health and an efficient Medicaid plan

- **Long Term Perspective:** MCNA invests in provider education and training to contribute to overall provider and member satisfaction

Building trust with the Nevada provider community is a top network development priority. With this long-term perspective in mind, MCNA will conduct initial and ongoing provider orientations and online training seminars (webinars), and provide a wealth of information through our Provider Portal and Provider Manual. MCNA's Provider Portal and Provider Manual educate providers on a wide spectrum of topics, and include our procedures for claims submissions, requirements for clean claims, payment and reimbursement options, submission of electronic and paper claims, and a complete user guide explaining the functionality of our Provider Portal.

Providers can find reference and educational materials on our web-based Provider Portal. These materials include provider manuals, program descriptions, claim submission guidelines, "how-to" video tutorials, ADA claim form completion instructions, and claim coding and processing guidelines. We make all efforts possible to maintain our provider network's awareness of changes in regulations, program administration, benefits, and other requirements that may impact their reimbursement or ability to treat our members.

MCNA will conduct regional training workshops prior to the operational start date to ensure providers experience a smooth transition to our program. These workshops will be the building blocks for winning their trust through open communication and active collaboration. Content covered in these workshops will also be available via a series of webinars. This dual approach to educational programming will allow providers multiple opportunities to receive training on MCNA's Provider Manual and learn about the operational aspects of the Nevada plan.

After go-live, workshops will be conducted each quarter on a regional basis and are designed to keep providers abreast of any changes to MCNA's policies and procedures, the DHCFP's requirements, or

federal requirements. The same content will again be available via webinars for providers and their office staff. All educational workshops, seminars, and orientation sessions will reinforce the need for providers to verify a member's eligibility prior to rendering services.

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

Recipient and Provider Mass Communications [§3.6.8 - §3.6.9]

MCNA recognizes the importance of educating our members about the services covered under their benefit plan and the importance of receiving timely preventive care. We understand that all general communications to recipients must be written at an eighth (8th) grade level of understanding reflecting cultural competence and linguistic abilities. The DHCFP must approve initial mass letter mailings and brochures or any subsequent change in content for members, exclusive of dental educational and disease management information, prior to release. If the DHCFP does not respond within ten (10) business days, MCNA may consider the communication approved.

Likewise, all general communications to providers including mass mailings, fax-blasts, brochures, batch emails, and communications specifically mentioned in this contract must be copied to the DHCFP. This provision does not pertain to communications on specific topics to individual providers.

Clinical Practice Guidelines [§3.6.1]

Our Utilization Review Criteria and Guidelines are based on the needs of our enrolled membership and contracted state plan requirements. The clinical guidelines address the provision of acute and chronic dental care services. [redacted]

Our Criteria and Guidelines are developed taking into account the following considerations:

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

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

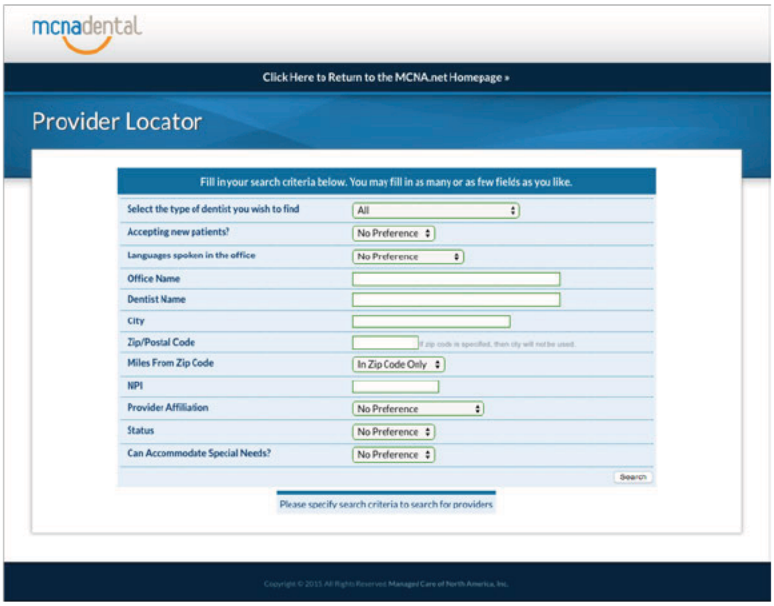
Each state's Utilization Management (UM) Committee is part of MCNA's quality improvement process. The committee is responsible for the development, adoption, and annual update of MCNA's Utilization Review Criteria and Guidelines. MCNA develops its clinical guidelines for preventive and therapeutic services based upon guidelines for appropriateness of care from the American Academy of Pediatric Dentistry, American Dental Association, American Association of Oral and Maxillofacial Surgeons, American Association of Endodontists, American Academy of Periodontology, and American College of Prosthodontists.

MCNA reviews our Utilization Review Criteria and Guidelines annually to ensure they are current with industry best practice standards and comply with our contractual agreements. A key part of the review process involves research and consultation with UM clinical staff, participating general dentists and specialists, and when necessary, expert consultants engaged by MCNA. The research results and recommendations are presented to the UM Committee, then to the QIC for final consideration and approval by the Board of Directors.

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

MCNA's Provider Directory [§3.6.7]

Our members can easily locate a participating dental provider by reviewing the Provider Directory included in their Welcome Packet, by visiting the dedicated MCNA Nevada website (www.mcnanv.net), or by calling our toll-free Member Hotline for assistance.



MCNA's Online Provider Directory

The Provider Directory in our Welcome Packet is organized so that a member can find a provider by their name or specialty. Our online Provider Directory interfaces directly with DentalTrac™, allowing any changes made in our provider network to be available online in **real-time** to members and stakeholders. As a result, members always have access to the latest, most accurate information regarding the nearest dental provider, including:

- Specialty

- Office Name
- Dentist Name
- Languages Spoken
- Ability to Treat Special Needs Members
- Ability to Accept New Patients
- Miles from the ZIP Code Requested

Members may contact the Member Hotline for assistance in selecting a dental provider. All members are free to choose a participating general dentist or pediatric dentist in our network, or if the member would like assistance selecting a provider, our Member Services Representatives (MSRs) are trained to ask the member questions about their preferences for a provider and recommend a provider that is likely to meet the member's needs.

We understand that listed providers must be active, currently providing care or accepting new patients and the provider's demographic data must be accurate. MCNA will provide the DHCFP with the most current provider directory upon contract award for each geographic service area. Upon request by the DHCFP, MCNA shall confirm the network adequacy and accessibility of its provider network and any subcontractor's provider network. When queried, at least 90% of listed providers will confirm participation in MCNA's network.

On a monthly basis, no later than the tenth (10) day of the month, MCNA shall submit to the DHCFP a list of all providers who have been enrolled and a list of all providers who are no longer participating or been removed from the active provider enrollment in the previous month.

MCNA's Nevada Provider Manual [§3.6.10]

Our Provider Manual contains a wealth of information specific to the Nevada Medicaid and CHIP dental managed care program. The Manual is developed by our Training and Quality Assurance Department. Our skilled team evaluates the RFP and contractual requirements and ensures that all relevant training content for the provider community is added. Once complete, the Manual is evaluated by MCNA's Communications Committee, which includes representatives from all key operational departments and senior management. After the Committee approves the draft Provider Manual, it is forwarded to the Compliance Department for submission to the Contract Monitor for review and approval.

MCNA's Provider Manual contains our policies and procedures that govern key processes such as:

- The definition for the population covered under the program
- The detailed benefit plans for each eligible population including covered services and limitations and exclusions
- Dental record keeping requirements and MCNA's dental record review process
- Details on MCNA's Grievance System including how to submit a complaint, grievance, or appeal, including the reconsideration process and State Fair Hearing process

- Information on how to file HIPAA-compliant paper and electronic claims, including a copy of the most current American Dental Association claim form
- Information about MCNA's free, online Provider Portal including: how to verify eligibility, and submit claims, authorization requests, and referrals
- Key contact information for MCNA and the DHCFP
- Frequently asked questions and answers
- Clinical criteria and guidelines
- MCNA's utilization management system and the program requirements of Medicaid
- Member rights and responsibilities
- Information about MCNA's quality improvement program
- The role of the Primary Care Dentist (Dental Home)
- Details on MCNA's program integrity efforts including how to report suspected waste, fraud, and abuse
- Information about MCNA's credentialing, re-credentialing, and Nevada Medicaid enrollment

The most recent version of the approved Provider Manual will be posted on our dedicated Nevada website and in our online Provider Portal. MCNA will furnish one (1) copy of the manual to each provider upon recruitment into the network before the provider has signed a contract, and must update all copies of the manual in each provider's possession when changes are made. Provider update notices sent via facsimile, mail, and/or e-mail may be utilized to update the provider manual when changes are made by MCNA. We understand this requirement may be met by furnishing one (1) copy of the manual and one (1) copy of the manual updates to each provider practice where several providers within the practice are participants in the network. If a provider agrees, the manual may be provided in electronic format. One (1) hard copy and one (1) electronic copy of the Provider Manual shall be provided to the DHCFP. That electronic copy must be updated with the same frequency as the hardcopy manual copies furnished to providers. The manual shall include all required information as detailed in the RFP.

Provider education is an integral component of our network development and retention strategy. In 2015, MCNA conducted over 6,000 provider orientations, in-office education sessions, and site audits.

Provider Portal

MCNA's online Provider Portal offers state-of-the-art web-based applications for our participating providers free of charge. MCNA's Provider Portal is a service module that is part of our management information system, DentalTrac™. This allows the Online Provider Portal to leverage our redundant, scalable, and secure technology framework that powers our MITA-aligned modular system. DentalTrac™'s technology framework includes all the network and communication hardware used to

support our hosted applications as well as all security and viral scanning programs involved with the communication portion of the applications.

Providers have unlimited access to our secure Provider Portal that support their routine administrative transactions with MCNA. This integrated, easy-to-use online portal offers an ideal solution for providers to perform the following necessary day-to-day functions:

- Verify member eligibility
- Submit claims
- Request pre-authorizations and referrals
- Print Remittance Advices (RAs)
- Submit claim appeals and reconsiderations
- Review a member's dental treatment history
- Create an appointment book
- View Member Roster
- View and update demographic information
- Access MCNA's Provider Manual
- Access program announcements and updates
- Access detail on MCNA's Provider Relations team including contact information and territory assignment maps

Dental Records [§3.7]

Compliance with Dental Guidelines and Accepted Practice Parameters [§3.7.1 - §3.7.2]

Provider dental records are a vital component of a high quality and trustworthy dental practice. MCNA conducts routine dental record reviews to ensure that our participating general dentists and specialists provide high quality dental care that is documented according to established national standards, DHCFP requirements, and state and federal law. MCNA's dental record documentation requirements will be distributed to providers via their dental provider agreement, Provider Manual, and MCNA's Provider Portal. Complete dental records must be maintained for each enrolled recipient by all contracted providers, in accordance with this RFP. The records shall be available for review by duly authorized representatives of the State and CMS upon request.

Routine dental record reviews enable MCNA to verify that provider treatment is delivered in accordance with our dental guidelines and generally accepted practice parameters. Additionally, our record review process enables MCNA to ensure that primary care providers are adhering to our Dental Home requirements. MCNA requires that member dental records be maintained on paper or in electronic format. MCNA's dental record policies are in compliance with state, federal and HIPAA guidelines and procedures that include standards for proper storage and retrieval of our member's dental records at the provider's office. Our written policies and procedures about dental record requirements ensure the confidentiality, accessibility and availability of records, and outline the record keeping and record review processes. The State shall have access to a recipient's dental record, whether electronic or paper, within 10 calendar days of request. The State has the right to obtain copies at MCNA's expense.

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

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

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

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

The reviews will be conducted for all offices. Each office will be reviewed at least once every three years. MCNA shall review a minimum of 10 records for each office to determine compliance. Larger file samples will be reviewed for large group practices given the more intricate administrative characteristics of this type of practice.

The Audit Tool we use captures the degree to which providers are complying with dental record guidelines adopted by MCNA. This process allows for the tracking and trending of individual and plan-wide provider performance over time and includes the following:

- Mechanisms and processes that allow for the identification, investigation, and resolution of quality of care concerns
- Mechanisms for detecting instances of over-utilization, under-utilization, and inappropriate utilization

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

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

MCNA will report the results of all record reviews to DHCFP quarterly and also provide an annual summary upon request.

Below is MCNA's Dental Record Review Audit Tool. This review thoroughly captures all required service delivery elements and **ensures that providers deliver and document** all required components of EPSDT screening.

MCNA's Dental Record Review Audit Tool [Page 1 of 2]

MCNA Dental
Dental Record Review Audit Tool
Proprietary and Confidential

Provider Name: _____ **Provider #**_____

Address: _____

Initial Review: _____ **Follow up Review:** _____

Reviewer: _____ **Date:** _____ **Facility#**_____

Answer all Questions Either Yes, No or N/A	PATIENT ID#	PATIENT ID#	PATIENT ID#	PATIENT ID#	PATIENT ID#
1 Do all pages contain a patient name and ID?					
2 Is there biographical/personal data (address, employer, home #, work #, legal guardianship, marital status, date of birth, sex)?					
3 Do all entries include services provided and a summary of procedures (including significant surgical procedures, past and current diagnoses or problems)?					
4 Is the provider identified on each entry? (provider name should be on each entry written or stamped)					
5 Do all entries include the name and profession of the practitioner rendering the services including the signature or initials? (credentials)					
6 Are all entries dated and signed? (person providing the care must sign and date the entry)					
7 Is the record legible and maintained in detail? Can you or the staff read the record? (complete and organized; maintained consistently)					
8 Is there a current medical history listing, past medical history and current diagnosis or problems (a list of significant illnesses and medical conditions)?					
9 Are allergies and untoward reactions/adverse reactions to medications/drugs and current medications prominently displayed and dated? (allergies and reactions must be noted) If no allergies, "NKA" documented)					
10 Is there a chief complaint or purpose of the visit, the objective findings of the practitioner, diagnosis, proposed treatment and prescriptions noted?					
11 Is there evidence of appropriate and timeliness of care (diagnosis consistent with the findings)?					
12 Is there documentation of studies ordered and referrals, including referral reports? (if applicable, documentation of referral, from a specialist, and a report from the specialist, if no referral or studies, mark N/A)					

MCNA's Dental Record Review Audit Tool [Page 2 of 2]

13 Is there a record of emergency services or records from OON providers, and/or special handling of high-risk individuals and/or hospital discharge summaries? (if there has not been any emergency treatment mark N/A)					
14 Are plans of action/treatment consistent with diagnosis (follow up plan such as a return visit)?					
15 Do all entries include the disposition (treatment indicated and if necessary prescriptions), recommendations, instructions to the patient and evidence of follow-up/return visit and outcome of the services rendered?					
16 Are problems from previous visits addressed? (if applicable)					
17 Does the record contain documentation that the enrollee has an Advanced Directive and/or was provided with written information concerning his/her rights regarding Advanced Directives? (Living Will or Power of Attorney, if member is under 18, mark N/A)					
18 Does the record have documentation of the primary language spoken by the member and translation needs of the member?					
19 Is there documentation identifying the member needing communication assistance? (such as braille, sign language or interpreter services)					

Reviewer Comments:

_____

_____

Areas for Improvement:

_____

_____

SCORE: _____ (score of 80% must be obtained)

Signature: _____ **Date:** _____

Dental Record Review Results Given to: _____ **Signature** _____

Ownership and Transfer of Dental Records [§3.7.3 - §3.7.4]

The recipient's dental record is the property of the provider who generates the record. MCNA will assist the recipient or the parent/legal guardian of the recipient in obtaining a copy of the recipient's dental records, upon written request, from the provider.

MCNA's provider agreement will require providers to furnish records within 30 calendar days from the date of request. We acknowledge and understand that each recipient or parent/legal guardian of the recipient is entitled to one (1) free copy of the requested dental records, and that the fee for additional copies shall not exceed the actual cost of time and materials used to compile, copy, and furnish such records.

When an enrolled recipient changes primary care providers and/or health plans, MCNA's contracted provider must forward all dental records in their possession to the new provider within 10 business days of the request.

Quality Assurance Standards [§3.8]

Quality Assurance and Performance Improvement [§3.8.1]

Skilled, experienced dental staff lead MCNA's Nevada plan. [redacted] Together with the Quality Improvement (QI) staff, they will ensure that our providers are educated about and engaged in our quality improvement initiatives.

[redacted]

[redacted]

The MCNA Organization is committed to continuous quality improvement. We are eager to partner with the DHCFP to ensure that quality dental care is available and accessible to all Nevada Medicaid and CHIP members. We will provide continuity of care to our members, and engage in outreach initiatives designed to increase the utilization of preventive dental care services.

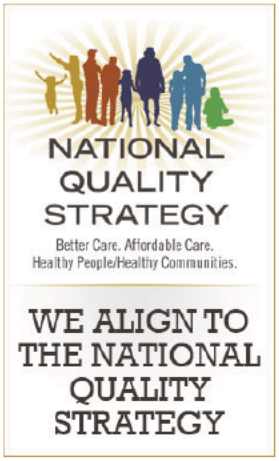
We understand that the quality and availability of preventive services are monitored and evaluated by the DHCFP in conjunction with the DHCFP's External Quality Review Organization (EQRO) contractor. MCNA will work collaboratively with the DHCFP and the EQRO in these quality monitoring and evaluation activities. Our Vice President of Dental Management and Quality Improvement, DeDe Davis, will serve as the designated lead for quality management. [redacted]

MCNA will provide all required data and reporting required by DHCFP and the EQRO, including ad-hoc reporting as needed. We will participate in all required and assigned activities, including additional activities requested by the State or its EQRO.

Performance Measure and Quality Approach [§3.8.2]

The goals and approach of MCNA's QI Program are designed to strategically support and align with the National Quality Strategy (NQS), which is led by the Agency for Healthcare Research and Quality on behalf of the U.S. Department of Health and Human Services (HHS). The NQS consists of three (3) aims, six (6) health care priorities, and nine (9) levers/actionable items to execute its strategy. MCNA

has adopted the NQS' three (3) aims as our overarching goals to drive better, more affordable health care for Nevada Medicaid and CHIP beneficiaries.



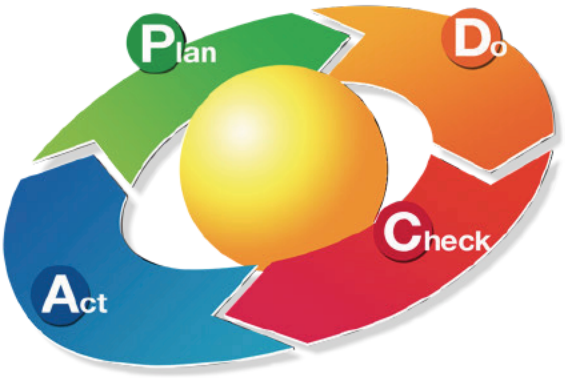
- **Better Care:** Improve overall quality by making oral health care more patient-centered, reliable, accessible, and safe.
- **Affordable Care:** Reduce the cost of quality oral health care for individuals, families, and government.
- **Healthy People/Healthy Communities:** Improve the health of the Nevada population by supporting proven interventions to address behavioral, social, and environmental determinants of oral health in addition to delivering higher-quality care.

[redacted]

Our experienced QI staff identifies the barriers to care for our members through extensive research utilizing materials published by state EQROs, oral health coalitions, child advocacy groups, academic institutions, and healthcare agencies. We complement our state-specific research with select materials published by similar institutions on a national level to establish objectives and **best-practice strategies** to achieve our performance goals.

MCNA identifies and prioritizes strategies to improve the oral health care and services for our members using the Plan-Do-Check-Act approach. This cycle is repeated until all targeted outcomes are achieved.

- **Plan**: Research the needs of the target population
- **Do**: Implement specific interventions
- **Check**: Evaluate for effectiveness
- **Act**: Make corrections or add interventions



Total Quality Management Methodology (The Deming Cycle)

We coordinate performance improvement projects (PIPs) with the EQROs that work with the states we serve. We collaborate with the EQROs to finalize target initiatives and identify reporting metrics to determine the effectiveness of our interventions and approaches.

MCNA understands that Nevada's Quality Strategy will be updated by the DHCFP to indicate the set of dental quality measures to be reported. We agree that the DHCFP and/or the EQRO may conduct on-site review as needed to validate dental measures reported. MCNA will use audited data and is responsible for ensuring all updates to the measures are reflected in the final, reported rates. The DHCFP reserves the right to require MCNA to conduct special focus studies and report on additional quality measures when requested. On an annual basis, MCNA will report on all performance measures listed in the State Quality Strategy.

We are committed to achieving a participation rate greater than or equal to the national average for EPSDT dental screenings for our Nevada members. The DHCFP and/or the EQRO may conduct desk and/or on-site review as needed, including evaluation of: policies and procedures for EPSDT, service delivery, data tracking and analysis, language in dental care provider contracts, and the process for member notification. MCNA's internal EPSDT quality improvement program includes monitoring and evaluation of the referrals that are the result of an EPSDT dental screening.

MCNA will submit the CMS 416 EPSDT Participation Report to the DHCFP for each quarter of the federal fiscal year (FFY), October 1st through September 30th, to track the progress being made throughout the year. The final CMS 416 Report will be submitted to the DHCFP no later than March 1st after the FFY reporting period concludes. MCNA will complete all dental line items of the CMS 416 Report applicable for dental care and submit separate reports for the NCU, FMC, and CHIP Medicaid expansion.

Should MCNA demonstrate a participation rate less than the Quality Improvement System for Managed Care (QISMIC) improvement measure, as determined by the DHCFP or its contracted EQRO, we understand that a Plan of Correction (POC) may be required.

Tracking Utilization of EPSDT Services and Preventive Care

MCNA's management information system has been supporting all operations since our inception. As a fully integrated and scalable MIS, DentalTrac™ supports the needs of nearly 3,500,000 Medicaid and CHIP members. DentalTrac™ is a proven platform that has successfully demonstrated its ability to process provider claims, verify eligibility, collect and report encounter data, and validate prior authorizations, all of which complies with DHCFP requirements.

Our MIS uses relational database management systems in its Online Transaction Processing (OLTP) and Online Analytical Processing (OLAP) database systems that are fully compliant with industry standards supporting Structured Query Language (SQL), and with interfaces such as Open Database Connectivity (ODBC) and Object Linking and Embedding (OLE).

DentalTrac™ tracks and maintains each member's:

- Dental service utilization
- Preventive treatment due dates (AAPD and EPSDT periodicity schedule compliance for members under 21)
- Referrals for corrective treatment
- Claims which indicate whether treatment was received including dates of service and procedures rendered

Monitoring Progress via Detailed Reporting [§3.8.3]

[redacted]

The flexibility built around DentalTrac™'s framework allows for a scalable and high-performance system capable of handling the capacity and workload described in this RFP as well as providing the seamless support necessary to interface with all DHCFP systems and standards, including the Nevada MMIS.

DentalTrac™ will generate all required reports including reports on EPSDT services delivered and utilization of services by NCU, FMC, and CHIP Medicaid expansion members in the format required and in accordance with the timeline specified by DHCFP and CMS.

Should MCNA fall short of the QISMIC improvement measure, DHCFP may require the submission of a plan of correction (POC). Unless otherwise specified by the DHCFP, MCNA must submit a POC within

30 days of DHCFP's request. The POC identifies the specific issue requiring corrective action and must:

- Describe the corrective action to be taken;
- Outline the goals of the corrective action;
- Provide a time-table for action;
- Identify changes in processes, structure, internal/external education;
- Describe follow-up monitoring, evaluation and improvement; and
- Identify the MCNA staff responsible for implementing and monitoring the POC.

The POC should identify improvements to existing outreach and education initiatives that will improve MCNA's rates and scores. The POC will be evaluated by the DHCFP to determine whether it satisfactorily addresses the actions needed to correct the deficiencies. If the POC is unsatisfactory, the DHCFP will indicate the deficiencies and MCNA will submit a revised POC within 30 calendar days. If MCNA's second plan is unsatisfactory, the DHCFP may declare a material breach. Within 90 calendar days after the vendor has submitted an acceptable POC or one has been imposed, the DHCFP will initiate a follow-up review, which may include an on-site review. MCNA understands that non-compliance can result in administrative sanctions and/or liquidated damages.

Our Experience

MCNA generates daily reports to monitor our utilization goals in the markets we serve. The results of these reports are used by our UM and Quality Improvement Departments to determine the need for additional outreach or intervention. For example, in the Louisiana Medicaid and CHIP dental program we recently implemented a Summer Sealant Slam to drive increased utilization of sealants for children age 6-9. **These efforts were extremely positive and our year-over-year comparison shows a 9.4% increase in utilization.** Please see below the outreach flyer sent to our network of dental providers about this initiative.

MCNA's 2016 Summer Sealant Slam Flyer

mcnadental

MCNA's 2016 SUMMER SEALANT SLAM is in Full Swing!

Don't forget - our sealant campaign is happening now and we need your office to help us reach our goals for increasing sealant placement for Louisiana EPSDT members.

We will add $10.00 to our standard fee

for each sealant placed on first permanent molars (TIDs 3, 14, 19, and 30) of eligible Louisiana EPSDT members aged 6 – 9 years.

The Summer Sealant Slam benefits your office and children in the Louisiana EPSDT Dental Program by:

- Automatically increasing your reimbursement by **$10.00** for CDT code **D1351** each time you submit a claim for any eligible MCNA member on **dates of service from July 25, 2016, to September 30, 2016.**
- Increasing awareness and utilization of dental sealants as a powerful preventive service.
- Providing MCNA members without a dental home access to these services at special **Sealant Saturday** events, which are hosted by MCNA in partnership with the Louisiana State University School of Dentistry.

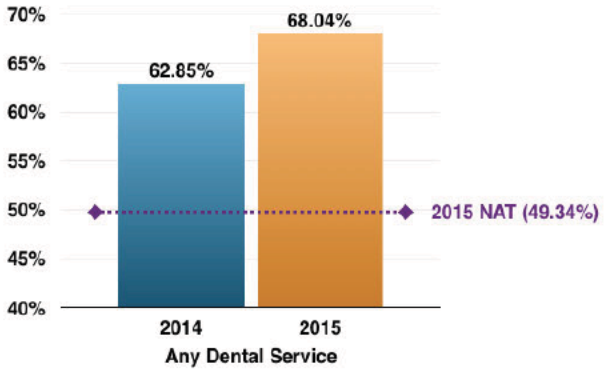
For more information, please call MCNA's Provider Hotline at **1-855-701-6262.** We look forward to connecting with you about this initiative and how we can assist your office in providing this important preventive service to the greatest number of members possible.

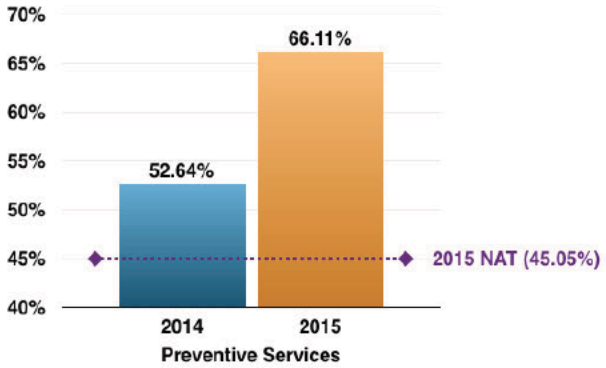
Toll Free: (855) 702-6262 • TTY: (800) 947-5277 • Web: http://www.mcna.net • Follow us on

MCNA_LA-P_SUMMER-SEALANT-SLAM-2016[1.0]

MCNA will produce and submit all required utilization reports and fulfill ad hoc requests from DHCFP within 10 business days of a request. **All ad hoc reporting will be provided to DHCFP free of charge**. We have years of experience reporting utilization metrics in the formats required by the states we serve.

Please see below a comparison of Texas CMS-416 results for dental service utilization and preventive care utilization in comparison to the national average (NAT) for federal fiscal years 2014-2015. Texas leads the nation in preventive dental care utilization.





[redacted]

[redacted]

[redacted]

Standards for Internal Quality Assurance Programs [§3.9]

MCNA's Internal Quality Assurance Program (QI Program) [§3.9.4, §3.9.6, §3.9.9 - §3.9.15, §3.9.21, §3.9.23]

MCNA has over a decade of experience in developing process improvements and interventions that enhance clinical efficiency, provide effective utilization, and improve outcome management for the Medicaid and CHIP members we serve. With a current membership of nearly 3,500,000, MCNA holds the most full-risk, dental managed care contracts with state agencies. Together with MCNA, our state clients have achieved some of the highest levels of success with preventive care and other quality measures in the nation. MCNA has been providing comprehensive dental benefits to Florida CHIP members through a contract with the Florida Healthy Kids Corporation since 2005. Our most recent audited HEDIS scores exceed the Medicaid national mean for all age cohorts. We have managed the dental benefits of Texas Medicaid and CHIP members since 2012, and Texas is ranked first in the percentage of children receiving preventive dental care in the nation. (source: FFY 2015 CMS 416 preventive care measure)

Our Quality Assurance and Performance Improvement Program (QI Program) is designed in accordance with 42 CFR §438.330 and 42 USC §300kk. The QI Program systematically monitors and evaluates the quality and appropriateness of care and services, and promotes improved patient outcomes. MCNA's policies and procedures define the scope of the QI Program including, but not limited to: the line of authority and accountability; the infrastructure and coordination with corporate entities; the Quality Improvement Committee's (QIC) membership and

Quality Improvement Leadership

Ronald Ruth, DDS
Chief Dental Officer

Dr. Ronald Ruth has over 45 years of dental practice experience as a Florida-licensed General Dentist and co-founded the first dental managed care plan in the State of Florida. Dr. Ruth currently serves on the URAC Dental Advisory Board.

DeDe Davis
VP of Dental Management and Quality Improvement

Ms. Davis has over 25 years of healthcare experience, with a focus on ensuring members receive the right care, at the right time, in the right setting.

committee responsibilities; the integration of focus groups; data use criteria; process for selection of performance improvement projects (including prioritization of high risk populations); and the development of our QI Work Plan that outlines the planned initiatives.

The QI Program structure has been established by MCNA's Board of Directors, which retains ultimate authority and accountability for the QI Program. The Board oversees and evaluates the impact and effectiveness of the QI Program, provides strategic direction, and ensures incorporation of the program into MCNA's business operations. [redacted]

The QIC meets on a quarterly basis and is accountable for the development, implementation and oversight of Nevada's comprehensive annual QI Program Description, Work Plan, and annual Program Evaluation. The QIC selects, directs and utilizes task forces, other MCNA committees, Member and Provider focus groups, and other plan activities to define the scope, develop the goals and objectives of the QI Program, and identify, define and direct the quality improvement activities. Complete minutes are maintained for all meetings and will be reported to the DHCFP following the end of each quarter.

Members of the Quality Improvement Committee are appointed by the Board of Directors. All provider advisory appointments and member appointments are at the discretion of the chair.

- Chaired by: Chief Dental Officer
- Co-Chair: Nevada Dental Director
- Plan President
- Nevada Executive Director
- Vice President of Dental Management and Quality Improvement
- Director of Quality Improvement and Risk Management
- Chief Operating Officer
- Chief Information and Security Officer
- Chief Compliance and Privacy Officer
- Senior Vice President and General Counsel
- Vice President of External Affairs and Deputy General Counsel
- Vice President of Operations
- Associate Vice President of Administration and Operations
- Director of Utilization Management and Case Management
- Director of Grievances and Appeals
- Director of Call Center Operations
- Director of Network Development
- Director of Credentialing
- Director of Claims Management
- Director of Human Resources
- Clinical Reviewers (licensed dentists)
- Participating Network Dentists

- Member or member representative from an advocacy group

MCNA understands that we must submit our QI Program description (IQAP) to the DHCFP for written approval prior to the contract start date. The following QIC functions are incorporated into the QI Program Description. For a complete listing, please see **Attachment 3-3**, MCNA's draft Nevada QI Program (IQAP).

- Providing oversight and review of the QI Program's subcommittees;
- Evaluating quality training materials prior to their dissemination, including ensuring compliance with CMS protocols;
- Implementing quality training for providers about standards for dental record keeping, utilization of preventive services (sealants, prophylaxis, and fluoride), missed appointments and continuity of care, oral hygiene instruction (brushing and flossing), and compliance with the American Academy of Pediatric Dentistry's periodicity schedule;
- Developing educational materials to teach parents and members about oral health and preventative services;
- Tracking indicators, reviewing studies and quarterly reports, and ensuring follow up on the resolution of opportunities for improvement;
- Suggesting and reviewing new and/or improved QI activities;
- Reviewing and approving all policies and procedures;
- Reviewing and approving the Dental Utilization Management Program and Plan;
- Assessing the quality and appropriateness of dental care furnished to members with special healthcare needs;
- Determining issues and subjects for review (e.g., accessibility and availability studies);
- Approving quality indicators for each of the reporting departments;
- Approving the selection of PIPs and/or focused studies, as well as the study design procedures;
- Monitoring the QI Work Plan and program activities to ensure assigned tasks are initiated and completed according to schedule, and overseeing the documentation of the results of activities;
- Reviewing, approving, and monitoring corrective action plans;
- Conducting individual primary care dentist (Dental Home) and dental practice quality performance measure profiling;
- Reviewing performance reporting on measures from delegated entities;
- Reporting findings to the Board of Directors, relevant stakeholders, other departments, and contracted providers (if applicable), as required but no less than quarterly; and
- Reviewing the scope, objectives, organization, and effectiveness of the QI Program at least annually, or more frequently as necessary, and presenting the results to the Board of Directors.

The QIC has the authority to promote organizational accountability by identifying, assessing, and correcting quality of care issues, to improve dental care services. The QIC and its four subcommittees are responsible for the implementation and operation of the QI Program. Meeting minutes are taken for the QIC and all subcommittees. The QIC's four subcommittees, and their scope of accountability are as follows:

- **Credentialing Subcommittee** supports MCNA's credentialing and recredentialing efforts. [redacted] The committee meets monthly or more frequently as needed. Primary functions under the committee's accountability include:
    - Review and approval or denial of applicants seeking network participation and those existing providers seeking recredentialing;
    - Review and evaluation of issues and/or trends for prospective and existing providers; and
    - Conducting ongoing monitoring and oversight of existing providers.

- **Peer Review Subcommittee** supports MCNA's efforts to provide due diligence to network providers regarding professional competence and provider disputes. It also works to ensure members receive high quality dental care according to prevailing standards of the dental care industry. The committee objectively and methodically assesses, evaluates and resolves issues related to the quality and appropriateness of care, safety and services. The Peer Review Subcommittee is chaired by MCNA's Nevada Dental Director, or his designee, and meets on an as needed basis. Primary functions under the committee's jurisdiction include:
    - Providing resolution to provider disputes involving adverse patient incidents associated with professional competence, professional conduct, and the quality of care and services delivered to members; and
    - Reviewing complaints or allegations against a provider and evaluating whether the severity of the issue requires a corrective action for that provider up to and including limitations, suspension, or termination from MCNA's participating provider network.

- **Utilization Management (UM) Subcommittee** supports MCNA's policy development and oversight process for dental utilization management. This committee monitors the medical appropriateness and necessity of dental care services utilizing clinical criteria. The committee uses both qualitative and quantitative analysis to discern dental practice patterns and utilization trends. [redacted] Primary functions under the committee's jurisdiction include:
    - Developing and assessing the UM portion of the QI Work Plan;
    - Monitoring for the consistent application of medical necessity criteria and clinical practice guidelines;
    - Reducing inappropriate and/or unnecessary dental services without adversely affecting the outcome of service delivery;
    - Monitoring service utilization patterns of members;
    - Reviewing and assessing trends in clinical grievances and appeals, and providing recommendations to improve the effectiveness of the utilization review process based upon findings; and
    - Reviewing the effectiveness of the case management program and recommending changes to improve processes as needed.

- **Grievances and Appeals (GAC) Subcommittee** supports the implementation and management of processes for member and provider complaints, grievances and appeals. [redacted] Primary functions under the committee's jurisdiction include:
    - Reviewing complaints, grievances, and appeals reports; and
    - Trending of complaints, grievances and appeals by nature and outcome to identify and target quality improvement opportunities.

All key data elements are captured in MCNA's management information system, DentalTrac™. Our fully integrated and scalable MIS has been supporting all operations since our inception, and supports the needs of the nearly 3,500,000 Medicaid and CHIP members we currently serve. DentalTrac™ is a proven platform that has successfully demonstrated its ability to process provider claims, verify eligibility, collect and report encounter data, and validate prior authorizations, all of which complies with Nevada requirements.

For detailed information about the powerful data collection and reporting capabilities of our MIS, please see the **Management Information System (MIS) [§3.13]** and **Reporting [§3.16]** sections of this response.

QI Program Evaluation [§3.9.7, §3.9.8.7, §3.9.9.4 - §3.9.9.5]

MCNA's policies and procedures define the scope of the QI Program including, but not limited to: the line of authority and accountability; the infrastructure and coordination with corporate entities; the Quality Improvement Committee's (QIC) membership and committee responsibilities; the integration of focus groups; data use criteria; process for selection of performance improvement projects (including prioritization of high risk populations); and the development of our Annual Work Plan (QI Work Plan) that outlines the planned initiatives.

The QI Department, in collaboration with the QIC, develops the QI Work Plan. DHCFP and External Quality Review Organization (EQRO) recommendations and input from our departmental leadership team are taken into consideration for annual updates to the QI Work Plan. Results are reported to the QIC. On an annual basis, the Work Plan is reviewed by the QIC and reported to the Board of Directors. As necessary, selected areas of performance from the Work Plan may be brought to the QIC and Board of Directors more frequently. The QI Work Plan may be expanded whenever additional opportunities for quality improvement are identified.

Under the direction of the CDO and Vice President of Dental Management and Quality Improvement, and with input from department heads, the Director of Quality Improvement and Risk Management produces a formal written assessment of the effectiveness of the QI Program. Without limitation, the QI Program Evaluation:

- Measures the progress of key performance indicators and quality improvement activities
- Identifies the interventions and activities that resulted in meaningful improvement
- Evaluates the progress made towards improving and/or sustaining service levels

- Evaluates PIP (clinical and non-clinical) initiatives under way during the preceding 12 months against established goals
- Integrates feedback and recommendations from DHCFP and its EQRO
- Identifies and eliminates barriers to success
- Integrates member and provider feedback from the advisory groups
- Assesses adequacy of resources allocated to execute the QI Program
- Evaluates the overall effectiveness, continuity, and current acceptability of the QI Program

The QI Program Evaluation guides the development of the QI Program and work plan for the following year. The evaluation assists staff in identifying the priority areas for study, annual quality improvement initiatives, resources needed to achieve objectives, and timeframes for the implementation of and the completion of initiatives. The QIC reviews the written evaluation report and assesses the adequacy of the program. The QIC approves the evaluation, revised QI Program and QI work plan for the upcoming year and presents it to MCNA's Board of Directors for final approval.

Collaboration with DHCFP

MCNA will work closely with the DHCFP and its EQRO throughout the contract term to ensure that our QI Program is focused on meeting DHCFP's quality goals, and to ensure positive oral health outcomes for our members. MCNA will submit Nevada's QI Program to DHCFP prior to the contract start date for written approval. Following DHCFP approval, MCNA will submit QI Program reports annually to DHCFP which, at a minimum, will include:

- QI activities;
- Recommended new and/or improved QI activities; and
- Evaluation of the impact and effectiveness of the QI Program, including all care management activities.

Additionally, MCNA will maintain and make available to the DHCFP, and upon request to any federal or state regulatory entities, studies, reports, protocols, standards, worksheets, minutes, or such other documentation as requested concerning its quality assurance activities and corrective actions.

Performance Improvement Projects [§3.9.1 - §3.9.3, §3.9.5]

MCNA continuously monitors performance on a variety of care and service indicators for our members. We identify opportunities for improvement by comparing our performance with national benchmarks and to our own performance over time. Per the RFP requirements, MCNA will implement performance improvement projects (PIPs) in both clinical care and non-clinical services such as system or service initiatives. [redacted]

The QI Department continually evaluates data and feedback from members and providers to identify challenges and barriers. The interventions are developed to address the specific issues associated with each PIP goal. Improvement in PIP measures will be demonstrated through ongoing measurement and analysis of intervention effectiveness.

At least quarterly, the results of PIPs will be reported to MCNA's Quality Improvement Committee (QIC) for review and discussion. The QIC reviews the progress of each PIP and ongoing results of each PIP measurement. The committee discusses these results and recommends or approves additional interventions, as needed.

Performance Improvement Projects (PIPs) will be managed internally within our Quality Improvement (QI) Department and led by the Vice President of Dental Management and Quality Improvement. Results of PIPs are tracked internally on an ongoing basis, and reported to our QIC.

Annually, the QI team will report on the results of PIPs as part of the annual QI Program Evaluation. The QI Program Evaluation is presented to the QIC and then to MCNA's Board of Directors. The QI Department will utilize the standard measures required by the DHCFP, including those that incorporate the requirements of 42 CFR §438, to capture and report on an annual basis all data elements about our clinical and administrative PIPs specified by DHCFP.

MCNA maintains a fully integrated management information system (MIS) that collects, analyzes, integrates, and reports data on provider and recipient characteristics in all operational areas including, but not limited to, utilization, grievances and appeals, and enrollment demographics such as race, ethnicity, sex, primary language and disability status. For more information about our proprietary MIS, DentalTrac™, and how it meets DHCFP data maintenance and reporting requirements, please see the **Management Information System (MIS) [§3.13]**, **Program Integrity [§3.15]**, and **Information Systems and Technical Requirements [§3.17]** sections of this response.

Monitoring Key Performance Indicators [§3.9.8, §3.9.22]

MCNA maintains a "dashboard" of quality indicators referred to as "key performance indicators" for every state we serve. Relevant metrics for all operational departments are tracked and trended. Operational data is measured in comparison to contractual performance standards. Clinical performance indicator data is compared to national benchmarks reported by the National Committee for Quality Assurance (NCQA), the American Dental Association's Dental Quality Alliance (DQA), and external quality review organizations (EQROs) contracted by the state agencies we serve.

MCNA's QI Department continuously monitors plan operations to identify areas for improvement. Each of our plans has a dedicated key performance indicator (KPI) dashboard that tracks contract performance across a spectrum of measures.

The KPI dashboard allows for the rapid identification and escalation by our supervisory staff of any performance standard issues affecting our plans. Each department monitors their operational performance on a daily, weekly, monthly, quarterly, and annual basis. The results of operations and our rate of success meeting the standards are reported to MCNA's QIC on a quarterly basis. Feedback generated through the dashboard will be incorporated into QI Program. Our Nevada KPI dashboard tracks contract performance across a spectrum of measures including identified performance standards from this RFP:

- Network Access and Availability
- Call Center
- Grievances, Appeals, and State Fair Hearings
- Claims Processing
- Encounter Data
- Reporting
- Key Persons
- Prior Authorizations
- Quality Measures

This dashboard approach ensures rapid identification and escalation by our supervisory staff of any performance standard issues affecting our plans.

Recipient Rights and Responsibilities [§3.9.16]

MCNA maintains policies and procedures that allow recipients the freedom to exercise their rights. MCNA's Member Services Department informs our members of their Rights and Responsibilities and ensures that they are treated in a respectful manner. MCNA has adopted the National Committee for Quality Assurance's (NCQA) model Member Rights and Responsibilities standards, which incorporates all federal and Nevada-specific requirements. Members are informed of their Rights and Responsibilities through their Member Handbooks, MCNA's website, and our Member Portal. Providers are informed via their Provider Manual, Provider Orientation Training Sessions, and the Provider Portal. The Member Services Department will:

- Incorporate Member Rights and Responsibilities into the departmental training materials.
- Ensure that each member is treated with dignity, respect, and consideration of privacy.
- Assist members with knowledge of who their primary dentist is should they not have this information, treatment choices, and assist them in obtaining any requested dental information.
- Inform members of their right to provide input concerning their dental treatment.
- Document if the member has questions regarding their rights and responsibilities.
- Provide a copy of Member Rights and Responsibilities upon request.
- Answer any question the member may have regarding rights and responsibilities by referring them back to the Member Handbook. If a member still has questions to help provide explanation or refer to an appropriate department.
- Have bilingual Member Service Representatives available to assist members.
- Have member materials available in English, Spanish, and other languages as needed.

Please see **Attachment 3-4**, MCNA's draft Nevada Medicaid and CHIP Member Handbook, for the full list of Member Rights and Responsibilities.

Ensuring Accessibility of Services

Access to dental care and services is vital to MCNA's philosophy of cultivating and maintaining good oral hygiene outcomes for our members. MCNA is committed to communication and education, and we believe these are the most important tools we have to influence member behavior. **We seek to empower members and their caregivers to take responsibility for their oral health.**

Each MCNA member receives a Member Welcome Packet upon enrollment, which consists of a Member Handbook, ID card, and an MCNA Provider Directory that lists primary dental providers and specialty providers near the member's home address. All materials are written for ease of understanding and at or below an 8th grade reading level, based on the Flesch-Kincaid grade level calculation formula. Topics addressed in MCNA's Member Handbook include, but are not limited to, the following:

- How to obtain services during regular hours of operation
- How to obtain urgent, emergency, and after-hours care
- How to obtain emergency out-of-service area dental care
- How to obtain the names, qualifications, and titles of dental providers who are accepting new patients
- How to access assistance from MCNA in finding a dental provider and scheduling an appointment
- How to file grievances, appeals, and State Fair Hearings (Please see the **Grievances, Appeals, and Fair Hearings [§3.12]** section of this response for a full description of MCNA's grievance and appeals process)

MCNA engages in additional outreach activities designed to promote the accessibility of dental care and services available to members, including outbound call campaigns and targeted member outreach at health fairs and other community events. Please see the **Recipient Services [§3.5]** section of this response for more information about how MCNA meets the needs of our members.

MCNA's Corporate Culture of Compliance

Our Compliance Program promotes an organizational culture that encourages ethical conduct and a commitment to compliance with the law. MCNA creates and maintains corporate policies and procedures that govern the manner in which we conduct our business. These policies and procedures are specific to each business area within the company. Compliance with 42 CFR §438; HIPAA; and HITECH requirements are integrated into all applicable policies and procedures and into our employee training. All MCNA employees receive compliance training within 30 days of initial hiring, upon adoption of updates to the Compliance Program, and annually as a condition of employment. Thirty days before an employee's anniversary, our Human Resources Department begins the process of reminding all employees of their upcoming annual training.

A critical component of MCNA's compliance with State and federal laws is conducting regular auditing and monitoring activities to identify and to promptly rectify any potential barriers to such compliance. Audits of MCNA's Compliance Program focus on regulatory compliance and at-risk areas. The Compliance Department conducts a series of monitoring and auditing activities on a monthly, quarterly, and annual basis to ensure that MCNA is meeting all State, federal, and accrediting organization requirements. Our monitoring techniques involve sampling protocols that permit the Compliance staff to identify if any compliance issues exist. Routine HIPAA assessments are also performed throughout MCNA. These audits focus on ensuring member information is properly maintained by employees in the workplace. The results of these audits are reviewed by MCNA's Compliance Committee and reported to the Board of Directors on a quarterly basis.

MCNA will comply with any applicable federal and State laws that pertain to member rights and ensure that its staff and affiliated providers also do this when furnishing services to members.

MCNA maintains a Compliance Hotline for employees, members, and providers to report violations of federal and State regulations regarding discrimination, privacy, and disability. MCNA employees found to have violated any HIPAA, ADA, or anti-discrimination requirements will be disciplined in accordance with MCNA's disciplinary policies, up to and including termination of employment.

Our participating providers are also required to implement mechanisms to guard against the unauthorized or inadvertent disclosure of confidential member information. Providers are informed about these requirements as they pertain to their practice through Provider Orientation Sessions and their Provider Manual. MCNA utilizes activities such as onsite visits and routine dental records reviews to verify that providers adhere to all applicable requirements and regulations. We also enforce the provisions of our participating provider agreements through administrative sanctions, the use of corrective action plans, additional training, and if necessary, termination of the provider's contract.

MCNA understands and agrees that all member satisfaction surveys must be of a statistically significant sample size and assess at least a sample of all recipients, recipient requests to change practitioners and/or facilities, and disenrollment by recipients.

Access and Availability, and Dental Record Keeping Standards [§3.9.17 - §3.9.18]

The ability of our members to access care from our network providers is greatly affected by the level of provider compliance with our prescribed appointment and wait times. MCNA's providers are contractually required to meet the appointment availability and wait time standards set forth in our contract with DHCFP. Our participating provider contract also prohibits hours of operation that are less than the hours of operation offered to fee-for-service patients. MCNA ensures our Nevada Medicaid and CHIP members will receive dental services on a timely basis. Please see our response to **Network [§3.6]** for additional information on our processes for monitoring and ensuring all standards are met.

MCNA's Participating Provider Agreement requires that member dental records be maintained on paper or in electronic format and contain all required elements. MCNA's dental record policies are in compliance with state, federal, and HIPAA guidelines and procedures that include standards for proper storage and retrieval of our member's dental records at the provider's office. We ensure that member dental records are maintained in a timely manner, legible, current, and that records are detailed and organized to permit effective and confidential patient care and quality review.

Routine provider dental record reviews are a key component of our QI Program. They enable MCNA to verify that provider treatment is delivered in accordance with our dental guidelines and generally accepted practice parameters. Additionally, our record review process enables MCNA to ensure that primary dental providers are adhering to our Dental Home requirements. Please see our response to **Dental Records [§3.7]** for additional information about MCNA's record keeping requirements and our review processes.

MCNA's Utilization Management Program [§3.9.19]

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

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

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

Pre-Authorization Review Requirements

MCNA accepts prior authorization requests submitted by providers **electronically**, via our free, easy-to-use online **Provider Portal**, or on **paper**. All three options are HIPAA-compliant and are directed immediately to our Utilization Management Department. All prior authorizations requiring medical necessity determinations are routed to a Clinical Reviewer through our state-of-the-art management information system, DentalTrac™. **MCNA maintains a staff of active licensed primary and specialty care dentists who serve as Clinical Reviewers and review all requests for authorization.**

Requests for services are reviewed to determine that the service is a medically necessary covered benefit and that the service is being delivered consistent with established criteria and guidelines. MCNA ensures that compensation to all individuals that conduct utilization management activities is not structured to provide incentives for the individual to deny, limit, or discontinue medically necessary dental services to any MCNA member.

Our Clinical Reviewers examine each pre-authorization and relate the existing conditions to the qualifying criteria to determine approval. They use criteria to evaluate information submitted by dentists such as x-rays, models, narratives, and chart notes to determine the medical necessity of requested procedures. Clinical reviewers will seek additional information from the requesting provider as needed.

The requesting provider is notified of the UM determination in real-time via MCNA's online Provider Portal. If a provider does not have access to the Provider Portal, a determination letter is mailed. The provider also receives telephonic notification of MCNA's determination for any urgent or emergent requests.

MCNA notifies our members in writing of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested within the timeframes outlined by DHCFP. Member notices are written to ensure ease of understanding and are in compliance with all state, federal, and DHCFP requirements. MCNA fully complies with all language requirements including the translation of member notices into Spanish, Tagalog, and other languages as required.

Member and provider notifications explain, at a minimum, the:

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

We make every effort to inform and assist our members, their authorized representatives, or providers with accessing the grievances and appeals system. MCNA educates our members and providers via the Member Handbook, Provider Manual, notices of decision, and through our website which is available in English, Spanish, and Tagalog. For detailed information about the mechanisms MCNA has in place for recipient appeals and grievances as well as provider disputes, please refer to the **Grievances, Appeals, and Fair Hearings [§3.12]** section of this response.

Clinical Practice Guidelines [§3.9.8.2, §3.9.8.4 - §3.9.8.6]

Our Utilization Review Criteria and Guidelines are based on the needs of our enrolled membership and contracted state plan requirements. The development of our clinical guidelines falls under the Utilization Management (UM) Subcommittee. MCNA develops its clinical guidelines for preventive and therapeutic services based upon guidelines for appropriateness of care from the American Academy of Pediatric Dentistry, American Dental Association, American Association of Oral and Maxillofacial Surgeons, American Association of Endodontists, American Academy of Periodontology, and American College of Prosthodontists.

On an annual basis, our Utilization Review Criteria and Guidelines are reviewed to ensure they are current with industry best practice standards and comply with our contractual agreements. A key part of the review process involves research and consultation with UM clinical staff, participating general dentists and specialists, and when necessary, expert consultants engaged by MCNA. The research results and recommendations are presented to the UM Committee, then to the QIC for final consideration and approval by the Board of Directors. For additional information about MCNA's clinical guidelines, please see the **Network [§3.6]** section of this response.

MCNA continuously uses the advanced auditing functions of DentalTrac™ to analyze our providers' utilization patterns for adherence to our approved criteria and clinical guidelines. We will encourage

compliance by educating our providers via the Provider Manual, provider newsletters, postings to the online Provider Portal, and during site visits, orientations, and provider webinars.

Our process will ensure that dental providers are consistently in compliance with the Utilization Management requirements of this RFP. Outlying providers will be administratively reviewed for compliance. When outliers are identified by Utilization Management Coordinators or Clinical Reviewers, MCNA's Quality Improvement Department may perform dental record reviews on a statistically significant sample of the provider's dental charts. MCNA maintains written procedures for corrective actions regarding non-compliant providers.

Continuity of Care [§3.9.20]

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

From a continuity of care perspective, the success of a member's dental care is entirely dependent on the ability of a treating dentist to complete the treatment plan. This is especially true for members whose health condition has been treated by specialty care providers or whose health could be placed in jeopardy if medically necessary covered services are disrupted or interrupted.

To facilitate continuity of care, every new member in active treatment transitioning into MCNA will be allowed to continue medically necessary covered services with an in-network or non-network provider, without prior approval from MCNA for a period of 90 days. Non-network care may continue until the member's records, clinical information and care can be transferred to an in-network provider, or until such time as the member is no longer enrolled with MCNA, whichever is shorter. For tracking purposes, MCNA encourages providers to submit a continuity of care (COC) form to ensure members receive services during the transitional period. Our management information system, DentalTrac™, maintains all continuity of care information for our members. The use of a single, unified system for all key operations areas ensures that data is available to all MCNA departments. Information regarding how to access services during the transition will be available online via MCNA's dedicated Nevada website and in our Member Handbook.

Our Approach to Handling Provider Disputes [§3.9.24]

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

We have a toll-free Provider Hotline that is available for providers to ask questions about the program, file a complaint, request information or seek resolution of a problem. The Provider Hotline is available 5:00 am until 5:00 pm PST throughout the State of Nevada, Monday through Friday, excluding state-approved holidays.

To ensure providers are aware of MCNA's provider complaint process, we will feature the toll-free number prominently on our website, in the Provider Manual, Provider Portal, provider education materials, and for non-network providers, on our Remittance Advices. The information will include specific content about the Provider Hotline, how to contact your Provider Relations Representative, and details on how to submit a complaint via email or surface mail.

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

When MCNA receives a provider complaint, the complaint is date stamped, triaged, and logged into the Grievances and Appeals module of DentalTrac™, which houses our electronic complaint tracking log. Once the case is logged, it is assigned to a designated Provider Relations Representative who is responsible for conducting a thorough investigation, including reviewing all pertinent facts and regulations, and ensuring all issues presented in the complaint are completely addressed.

State Quality Assessment and Performance Improvement Strategy [§3.10]

Nevada's State Quality Strategy

MCNA is committed to the delivery of the highest quality services and continuous quality improvement across our organization. We understand that the DHCFP has developed a comprehensive Medicaid and CHIP managed care Quality Assessment and Performance Improvement Strategy as described in section 3.10 of the RFP. MCNA will fully incorporate and comply with all elements of the State's strategy and will work with the DHCFP and its EQRO to drive improvement in targeted measures to improve the overall health of our Nevada members. Below are specific examples of our experience in increasing care through performance improvement projects (PIPs), soliciting and incorporating member and provider feedback, and ensuring that we promote cultural competency internally and between our members and their dental care providers.

We look forward to bringing our proven approach to the Nevada Medicaid and CHIP dental program.

Performance Improvement Project Experience

We coordinate performance improvement projects (PIPs) with the external quality review organizations (EQROs) that work with the states we serve. The EQROs work with us to finalize target initiatives and identify reporting metrics in order to determine the effectiveness of our interventions and approaches. For example, the Institute for Child Health Policy (ICHP) serves as the EQRO for the Texas Health and Human Services Commission and the Florida Healthy Kids Corporation, and we work closely with them to drive quality metrics in both states.

Proven Texas Experience

MCNA has extensive experience in the development and successful delivery of performance improvement projects. **We recently scored 100% on our second annual PIP progress reports submitted to the Texas Health and Human Services Commission** as a part of our Quality Assessment and Performance Improvement (QAPI) Program for their Medicaid and CHIP dental program. Our Texas-specific PIPs were designed to improve the rate of members receiving annual dental visits (ADVs), a measure of the Healthcare Effectiveness Data and Information Set (HEDIS). The **perfect score that MCNA earned from the Texas EQRO** reflects our ability to effectively identify, design, implement, and manage a meaningful PIP.

The graphs below reflect the improvements we have measured within the Texas Medicaid and CHIP populations. MCNA's utilization rates for ADV have increased from the baseline rate in 2012 within both populations in each year that our PIP has been implemented. **Our rates have exceeded the National Committee for Quality Assurance's (NCQA) 90th percentile benchmark** and measurements taken YTD for calendar year 2016 indicate sustained growth. Please see below a graph illustrating performance from inception through the end of the latest full calendar year (the CHIP Program has a limited benefit in Texas).

Proven Florida Experience

MCNA has been serving the CHIP members of the Florida Healthy Kids Corporation (FHKC) since 2005. Our performance improvement projects have yielded very beneficial results in terms of improving HEDIS scores for Florida CHIP members. The most recent evaluation of MCNA's performance improvement projects for FHKC, published by the Corporation's EQRO, the Institute for Child Health Policy (ICHP), in September 2016, are illustrated in the slides below.

Increasing the ADV is one of our most important deliverables to our clients, and MCNA has continually achieved increases in the HEDIS ADV score for the Florida Healthy Kids program. Over the past six years, MCNA has **achieved an 11.5% increase** in the HEDIS ADV measure. The measure rose from 55.4 to 61.7, a statistically significant improvement.

MCNA consistently exceeds the HEDIS benchmark for the Florida Healthy Kids Corporation. **In 2015 and 2016, we had the highest dental HEDIS scores in each HEDIS age band across all dental plans for this program.** MCNA has achieved the highest HEDIS scores in the program for the past 6 years and has demonstrated year-over-year improvement. Additionally, MCNA was the only plan to meet all preventive service PIP goals for 2015-2016.

MCNA's FHKC HEDIS Scores:

- 2015: **61.7%**
- 2014: **61.7%**
- 2013: **60.4%**
- 2012: **58.8%**
- 2011: **57.9%**
- 2010: **55.4%**

Slides from the Institute for Child Health Policy

DENTAL PLANS

DENTAL PLANS: EVALUATING PREVENTIVE SERVICES PIPs (2015-2016)

Type of Preventive Dentistry

MCO	Preventive Service
Argus	1. **Preventive Dental Services** (specifying measures for members enrolled ≥1 month and those enrolled ≥3 months)
DentaQuest	1. **Preventive Dental Services** (specifying measure for members enrolled ≥1 month, ≥3 months, ≥6 months, or ≥12 months continuously) 2. **Topical Fluoride Services** (specifying measure for members enrolled ≥1 month, ≥3 months, ≥6 months, or ≥12 months continuously)
MCNA	1. **Preventive Dental Services** (specifying measure for members enrolled ≥1 month, ≥3 months, ≥6 months, or ≥12 months continuously) 2. **Dental Sealants** (specifying measure for members ages 6-9 with the above enrollment periods) 3. **Dental Sealants** (specifying measure for members ages 10-14 with the above enrollment periods)

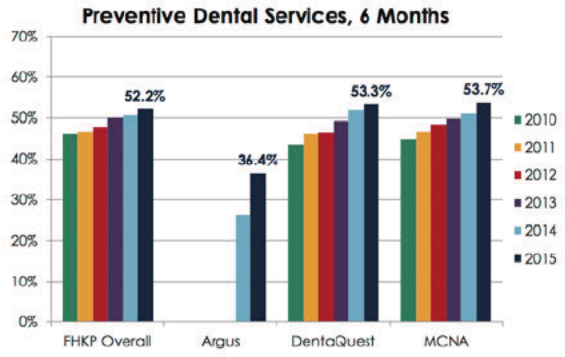
Goal Met: ✓ Goal Partially Met: O Goal Not Met: X

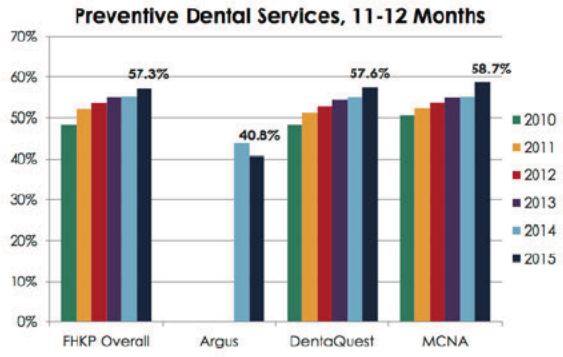
Measure	Argus	DentaQuest	MCNA
Study Topic	✓	✓	✓
Study Question	✓	✓	✓
Study Indicator	✓	✓	✓
Identify Population	✓	✓	✓
Sampling Methods	NA	NA	NA
Data Collection	✓	✓	✓
Interventions	X	O	✓
Data Analysis	✓	✓	✓
Real Improvement	✓	✓	✓
Sustained Improvement	NA	✓	✓

UF Institute for Child Health Policy UNIVERSITY of FLORIDA — Implementation Science — Biomedical Informatics — Comparative Effectiveness Research — Population Health

DENTAL PLANS

PREVENTIVE DENTAL SERVICES





The FHKP has demonstrated significant and sustained improvement in Preventive Dental Services over baseline.

Note: Argus joined the FHKP in 2013 and therefore has fewer years of reportable data than the other dental plans.

UF Institute for Child Health Policy UNIVERSITY of FLORIDA — Implementation Science — Biomedical Informatics — Comparative Effectiveness Research — Population Health

[redacted]

"Summer Sealant Slam" Member Postcard

"Summer Sealant Slam" Provider Flyer

mcnadental

MCNA's 2016 SUMMER SEALANT SLAM is in Full Swing!

Don't forget - our sealant campaign is happening now and we need your office to help us reach our goals for increasing sealant placement for Louisiana EPSDT members.

We will add $10.00 to our standard fee

for each sealant placed on first permanent molars (TIDs 3, 14, 19, and 30) of eligible Louisiana EPSDT members aged 6 – 9 years.

The Summer Sealant Slam benefits your office and children in the Louisiana EPSDT Dental Program by:

- Automatically increasing your reimbursement by **$10.00** for CDT code **D1351** each time you submit a claim for any eligible MCNA member on **dates of service from July 25, 2016, to September 30, 2016.**
- Increasing awareness and utilization of dental sealants as a powerful preventive service.
- Providing MCNA members without a dental home access to these services at special **Sealant Saturday** events, which are hosted by MCNA in partnership with the Louisiana State University School of Dentistry.

For more information, please call MCNA's Provider Hotline at **1-855-701-6262.** We look forward to connecting with you about this initiative and how we can assist your office in providing this important preventive service to the greatest number of members possible.

Toll Free: (855) 702-6262 • TTY: (800) 947-5277 • Web: http://www.mcna.net • Follow us on

MCNA_LA-P_SUMMER-SEALANT-SLAM-2016[1.0]

Sealant Campaign Letter [Page 1 of 2]

July 25, 2016

Smith Family Dentistry
123 Main Street
Baton Rouge, LA 70801

RE: 2016 Summer Sealant Campaign

Dear MCNA Provider:

We are pleased to announce the launch of our 2016 Summer Sealant Campaign. At MCNA, we take pride in delivering high quality access to dental care and service excellence to our participating providers. As you may know, in 2010 the Centers for Medicare and Medicaid Services (CMS) challenged all states to increase the rate of sealant use for 6-9 year olds by 10 percentage points over a five-year period. Increasing sealant use for our members is a top priority for MCNA but we cannot accomplish this without your help.

To better understand the barriers providers face in the delivery of sealants, we sought counsel from our Louisiana Dental Advisory Group (DAC), which is comprised of MCNA participating providers, and representatives from the LSU School of Dentistry and the Louisiana Dental Association (LDA). The DAC is the voice of our provider network and they have given us the following recommendations for increasing sealant use:

1. **Increase the fee associated with each sealant.** As part of MCNA's Summer Sealant Campaign, we will be adding $10.00 to our standard fee for each sealant placed on all eligible 6-9 year olds on dates of service from July 25, 2016 to September 30, 2016.

   [Terms: $10.00 will be added to Code D1351 rate ($25.51 + $10.00) for sealants applied to first permanent molars TID Nos. 3, 14, 19, and 30.]

2. **Place a notification banner on the eligibility screen for 6-9 year olds.** MCNA has added a Benefit Alert that will appear on the eligibility screen for all 6-9 year olds in the portal and on the print eligibility confirmation page.

3. **Distribute a roster of eligible members to providers so they can contact members and schedule an appointment.** MCNA has attached an additional listing of eligible members that were seen by your practice at least once during the last nine months. This listing includes only 6-9 year olds who are currently eligible to receive sealants in

Sealant Campaign Letter [Page 2 of 2]

2016 Summer Sealant Campaign
July 25, 2016
Page 2

accordance with the Louisiana benefits. We are requesting your assistance in outreaching to these members to schedule an appointment for AAPD recommended preventive care, including sealants. For your convenience, we have included the member's last date of service in your practice and the most recent member contact information.

In addition to the foregoing initiatives, MCNA will assist you in making the most of our 2016 Summer Sealant Campaign as follows:

- Our Care Connections Team of skilled multi-lingual member advocates is making outbound calls to members to provide education about the benefits of preventive care and to assist them with scheduling an appointment.
- We are sending text message reminders promoting preventive dental care and our member services hotline to assist members in scheduling an appointment.
- We are collaborating with the LSU School of Dentistry to hold a Sealant Saturday event inviting only those members who do not yet have a dental home.
- Our Member Services team reviews every incoming member call for internal care gap alerts, including those for sealants. The representatives will make every effort to assist the member with scheduling an appointment prior to completing the call.

MCNA recognizes the time and effort you and your staff commit to providing services to our members. We strive to reduce your administrative burden as much as possible so that you can focus on the delivery of high quality dental care. We sincerely appreciate your partnership and look forward to improving the clinical outcomes for Louisiana's EPSDT members

Sincerely yours,

DeDe Davis
Vice President of Dental Management
And Quality Improvement

Dr. David McKeon
Executive Director, Louisiana Plan

200 West Cypress Creek Road • Suite 500 • Fort Lauderdale, Florida 33309
(855) 701-6262 • Fax (504) 335-2263 • www.mcna.net

Member Input

We solicit member input in a variety of ways, from satisfaction survey results to topic-specific focus groups. We reach out to state agencies and advocacy organizations to help identify candidates to participate in our focus groups and topic-specific workgroups. Once we have determined committee membership, we make every effort to select meeting locations that are central to their residences and ensure scheduled meeting times do not cause workday interruptions.

At each focus group meeting, meeting minutes will be taken, which will then be presented to the QIC on a quarterly basis. This process will ensure that advisory committee feedback is integrated into the QI Program.

Proven Experience

Population-specific, **leading-edge outreach** efforts are MCNA's specialty. We solicit member input to assist with targeted population outreach efforts for underserved groups to reduce health care disparities based on factors such as racial, ethnic, and socioeconomic status. Children of Migrant Farm Workers (CMFWs) are one example of a special population identified as needing additional assistance because of unconventional living conditions, migratory work patterns, unhealthy working conditions, poor nutrition, limited English proficiency.

MCNA recognizes the importance of ensuring that this very mobile population remains compliant with the EPSDT periodicity schedule. Our **hands-on approach to care** for the CMFWs is an example of our commitment to reducing health care disparities for members of racial or ethnic minorities.

With input from migrant families, MCNA pioneered and developed targeted member materials for the CMFW group using a popular format known as a **fotonovela**. The fotonovela is a comic book style communication format favored by the Hispanic community. **The Texas Health and Human Services Commission commended MCNA's "out of the box" outreach approach.**

Please see the following fotonovela flyer and a sample postcard that MCNA sends monthly to CMFWs who are not compliant with the periodicity schedule. These initiatives have led to a continual increase in the number of CMFWs who receive preventive care. MCNA leads Texas in the number of points awarded for Migrant initiatives. MCNA has provided more accelerated services to children of migrant farmworkers than any other medical or dental plan in the State of Texas. **MCNA looks forward to partnering with agencies across the State of Nevada to identify and outreach to underserved populations.**

MCNA's Fotonovela Flyer

CMFW Outreach Postcard

Promoting Cultural Competency

MCNA is focused on being a culturally competent organization. Our staff is drawn from the many cultures we serve, and they embody MCNA's strong commitment to recognizing and appreciating all cultures. Our dedication begins at the very highest level of our organization, with our Board of Directors being ultimately accountable for activities related to cultural competency.

The U.S. Department of Health and Human Services, Office of Minority Health, has issued national Culturally and Linguistically Appropriate Services (CLAS) standards, and MCNA is committed to a continuous effort to perform according to those standards and eliminate disparities in dental care between diverse populations. Our Cultural Competency Program will be provided to DHCFP during the Readiness Review and thereafter as required.

Our Director of Quality Improvement ensures that we meet our own internal cultural competency goals and externally mandated objectives, and drives cultural training throughout our company including training of all new employees within thirty (30) days of hire. By engaging each level of management in our program, we ensure that culturally competent services are delivered to people of all cultures, races,

ethnic backgrounds, religions, and those with disabilities in a manner that recognizes the worth and dignity of each individual.

Our provider network is comprised of diverse dental practitioners who value people of all races, ethnicities, and socioeconomic backgrounds. We actively monitor our providers' ability to communicate in different languages to ensure all members are well-served. All network providers are required to comply with MCNA's Cultural Competency Program and the Americans with Disabilities Act (ADA).

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

We understand that the DHCFP will provide race, ethnicity, and primary language spoken data for the Medicaid population to MCNA through a monthly interface. We may alert the DHCFP, as part of the demographic update interface with DWSS NOMADS system, of any known discrepancies in the race and ethnicity or primary language data received from the DHCFP.

Fiscal Requirements [§3.11]

Vendor Fiscal Standards [§3.11.1]

MCNA understands that the State of Nevada Division of Insurance (DOI) regulates our financial stability and we will comply with all DOI standards in addition to the managed care program standards described in this section.

Performance Security Deposit [§3.11.2]

MCNA will provide a performance security deposit in the form of a bond furnished by a surety company authorized to do business in the State of Nevada to the DHCFP in order to guarantee payment of our obligations under this contract. The performance security deposit may be utilized by the DHCFP to remedy any breach of contract or imposed sanctions. The surety company must be:

- A.M. Best A-VII rated insurance company;
- Certified by the Department of Treasury, Financial Management Services for Nevada; and
- Licensed by the Nevada Department of Business and Industry, Division of Insurance.

An initial performance security deposit of $4,000,000 must be provided within ten (10) business days following award of the contract. This amount must be reviewed at the end of the first quarter of the contract period and adjusted to equal the actual required security deposit amount. The amount of the performance security deposit shall be equal to one hundred and ten percent (110%) of the highest month's total capitation amount in the first quarter or four million dollars ($4,000,000), whichever is greater. This must be deposited with the State Treasurer within fifteen (15) calendar days after the end of the first quarter of the contract. The total capitation amount is the sum of all capitation payments for all recipients for the month.

We acknowledge and agree that after the initial year of the contract the DHCFP will require MCNA to increase the performance security deposit amount to reflect an amount equal to one hundred and ten percent (110%) of the preceding year's highest month's total capitation payment or four million dollars ($4,000,000), whichever is greater.

MCNA agrees to maintain the performance security deposit after the contract term for a length of time to be determined by the DHCFP in order to cover all outstanding liabilities. [redacted]

Vendor Liability [§3.11.3]

All MCNA subcontracts will include provisions that ensure members are not held liable for the following:

- MCNA's debts, in the event of insolvency;
- For services provided to members in the event of the organization failing to receive payment from the State for such services;

- For services provided to a member in the event a health care provider with a contractual, referral, or other arrangement with the vendor fails to receive payment from the State or the organization for such services; or
- Payments to a provider who furnishes covered services under a contractual, referral, or other arrangement with MCNA in excess of the amount that would be owed by the recipient if MCNA had directly provided the services.

All provider agreements will also contain continuity of care provisions that ensure continuation of services to members during insolvency pursuant to the Centers for Medicare and Medicaid Services, State Medicaid Manual (SMM) 2086.6.B.

Reliable, Accurate, and Knowledge Driven Claims Processing System [§3.11.4, §3.11.4.1, §3.11.4.3 - §3.11.4.4, §3.11.4.6 - §3.11.4.10]

Understanding claims processing and adjudication requires an extensive understanding of program benefits, proper standards of care, provider practice patterns, and member needs and behaviors. In 2015, MCNA processed approximately 18 million dental claims (97.5% electronically) with an accuracy level above 99.9%. We also processed over 98% of clean claims within 20 business days of receipt. **MCNA is committed to providing Nevada with the same levels of efficiency and accuracy.**

MCNA's record of successful and prompt implementations has been flawless throughout our transitions for Medicaid and CHIP programs in Texas, Louisiana, Florida, and Iowa. Our project implementation team coordinates with all critical MCNA business units to ensure that project-specific key resources are aligned and in place for a successful implementation. Our project implementation team will apply time-tested methodologies using our structured approach to success. The expertise and knowledge cultivated throughout our organization ensures that MCNA operates in a cohesive manner without the "silo" effect found in other organizations.

Our claims management system, an essential component of our fully-integrated, proprietary, and enterprise-wide management information system (MIS), DentalTrac™, and our experienced staff ensure accurate, prompt payment of claims while maintaining a high degree of provider satisfaction and enabling unparalleled reporting capabilities. We will meet or exceed the contractual requirement to accurately pay ninety-five percent (95%) of claims upon initial submission.

MCNA shall be responsible for paying all claims for properly accessed and, if necessary, authorized covered services provided to enrolled members on dates of service when they were eligible for coverage unless the services are excluded under the DHCFP managed care contract or the Nevada Medicaid State Plan. MCNA will adjudicate and pay all claims in accordance with state and federal statutes and regulations. We acknowledge that not meeting all federal requirements, including those for timely claims payment, may be considered a breach.

We provide ample training to providers about our claims processes, including how to file both electronic and paper claims. This information is included in MCNA's Provider Manual, online Provider Portal, and is covered in our provider orientation training sessions. Should a provider have any questions about our claims processes, they can contact a Provider Relations Representative or our dedicated Nevada Provider Hotline. MCNA allows both network and non-network providers to submit an initial claim for

covered services. In-state network providers may submit claims for reimbursement up to 180 days from the last date of service, and out-of-state providers will have 365 days from the last date of service unless a shorter time period is negotiated. MCNA accepts the most current version of the ADA claim form, and we do not enter into alternative payment schedules. We will pay interest to a provider on a claim that is not paid within the time provided in the contract or agreement at a rate of interest equal to the prime rate at the largest bank in Nevada, as ascertained by the Commissioner of Financial Institutions, on January 1 or July 1, as the case may be, immediately preceding the date on which the payment was due, plus six percent (6%). The interest must be calculated from thirty (30) days after the date on which the claim is approved until the date on which the claim is paid.

MCNA's claims management system and processes are supported by well-documented policies and procedures designed specifically to address the needs of our state clients including all state and federal requirements. We continually audit our performance for both procedural and financial accuracy. **In 2014, MCNA received full claims processing accreditation from URAC.** This ensures that our highly trained claims management team is able to operate efficiently and reliably against the strictest national guidelines and benchmarks without compromising quality or performance metrics.

The DentalTrac™ Claims module is designed specifically to operate public sector programs such as the Nevada Medicaid Program. DentalTrac™ enables us to deliver exceptional service levels across all of our claims capability **core competencies and integrated components** (CCIC), including:

- Administrative and financial adjudication accuracy
- Clean claims payment turnaround
- Cost avoidance and third party recovery
- Systematic detection of fraud, waste, and abuse
- Accurate, timely, and complete encounter submissions

MCNA's claims management system within DentalTrac™ is specially designed to be easily configured and re-configured to accommodate new or changing requirements, whether they arise from legal or regulatory change, or from the changing practices of our business partners. A business process-oriented methodology decouples low-level coding from process design, yielding a building-block approach to system configuration that maximizes flexibility, rapid development, and correctness.

DentalTrac™ implements a variety of edits that ensure claims are processed correctly. For example, our system includes edits to prevent unbundling of customarily bundled services, avoid paying duplicate claims, and pay certain State or local government providers the federal share only in accordance with Nevada requirements.

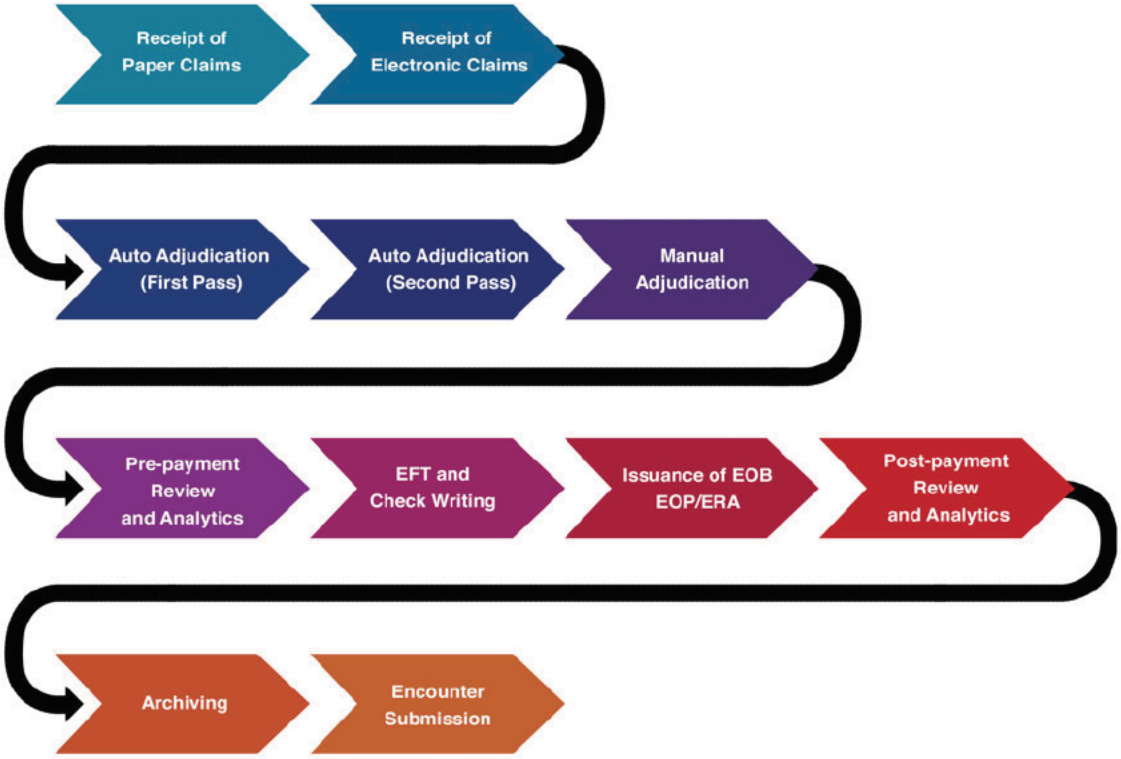
While our system has been designed to make change easy, any such change is subject to stringent software quality assurance and change management processes. Through our modern, rules-based MIS, we rapidly create new and adapted products and business processes to meet evolving business needs. Our claims management information system capabilities are in production today managing all of our lines of business, including dental managed care programs in Florida, Louisiana, Texas, and Iowa

where we have met or exceeded the performance requirements specified in this RFP. We understand that new and amended laws, policies, and regulations could affect the claims-processing functions required by this RFP, and we will adapt our claims management system accordingly at no cost to the State.

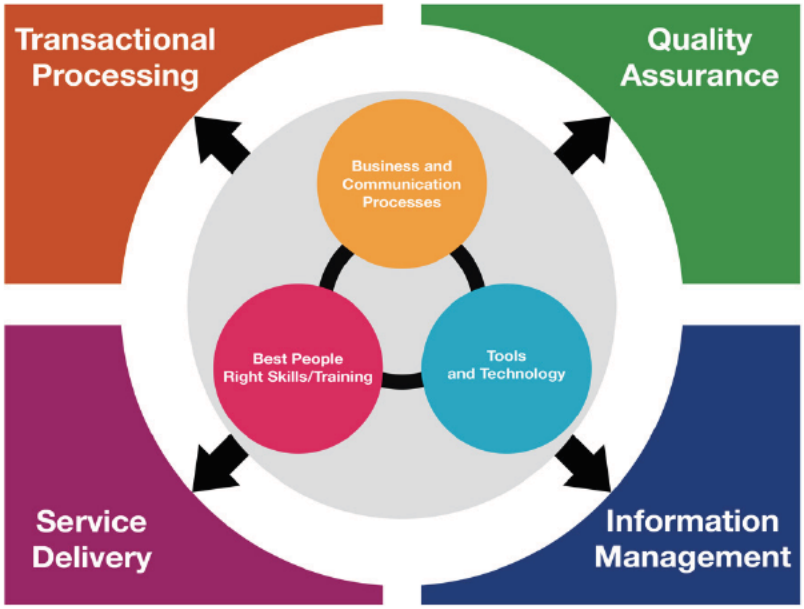
Claims Management Overview

MCNA's state-of-the-art claims management system supports all modern claims capabilities, including electronic data interchanges (EDI), HIPAA transactions, and a DHCFP compliant claims adjudication process. We seamlessly process claims from receipt to the submission and reconciliation process as outlined below:

- Receipt of electronically submitted claims through electronic data interchange (EDI)
- Receipt of paper claims
- Initial auto adjudication (first pass)
- Second-attempt auto adjudication following resolution of certain suspension edits
- Manual processing for claims that cannot be auto-adjudicated
- Electronic funds transfer (EFT) and check-writing process
- Issuance of EOP and/or remittance advice (RA)
- Completing appropriate prepayment and postpayment analytics
- Archiving claim records and data
- Encounter submission and reconciliation



We offer Nevada a comprehensive turnkey solution to claims processing using industry best practices in workflow automation, dynamic case management, business process management, and rules management. These modern claims capabilities result in a highly efficient environment that is interwoven within all aspects of our operations to deliver continuous and self-improving quality outcomes. Our claims management system and processes are an integral component of our claims capability core competencies and integrated components (CCIC) model as shown below:



[redacted]

Claims Payment Accuracy and Quality Assurance [§3.11.4.10, §3.11.4.12 - §3.11.4.14]

Quality assurance (QA) is another core component of MCNA's claims capability core competencies and integrated components (CCIC) model. QA is an integral part of everything we do, and having quality initiatives enforced by our MIS reflects our commitment to perform at the highest quality standards. As part of our internal quality initiatives, we have established corporate accuracy standards across our entire operation, including those related to claims adjudication.

Our approach to continuous quality improvement is ingrained in MCNA's corporate culture. We implement checks and balances such as regular review and audit of our claims processes to ensure accuracy and timeliness. Our quality approach is defined by role. The chart below illustrates the accuracy requirements for claims automatically adjudicated by the DentalTrac™ system as well as by each level of claims examiner.

Role	Procedural Accuracy	Financial Accuracy
Auto Adjudication	99%	99%
Examiner Level 1	95%	98%
Examiner Level 2	96%	98%
Senior Examiner	98%	99%

We have multiple quality assurance processes and audit standards in place to ensure we are constantly meeting and exceeding our internal standards and contractual requirements.

As part of our commitment to adhering to all DHCFP requirements referenced in this RFP, we acknowledge that we will meet and exceed all claims processing requirements, including but not limited to:

- MCNA will provide the DHCFP with information prior to implementation of any changes to the DentalTrac™ system's claims processing functions as described in this response and incorporated by reference in the contract.
- We will ensure that a medical review of claims will be conducted when the appropriateness of service, procedure, or payment is in question. All medical reviews are conducted by licensed dentists and dental specialists.
- MCNA will comply with 42 CFR §447.26, on Provider Preventable Conditions (PPCs) – Payment Policy. We will deny or recover payments to healthcare professionals and inpatient hospitals for care related to the treatment of the consequences of PPCs and Other Provider Preventable Conditions (OPPC) that meet the State's criteria.
- Withhold all or part of payment for any claim submitted by a provider that is:

  - Excluded or suspended from a federal healthcare program for fraud, abuse, or waste
  - On State authorized payment hold
  - With debts, settlements, or pending payments due to the State or the Federal Government

- Provide all safeguards to prohibit submission of duplicate claims
- Have a program to detect and promptly report suspected fraud and abuse and to cooperate in any prosecution
- Process retrospective claim adjustments, including automated electronic mass adjustments processed in a batch format whereby a retroactive rate change or other change can be processed to ensure correct provider payment or other adjustments in the designated claims payment format

Verifying Receipt of Services [§3.11.4.11]

MCNA has a process in place to verify whether members received services billed by providers in accordance with 42 CFR §455.20 (Beneficiary Verification Procedures). Our Special Investigations Unit (SIU) selects a random sample of members to survey each month. The verification process is conducted by sending members a copy of their Explanation of Benefits (EOB) or by member phone interviews. MCNA will report all member verification activities to:

- MCNA's Fraud, Waste and Abuse Committee on a quarterly basis; and
- To DHCFP in the frequency required by the Agency.

When warranted, MCNA sends additional verification of services letters to members and conducts member phone interviews in connection with targeted provider investigations, provider profiling activities, and other program integrity undertakings. The following situations may warrant attempting to contact a member by phone to ascertain whether the billed services were rendered:

- Excessive visits or services
- A questionable service
- A recurring billing pattern

SIU will request dental records for discrepancies identified during the verification process. Those records will be evaluated and if the billed services are not listed in the record, a full investigation will be opened and funds will be recouped.

Financial Solvency [§3.11.5]

MCNA Insurance Company, the offeror, is a Texas Accident and Health Insurance Company licensed in 13 states. The Company is a wholly owned subsidiary of MCNA Health Care Holdings, LLC, and operates state-wide Medicaid and CHIP dental programs serving approximately 1.5 million children in

Texas, 1.45 million children and adults in Louisiana, and approximately 13,000 adult members in Iowa. Commencing on February 1, 2017, MCNA will provide dental managed care services to over 280,000 Idaho Medicaid and CHIP enrollees on a full-risk basis. We are pleased to provide the State of Nevada with assurances of our financial solvency and strong fiscal track record.

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

We will submit a copy of our annual Independent Auditor's Report to the DHCFP, as submitted to the Division of Insurance. MCNA will also submit our quarterly and annual financial reports to the DHCFP. For evidence of our financial capacity, please see the following attachments:

- Current year interim, unaudited, GAAP-basis 2016 quarterly balance sheets and profit and loss statements for MCNA Health Care Holdings, LLC, and subsidiaries **(Attachment 3-6).**
- Current year interim, unaudited, GAAP-basis 2016 quarterly balance sheets and profit and loss statements for MCNA Insurance Company **(Attachment 3-7)**.
- Audited, GAAP-basis 2015 and 2014 financial statements with footnote disclosures for both the Offeror and the Consolidated Parent Company **(Attachment 3-8)**.

COB, TPL, and Subrogation [§3.11.6 - §3.11.7]

As part of our due diligence in the proper management and administration of Medicaid and CHIP programs, MCNA investigates every claim that may be subject to coordination of benefits (COB) or the subrogation process using DentalTrac™'s COB and third-party liability (TPL) module.

The COB/TPL module is capable of exchanging member information with state agencies and TPL contractors to identify members with third-party dental insurance coverage. MCNA's claims management system flags claims with potential COB, TPL, or subrogation issues. These claims are routed to our Recovery and Subrogation Unit (RSU) for additional review and processing.

Another COB/TPL function in DentalTrac™ is the auto-generation of letters of inquiry to our members or providers regarding the possibility of other third-party liability. Our system tracks letters of inquiry that are sent but not returned in order to send a second request in a timely manner to complete any open claims.

MCNA diligently pursues all TPL resources in accordance with Section 607(1) of the Employee Retirement Income Security Act of 1974 [29 USC and 1167 (1)] service benefits plans and Section 6035 of the Deficit Reduction Act of 2005. Additionally, we will utilize all information made available by DHCFP to pursue TPL resources. The exceptions to the TPL rule are: Indian/Tribal Health Services (IHS); Children with Special Health Care Needs (CSHCN); and State Victims of Crime.

MCNA identifies potential TPL, including Medicare, and denies the claim if it is for a service covered by other insurance based on the member's type of TPL coverage and type of service. We allow for TPL overrides when the other insurance is exhausted or the service is not covered by the other liable party, making Medicaid the payer of last resort for the claim.

Once the correct order of benefits is determined in these COB/TPL cases, our claims management system automatically applies such determination when processing claims. When MCNA is the primary payer, it will process the claim. If the order of benefits determination shows we are other than primary, our business processes and system rules will prompt for the entry of the amount paid by the primary payer before it will calculate our liability. The system enforces third-party recovery by ensuring Medicaid is the payer of last resort, including alerting MCNA staff when COB situations are identified post-payment.

Our COB/TPL processes have enabled MCNA to comply with all federal and state requirements in the markets we serve. We understand that TPL recoveries will be incorporated into capitated rate development by the DHCFP and its actuary, and that MCNA has 365 days from claim paid date to recover TPL payment. MCNA will maintain the minimum historical TPL eligibility data online in accordance with State and federal rules and regulations for a minimum of 72 months.

Coordination of Benefits

MCNA's DentalTrac™ system makes COB and TPL data available to all relevant business units and staff to increase the effectiveness of our cost avoidance efforts and the recovery of overpayments. Our MIS captures all COB/TPL information at the member level within the member's eligibility record. Capturing COB/TPL information in this way allows it to carry over to all activities related to a member (e.g., multiple claims instead of only one claim). Sources of this information include DHCFP TPL files, enrollment data, claims data, and statements recorded directly from members or providers during discussions with our call center representatives.

The advanced business process mapping (BPM) and rules-based engine in DentalTrac™ automatically flags claims where the member record indicates the presence of COB or TPL information. In cases where the member does not have that information documented in the member level record but a claim indicates its existence, DentalTrac™ automatically builds an electronic COB/TPL case file for that member. MCNA's claims examiners may also identify a need for COB when manually processing a claim. The claims examiner moves forward at that time to create a case file with the pertinent

information for the member. In all situations, these case files are routed in real time to the Recovery and Subrogation Unit (RSU) staff for further review.

In the event the COB/TPL information does not match the information documented in the member record, the claim is routed using our automated workflow process to the RSU staff. The RSU staff verifies COB/TPL data from the carrier and updates the member's record accordingly. Once the COB/TPL is established, our RSU staff review the other carrier's EOB/RA and claim image information captured during claim submission. The other carrier's allowed amounts at the line level are captured before finalizing the adjudication of the claim. This information is entered into the member record and the claim record. MCNA then includes that claim as a part of regular reporting on cost-avoided dollars and provider-reported savings to DHCFP.

MCNA facilitates coverage and appropriate payment in all COB situations. Our comprehensive coordination of benefits process provides access to coverage and care for the member while ensuring that Medicaid is the payer of last resort.

Pay and Chase and Subrogation Activities

Pay and chase scenarios should be rare when it comes to dental benefits, but MCNA's staff remains alert to claims payment patterns and circumstances that indicate an overpayment. MCNA's pay and chase activities are triggered when we identify that a member had coverage with another insurer after paying a provider for services rendered. We contact the liable third party insurer and initiate the coordination of benefits (COB), adhering to all state and federal regulations governing our pay and chase activities. MCNA will collect any monies due from the liable third-party insurer. MCNA **maintains transparency** in all recovery efforts. We seek to minimize the involvement of members and providers in our recovery effort in order to avoid causing them unnecessary aggravation.

Our protocols for handling pay and chase and subrogation activities follow the same objectives as defined in our Cost Containment Initiatives. Our RSU team and our DentalTrac™ system verify any change of status in our member demographics as related to TPL to identify any current or historical claim that may need review. For claims that have already been adjudicated and paid, DentalTrac™ automatically initiates the subrogation and recovery process the moment RSU staff confirms the information about other insurance availability.

Our MIS routinely exchanges TPL data with external vendors and other state Medicaid agencies, which triggers this process. MCNA will determine if casualty claims are filed and recover costs through subrogation on behalf of both Medicaid and CHIP members. We will utilize the EVS eligibility system and TPL data provided by the DHCFP to assist in accomplishing this objective.

The RSU team ensures that the primary carrier is contacted and billed within 60 days after confirming the payment hierarchy and their payment responsibility. MCNA sends letters to all parties involved. Our MIS ensures that our handling of all written notices complies with DHCFP and federal regulations.

We understand and acknowledge that the DHCFP will monitor and evaluate our TPL and subrogation collection reports to validate collection activities and results. MCNA will then be expected to meet or exceed baseline target collections as determined by the DHCFP and its actuaries, and the baseline

target amount will be built into future rates. Further, we agree that if MCNA does not meet or exceed baseline TPL and subrogation collections, the DHCFP will conduct a review to determine if there is a legitimate reason, and that if none exists, the difference between baseline and actual collections will be deducted from our costs before the data is used to set future rates. MCNA understands that the DHCFP will prospectively adjust capitation rates to account for expected TPL collections.

Reserving [§3.11.8]

MCNA has a well-established, actuarially sound process for estimating and tracking incurred but not reported (IBNR) claims. We will provide documentation of our IBNR review and include certification by an actuary. Our methodology reserves funds by major categories of service (e.g., hospital inpatient, hospital outpatient, physician, and pharmacy) to cover both IBNR and reported but unpaid claims (RBUCs). As part of our reserving methodology, MCNA conducts annual reviews to assess the actuarial validity of our process and we make adjustments as necessary.

Prohibition on Payments to Institutions or Entities Located Outside of the United States [§3.11.9]

Pursuant to Section 6505 of the Affordable Care Act (ACA), which amends Section 1902(a) of the Social Security Act (the Act), MCNA shall not provide any payments for items or services provided under the Medicaid State Plan or under a waiver to any financial institution or entity located outside of the United States (U.S.).

We understand and acknowledge that payments for items or services provided under the Medicaid State Plan to financial institutions or entities such as provider bank accounts or business agents located outside of the U.S. are prohibited by this provision, including payments to telemedicine providers located outside of the U.S. Any payments for items or services provided under the Medicaid State Plan or under a waiver to any financial institution or entity located outside of the U.S. may be recovered by the State from the vendor.

Additionally, MCNA agrees that tasks which support the administration of the Medicaid State Plan that may require payments to financial institutions or entities located outside of the U.S. are not prohibited under this statute, including payments for outsourcing information processing related to plan administration, or outsourcing call center activities related to enrollment or claims adjudication.

Grievances, Appeals, and Fair Hearings [§3.12]

Our Grievance and Resolution System [§3.12.1 - §3.12.2, §3.12.5.4(A)]

MCNA is **committed to ensuring prompt resolution** of all grievances and appeals. Our Grievances and Appeals Department provides a fair, thorough, timely investigation and resolution of all such issues lodged by our members and providers acting as their authorized representatives.

In 2015, MCNA resolved 100% of grievances and appeals within 30 days of receipt.

MCNA has a proven track record of resolving grievances and appeals well in advance of contractually required time limits. We comply with all state, federal and DHCFP requirements. Our proprietary management information system (MIS), DentalTrac™, is used by MCNA staff to record, investigate, resolve, and enable analysis of all grievances and appeals. DentalTrac™ allows for a complete audit trail, which tracks every step of the grievance and appeal system to ensure timely and accurate resolutions for our members and providers.

We make every effort to inform and assist our members, their authorized representatives, or providers with accessing the grievances and appeals system. MCNA educates our members and providers via the Member Handbook, Provider Manual, notices of decision, and through our website which is available in English, Spanish, and Tagalog. Language describing our processes will be included in MCNA's Nevada-approved Member Handbook. The timeframes applicable for filing member grievances and appeals and for MCNA to respond are outlined in the Member Handbook. The handbook and all written notifications are provided in the member's primary language and are written to **ensure ease of understanding**. The handbook is also available in alternative formats such as Braille and audio upon request. To ensure consistent messaging with members and providers, MCNA uses agency approved templates for written notifications regarding grievances and appeals.

There may be barriers that impede a member's ability to effectively navigate the grievances and appeals system, or access services. In Texas, MCNA employs experienced **Member Advocate and Outreach Specialists** (MAOS) to ensure members receive appointment reminders, assistance with scheduling dental appointments, transportation assistance, oral health education, and **one-on-one personalized assistance with submitting grievances and appeals** and understanding plan benefits. **This proven, member-centered approach will be replicated in Nevada.** MCNA also provides additional resources for members with disabilities and those requiring linguistic and translation services during the grievance and appeal system by utilizing the following:

- TTY/TDD line capability for hearing impaired members
- Member Services Representatives who speak English, Spanish, French, Creole, Tagalog, and other languages
- Free translation services available in over 200 languages
- Large print or Braille materials for members with impaired sight
- Additional accommodations for members with special health care needs

Additionally, our Member and Provider Service Representatives are thoroughly trained to assist members and providers via our toll-free hotlines. **MCNA's highly trained and dedicated staff assists**

members and their representatives by providing a full understanding of how to avail themselves of the grievance and appeals processes. Our grievance and appeals system includes a grievance process, an appeal process, and access to the State Fair Hearing system. MCNA complies with 42 CFR §§438.400–410 and Section 3.12 of this RFP.

MCNA understands that our member grievance and appeal system must be in writing and submitted to the DHCFP for review and approval during the Readiness Review, and at any time thereafter if the policies and procedures have been revised or updated (not including grammatical or readability revisions or updates). MCNA will not implement any policies and procedures concerning our member grievance and appeal system without first obtaining the written approval of the DHCFP.

Grievance Process [§3.12.1.1, §3.12.5.1, §3.12.8.1]

MCNA considers a grievance any expression of dissatisfaction by a member or provider about any action taken by MCNA or a provider, other than an Adverse Action. Members and providers can file grievances orally or in writing.

[redacted] MCNA will ensure that all grievances are resolved within 90 days of receipt.

[redacted]

MCNA prides itself on ensuring prompt attention to all quality of care issues. Upon completion of the grievance review, the member is sent a disposition letter advising them that any quality of care issues have been referred to the Quality Improvement Department for further investigation and resolution.

Notices of Action [§3.12.3 - §3.12.5]

MCNA notifies our members and providers in writing of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. Notice is provided as expeditiously as the member's health requires and within the State's established timelines. Standard authorization decisions must be 14 calendar days following receipt of the request for service. If the turnaround timeframe for a standard authorization could jeopardize the life, health or ability of the member to attain, maintain or regain maximum function, MCNA will provide an expedited service authorization within 72 hours of receipt. The timeframe for both standard and expedited authorization may be extended for up to 14 additional calendar days if the member or provider requests the extension, or if MCNA justifies (to the DHCFP upon request) a need for additional information and how

the extension is in the member's interests. MCNA shall provide written notice of the reason for the extension and inform the member of their right to file a grievance.

Member notices are written to ensure ease of understanding and comply with all State, federal, and DHCFP requirements. MCNA fully complies with all language requirements including the translation of member notices into Spanish and other languages as required. A written Notice of Action shall meet the following requirements and must explain:

- Action MCNA has taken or intends to take
- Reasons for the action
- Specific regulations that support, or the change in federal or State law that requires the action (if applicable)
- Member's or provider's right to file an appeal with MCNA and that the member may represent himself or use legal counsel, a relative, a friend, or other spokesperson
- The procedures for exercising the member's right to appeal
- The member's right to request a State Fair Hearing after exhausting MCNA's internal appeal procedures
- The circumstances under which expedited resolution is available and how to request it
- The member's right to have benefits continue if the appeal is filed on or before the latter of the following: within 10 calendar days of MCNA mailing the Notice of Action or the intended effective date or the proposed action pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services
- The member's right to request an evidentiary hearing if one is available or a state agency hearing, or in cases of action based on change in law, the circumstances under which a hearing will be granted

MCNA provides a written Notice of Action to members when MCNA takes action or makes an adverse determination affecting the member. If a provider has made a request on a member's behalf and MCNA makes an adverse determination, the provider is notified but this notification need not be in writing.

MCNA gives notice at least 10 calendar days before the date of action when the action is a termination, suspension, or reduction of previously authorized covered services. This timeframe may be shortened to five (5) days if probable member fraud has been verified. A Notice of Action is provided on the date of the action for denials of payment.

Notices are provided on the date that the timeframes expire when service authorization decisions are not reached within the State's timeframes. Untimely service authorizations are considered adverse actions. MCNA gives notice by the date of the action for all applicable circumstances outlined in this RFP, including the denial of payment.

Member Appeals [§3.12.1.2 - §3.12.1.3, §3.12.1.5 - §3.12.1.7, §3.12.2.2, §3.12.2.5, §3.12.5.2 - §3.12.5.3, §3.12.5.4(B,C,D), §3.12.5.5 - §3.12.5.6, §3.12.5.8]

MCNA members, their authorized representatives, or providers have the opportunity to file an appeal if they disagree with MCNA's actions related to services. An appeal is a specific request for review of one of the following actions:

- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner; or
- The failure of MCNA to process grievances, appeals or expedited appeals within required timeframes including resolution and notification.

Members and providers can file appeals in person or by phone, mail, fax, or email. Appeals must be received by MCNA within 90 calendar days from the date on MCNA's Notice of Action. In the event a provider files an appeal on the member's behalf, with the exception of an expedited appeal, the provider must first obtain the member's written permission. We make every effort to resolve appeals as quickly as the member's condition requires and to notify members in their primary language of the disposition of the appeal.

MCNA members and their representatives have a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing if they feel it will help support their case. Once the documentation is compiled, the Administrator routes the case file to the Utilization Management Department for investigation and review by one of our Clinical Reviewers who is a **dentist with the appropriate expertise**.

A Notice of Determination is sent to the member and the requesting provider no later than 30 days from the date we received the appeal, and includes:

- The resolution;
- A well-reasoned explanation on how MCNA made the decision;
- The date of the decision;
- Their right to a State Fair Hearing;
- How to obtain the State Fair Hearing;
- The rules that govern representation;
- The right to request continuation of benefits while the hearing is pending and how to make this request;
- That the member may be held liable for the cost of those benefits if the State Fair Hearing's Officer upholds MCNA's action; and
- The summary of the facts asserted by each party.

All Notices of Action will be compliant with 42 CFR §438.408. For appeals **not** resolved wholly in favor of the member, MCNA will inform the member of their right to request a State Fair Hearing and explain how to make that request. The vendor shall notify the member of the disposition of the grievance and appeal in written format. If a member exercises their right and requests a State Fair Hearing, MCNA will provide full support to members and their representatives to make sure they are fully informed of how to navigate the process. MCNA understands that DHCFP will conduct an annual audit of the appeals process to ensure compliance with federal, State, and contractual requirements.

Process for Review of Expedited Appeals [§3.12.5.7]

If the turnaround timeframe for a standard appeal or a delay in the delivery of the service could jeopardize the life, health or ability of the member to attain, maintain or regain maximum function, the member or provider can request expedited review of an appeal involving an expedited clinical issue verbally or in writing. MCNA's toll-free Member and Provider Hotline Representatives will assist members and providers with this process. [redacted]

Continuation of Benefits [§3.12.7]

At any time during the appeal process, the member may request the continuation of services if applicable criteria are met. If a request is made in accordance with DHCFP guidelines, the Administrator contacts the member to inform them that the benefits will continue until the grievance determination is made. MCNA shall continue the member's benefits while an appeal is in process if all of the following conditions are met:

- The appeal is filed on or before the later of the following:
    - Within 10 calendar days plus mailing time of MCNA mailing the Notice of Action, or

  - The intended effective date of MCNA's proposed action
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
- The services were ordered by an authorized provider
- The authorization period has not expired
- The member requests continuation of benefits

Continued or reinstated benefits will be maintained until the member withdraws the appeal, the member does not request a State Fair Hearing with continuation of benefits within 10 days from the date MCNA mails an adverse appeal decision, a State Fair Hearing decision adverse to the member is made, or the service authorization expires or authorization limits are met.

If the final resolution of the appeal is adverse to the member, MCNA may recover the cost of the services furnished while the appeal was pending, to the extent that they were furnished solely because of the requirements of RFP section 3.12.7 and in accordance with policy set forth in 42 CFR §431.230(b).

Member State Fair Hearings [§3.12.6]

A member, member's representative, or the representative of a deceased member's estate has the right to request a State Fair Hearing from the DHCFP when they have exhausted MCNA's appeal system without receiving a wholly favorable resolution decision. The request for a State Fair Hearing must be submitted in writing within 90 calendar days from the date of the notice of resolution.

MCNA informs the member of their right to a State Fair Hearing, how to obtain such a hearing, and representation rules in writing pursuant to 42 CFR §431.200(b); 42 CFR §431.220(5); 42 CFR §438.414; and 42 CFR §438.10(g)(1). Grievances are not eligible for referral to the State Fair Hearing process.

Once the member requests an appeal review through the State Fair Hearing process, MCNA's Grievances and Appeals staff and Clinical team will coordinate with DHCFP and provide any assistance the Agency may need to complete its review of the case. When a member requests a State Fair Hearing to review an adverse determination made by MCNA, we participate in the process at our expense.

If the member receives services during the State Fair Hearing process, the member will be informed that if the appeal is overturned by the State Fair Hearing Officer, MCNA will pay for or authorize the services, and if the appeal is upheld, the member may have to pay for the services in accordance with federal requirements and this RFP. Upon receiving the decision, the Grievances and Appeals tracking system will be updated to capture the decision date and final decision. MCNA acknowledges that we are bound by the decision of the Fair Hearing Officer.

Expedited State Fair Hearing [§3.12.9]

MCNA recognizes that the State's timeframe for reaching an expedited State Fair Hearing decision when the appeal was first heard through MCNA's appeal process is as expeditiously as the member's health condition requires, but no later than three (3) working days from the State's receipt of a hearing request for a denial of service that: meets the criteria for an expedited appeal process but was not resolved within MCNA's expedited appeal timeframes, or was resolved wholly or partially adversely using MCNA's expedited appeal timeframes.

We also understand that the State's timeframe for reaching an expedited State Fair Hearing decision when the appeal was made directly to the State's Fair Hearing process without accessing MCNA's appeal Process is as expeditiously as the member's health condition requires, but no later than 3 working days from the State's receipt of a hearing request for a denial of service that meets the criteria for an expedited resolution.

If MCNA or the Fair Hearing Officer reverses an action to deny, limit, or delay services that were not furnished while the appeal was pending, MCNA shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires. If MCNA or the State Fair Hearing Officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, MCNA shall pay for those services.

MCNA's grievances and appeals processes are designed to be **member-centric**, and ensure open issues are resolved in a **timely and sensitive manner**. Our processes will comply with all requirements outlined in the RFP. Our current policies and procedures comply with 42 CFR §438.402, and we have revised and updated them to reflect the requirements of DHCFP. MCNA will submit these policies and procedures for review and approval by the Agency.

Please see the following flowchart that depicts MCNA's grievance and appeal process.

Provider Grievances and Appeals [§3.12.8, §3.12.8.1]

MCNA maintains processes to resolve any provider grievances and appeals that are separate from, and not a party to, grievances and appeals submitted by providers on behalf of members. MCNA will accept written or verbal grievances and appeals that are submitted directly by the provider as well as those that are submitted from other sources, including the DHCFP. A verbal appeal must be followed by a written, signed appeal. The verbal request, however, will count as the date of receipt of the grievance or appeal. MCNA maintains an electronic record of each provider grievance and appeal that includes a description of the issue, the date filed, the dates and nature of actions taken, and the final resolution. The final, written decision is rendered within the following timeframes:

- Ninety (90) calendar days after a grievance is filed; and
- Thirty (30) calendar days after an appeal is filed.

MCNA understands that written grievances and appeals procedures must be included for review and approval during Readiness Review and anytime thereafter when provider grievances and appeals policies and procedures have been revised or updated. MCNA will not implement any policies or procedures concerning its provider grievance and appeal system without first obtaining the written approval of the DHCFP.

Provider State Fair Hearings [§3.12.8.2, §3.12.9.2 - §3.12.9.3]

When a provider has exhausted MCNA's internal appeals process, the provider has the right to submit a written request to the DHCFP for a State Fair Hearing. MCNA notifies providers of this right as part of our provider contract and when the outcome of an appeal is not wholly in favor of the provider pursuant to 42 CFR §431.200(b); 42 CFR §431.220(5); 42 CFR §438.414; and 42 CFR §438.10(g)(1).

A State Fair Hearing decision will be made within ninety (90) calendar days from the date of request. Disputes eligible for the State Fair Hearing process include:

- Denial or limited authorization of a requested service;
- Reduction, suspension or termination of a previously authorized service;
- Denial, in whole or in part, of payment for a service;
- Demand for recoupment;
- Failure of the vendor to meet specified timeframes (e.g., authorization, claims processing, appeal resolution); and
- The denial for disenrollment for good cause.

The DHCFP will not accept requests for State Fair Hearings that address provider enrollment, termination or other contract disputes between MCNA and its providers and/or subcontractors. Likewise, grievances are not eligible for State Fair Hearings.

MCNA understands that we are bound by the decision of the Fair Hearing Officer and must comply with any decision resulting from the Fair Hearing process.

The DentalTrac™ Grievance and Appeal Module [§3.12.1.4]

DentalTrac™ has a customized module for tracking Grievances and Appeals. All users benefit from a unique workflow management tool that ensures the timely and thorough handling of all cases. The activities involved in researching and resolving cases, including all documentation and communications exchanged, are recorded in the DentalTrac™ system for easy reference and superior tracking. The DentalTrac™ Grievances and Appeals module includes the following details in each grievance and appeal record:

- Complete description of the nature of the grievance or appeal
- Nature type
- Member's name, address and Medicaid ID
- Provider's name and address
- Name of person filing the grievance or appeal
- Priority status (standard or expedited)
- Complete description of MCNA's findings
- Reason for the pre-authorization denial
- Name of the Administrator or Clinical Reviewer who conducted the review
- Final dispositions and recommendations
- Date of receipt, resolution, and the member notification of the disposition
- Date of State Fair Hearing request and decisions
- Copies of all notices and documentation compiled during the processes

Our enhanced Business Rules Management System does not allow a document already stored within DentalTrac™ to be altered. Our MIS further ensures the security of all stored documents by maintaining a complete audit trail of the following information:

The integration of this technology into the core of our MIS framework provides MCNA with a superior capability to preserve in an orderly and accessible manner all documents pertaining to grievances, appeals, investigations, and resolutions.

Please see the following screenshots of MCNA's Grievances and Appeals Module and a sample grievance case detail page.

MCNA maintains well-defined procedures for logging, tracking, and monitoring grievances from the initial receipt to final disposition. DentalTrac™ time stamps each grievance and appeal enabling the creation of a complete audit trail to ensure compliance with all timeliness requirements. Our tracking system supports our grievance process and has the capability to track cases when they are received and resolved, as well as those that are in the process of resolution. The system allows the Grievances and Appeals Department to store all documents related to the case.

DentalTrac™'s reporting capabilities allow for the generation of standard and customized reports, in formats that will fully comply with DHCFP's reporting requirements and any ad-hoc requests. We will submit to the DHCFP monthly and quarterly reports that document the grievance and appeal activities listed on the templates located in ***Attachment T, Forms and Reporting Guide***. The report will be broken out by hearing issue, date requested and date resolved, program and outcome for tracking, trending and corrective action.

MCNA is committed to meeting DHCFP's performance standards and reporting requirements as outlined in this RFP.

Aggregation and Analysis of Grievance and Appeal Data to Improve Our Performance [§3.12.5.8 - §3.12.5.9]

For quality improvement purposes, MCNA tracks and trends all key performance indicators (KPIs) for our grievance and appeals processes. The activities involved in researching and resolving the case, including all documentation and communications exchanged, are recorded in the DentalTrac™ system for easy reference and superior tracking. Our MIS generates extensive management reports that are used by MCNA's Grievances and Appeals Committee to identify consistent patterns of grievances and appeals filed by members and providers. When a pattern is identified, action is taken by the committee to investigate the pattern and recommend corrective actions. All activities conducted by the Grievances and Appeals Committee are reported to the Quality Improvement Committee (QIC).

[redacted]

MCNA looks forward to providing our new Nevada Medicaid enrollees with the same high level of service we provide to nearly 3,500,000 members throughout the nation.

Management Information System (MIS) [§3.13]

[redacted]

All of our HIPAA ASC X12N transaction files are **fully compliant to HIPAA 5010** requirements. We support the full set of HIPAA 5010 transaction files as well as the ICD-9 and ICD-10 code sets.

Interfacing with DHCFP Systems

MCNA is capable and ready to interface with the DHCFP for real-time connectivity to all DHCFP-approved systems. DentalTrac™ supports all standards of DHCFP, including standard and proprietary code sets. The DentalTrac™ system meets the system and data integration requirements of this RFP and enables MCNA to exchange data with our customers and other third parties such as enrollment brokers and fiscal intermediaries with ease.

We have significant experience in partnering with agencies to refine our management information system to meet new requirements and enhance the support of services delivered to our members, providers, and clients. Our DHCFP-dedicated Information Technology Systems (ITS) work group is committed to ensuring that our MIS and technologies conform to the applicable DHCFP or State standards for website structure, coding, and presentation. The ITS work group will also ensure all our applications, operating software, middleware, and networking hardware and software interoperate as needed with the DHCFP and/or State systems and conform to applicable standards and specifications set by the DHCFP and/or the state agency that owns the system.

MCNA has been managing Medicaid and HIPAA file format transmissions for over a decade, exchanging data with over 75 trading partners. Our Electronic Data Interchange (EDI) subsystem exchanges data involving encounters, updates to enrollment, eligibility inquiries, claims encounters, and payment acknowledgments. Currently, our MIS interfaces with all major clearinghouses, state Medicaid agencies' secure systems, commercial plans' subsystems, Health Level Seven, and third-party administrators nationwide.

As part of the implementation, MCNA's ITS will work with the DHCFP to define the protocols, file layout definitions, and exchange of information from DHCFP's MMIS to our MIS to ensure continuity of care, proper management of benefits, and fiscal responsibility. **We have extensive experience in the transition and control of large-scale implementations of Medicaid dental programs**. Our approach to effectively managing the many data feeds, processing, and acceptance of critical data exchanges to and from the DHCFP is based on proven and self-guided best practices from our experience with other state agencies. Whether HIPAA X12N standard file formats or proprietary file formats are used by DHCFP, the level of coordination utilized by MCNA lets all parties involved ensure communications, data dictionaries, and data mappings are established appropriately to allow us to generate files in the State's prescribed formats for upload into the DHCFP's systems used specifically for program integrity and compliance purposes.

DentalTrac™ has been built from the ground up to take into account data integrity and to house audit controls to support all business operations. We use a combination of thorough safeguards, policies,

monitoring tools, and automated business processes to ensure systematic, ongoing, and auditable adherence to HIPAA regulations, mandates, rules and standards per HIPAA Security (45 CFR §164), HIPAA Privacy (45 CFR §160 and §164), and HIPAA Transaction & Code Set (TCS) (45 CFR §164).

MCNA employs dedicated systems and network engineers to support our rigorous information security program. Our engineers use a combination of network, security monitoring, encryption technologies, and a 24x7x365 Network Operations Center to protect our environment and ensure the confidentiality and integrity of our data, as evidenced in our SOC 2 Type 2 certification. Protecting the data of our members, network providers, and clients is a top priority for MCNA. We continuously monitor our environment for potential threats, whether internal or external, and follow strict guidelines defined in our security protocols to promptly assess and evaluate threats to the security and integrity of our environment and take any necessary mitigating actions.

Supported File Format Standards	
HIPAA ASC X12 270/271	Hea th Care E g b ty Benef t Inqu ry and Response
HIPAA ASC X12 276/277	Hea th Care C a m Status Request and Response
HIPAA ASC X12 277CA	Hea th Care C a ms Acknow edgement
HIPAA ASC X12 277U	Hea th Care C a ms Status Response
HIPAA ASC X12 278	Hea th Care Serv ces - Request for Rev ew and Response; Hea th Care Serv ces Not f cat on and Acknow edgment
HIPAA ASC X12 820	Payro Deducted and Other Group Prem um Payment for Insurance Products
HIPAA ASC X12 834	Benef t Enro ment and Ma ntenance
HIPAA ASC X12 835	Hea th Care C a m Payment/Adv ce
HIPAA ASC X12 837D	Hea th Care C a m: Profess ona , Inst tut ona , and Denta , nc ud ng coord nat on of benef ts (COB) and subrogat on c a ms
HIPAA ASC X12 997	Funct ona Acknow edgement
HIPAA ASC X12 999	Funct ona Acknow edgement
NSF	Nat ona Standard Format
HL7	Hea th Leve Seven
XML	Extens b e Markup Language
UDF	User Def ned F e

Secure Storage of Data

[redacted]

Eligibility Data [§3.13.3]

DentalTrac™'s comprehensive eligibility and enrollment module uses a sophisticated **business rules engine to process benefit and enrollment data transmissions** and to determine eligibility and benefits of members. Our system accepts HIPAA-format and proprietary member enrollment files transmitted daily by trading partners. DentalTrac™'s sophisticated EDI subsystem also allows us to accept eligibility and enrollment data in virtually any data format provided. We are able to process data files with fixed or varying layouts, file formats, and delivery methods.

Currently, we receive and process eligibility and enrollment data files from 12 different trading partners, most using HIPAA ASC X12N 834 file format and the rest using proprietary file formats. Our EDI subsystem and our Automated Communications Module (ACM) are responsible for automatically retrieving data files from our trading partners, applying all validation and business rules applicable to each trading partner and program administration. Scheduling the retrieval of data files from our trading partners can be configured with granularity down to a one-minute interval.

Nevada MMIS enrollment files will be received and processed monthly, or on any frequency deemed necessary by DHCFP.

Upon processing eligibility and enrollment files, DentalTrac™ follows business rules that trigger multiple validation checks during the process and executes the necessary steps to satisfy contractual compliance. During the validation points, DentalTrac™ generates integrity checksums and reports that

confirm the electronically transmitted data file was not altered in any way during processing. The execution of additional steps throughout the loading of eligibility and enrollment files include:

- Normalizing and validating member addresses
- Linking records for the same enrolled recipient that are associated with different Medicaid and/or Nevada Check Up identification numbers
- Reconciling members to households
- Assigning members to Primary Dental Providers (PDPs), if applicable
- Generating ID cards, member handbooks, and provider directories
- Reconsidering claims data
- Providing processing results and reports to internal staff and meeting plan-required notifications

DentalTrac™ leverages its uniform data dictionary to enforce referential integrity checks when loading and processing eligibility and enrollment files. Members are assigned a unique member number that persists across changes in demographics and changes in eligibility benefits and categories. Member eligibility is managed through non-overlapping dated eligibility spans which are linked to the member's record. All information in the eligibility and enrollment files provided by DHCFP's MMIS will be stored within DentalTrac™ and linked to the member's profile for referential and reporting purposes.

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

Our Enrollment Coordinator works with the Member Services Department to ensure the accuracy and timeliness of member enrollment information. All plan-approved changes to a member's eligibility record will be made when the daily file is processed such that, in real-time, the record reflects the most recent eligibility detail **ensuring members always obtain the services to which they are entitled**. Our Member Services Representatives also have functionality available to them to capture additional information from our members, which may not always be available in the eligibility and enrollment files. This additional information may be critical to the successful delivery of services to our members.

Additionally, DentalTrac™ uses standard postal software as part of an automated reconciliation process to verify that the residential address for each enrollee in the enrollment file matches the address listed in our records. All addresses go through a data hygiene process that is critical to ensure the highest degree of validation and deliverability of any material we may need to send to members. Our data hygiene process helps us validate, correct, and standardize all address data with USPS Coding Accuracy Support System (CASS) processing support.

MCNA updates the Eligibility and Enrollment module of our DentalTrac™ MIS whenever changes to enrolled recipient information such as names, phone numbers, and addresses are discovered. We will notify DHCFP in the method and format required of any inaccurate recipient addresses and all updates made to our eligibility database.

DentalTrac™'s extensive logging capabilities maintain an audit trail for all current and retroactive changes to enrollment data, whether those changes arise from manual updates or from processing an electronic transmission. **MCNA will accept and manually process changes from the DHCFP, such as adding additional beneficiaries in the system.**

All member-related materials are also tracked within DentalTrac™, either automatically during the loading and processing of enrollment files or via manual updates done by our Member Services Representatives or Enrollment Coordinators. Changes to member records may trigger the **automatic mailing of member handbooks or welcome packets**. These materials will be automatically produced and mailed to new members within five (5) business days of receipt of eligibility and enrollment files from DHCFP.

By the time of Readiness Review, MCNA will finalize a process to accept and load an initial full file of recipient eligibility data from DHCFP into our DentalTrac™ system. We will also finalize the process to accept and update monthly recipient eligibility data from DHCFP in DentalTrac™.

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

The EM will be responsible for:

- Ensuring that enrollment files received are processed within the DHCFP-specified time frame
- Reconciling the enrollment data
- Reviewing enrollments and disenrollments to identify potential issues, and ensuring each member's eligibility status is accurate
- Notifying the DHCFP if the addresses of recipients are not accurate
- Notifying the State if any issues are identified during processing of the file

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

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

Please see the **Enrollment Requirements and Limitations [§3.4]** section for a flowchart illustrating our current enrollment and eligibility process for handling electronic and ad-hoc requests. The flexibility

of DentalTrac™ allows us to incorporate changes to our business processes to meet the notification requirements of DHCFP.

MCNA's CEO, CFO, or CIO shall certify the truthfulness, accuracy, and completeness of all enrollment information, encounter data, payment data, and other information submitted to the State for purposes of developing vendor payment in compliance with applicable certification requirements for data and documentation specified by DHCFP pursuant to 42 C.F.R. §§438.604, 438.606, and 457.950. We understand that compliance with the requirements for data certification in this agreement is a condition for payment by the government and we agree to comply with all applicable laws and regulations.

EPSDT Tracking System [§3.13.6]

MCNA fully integrates all member data to create a unique member eligibility record for each individual we serve to ensure a comprehensive, coordinated approach to quality dental treatment. DentalTrac™, our comprehensive, sophisticated technology solution, maintains all claims data received from providers including all information that the State of Nevada will need to complete the annual EPSDT report (Form CMS-416) in accordance with CMS requirements.

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

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

Operational Requirements [§3.14]

Proposed Personnel/Management Approach

MCNA's proposed personnel and management approach combines the financial strength of MCNA Insurance Company and the unparalleled dental managed care experience of its affiliate, Managed Care of North America, Inc., to deliver to the Nevada Department of Health Care Financing and Policy, a turnkey solution for a seamless transition.

MCNA was founded by Jeffrey P. Feingold, DDS, MSD, a Florida-licensed Periodontist and Diplomate of the American Board of Periodontology. With a staff of over **550**, MCNA has the infrastructure and experience to deliver **best-in-class** dental benefits management to our clients.

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

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

Under the guidance and leadership of Dr. Feingold, MCNA's personnel and management approach for Nevada includes the following components:

- A locally based operation supplemented by experienced, veteran MCNA team members
- A well-defined staffing plan
- Contract oversight

Key Personnel [§3.14.3.2 - §3.14.3.3]

Nevada is a priority to our organization, and as such, our most valuable resources will be dedicated to the success of this contract. All persons employed by MCNA to provide services under this contract will have the appropriate training, education, and experience to fulfill the requirements of their positions and will be fully vetted to ensure they are legally authorized to do so under Nevada law. While some employees may be assigned to more than one area, we will ensure that the Nevada Operations Manager will hold no more than one (1) position. MCNA understands DHCFP may remove any staff from the project at any time.

The table below represents the MCNA team who will provide ongoing leadership and support to Nevada. MCNA will notify DHCFP in writing within seven (7) calendar days of any changes to the following positions.

Name and Title	Area of Responsibility
Jeffrey P. Feingold, DDS, MSD *Chairman and Chief Executive Officer*	• **Executive Management**
Glen S. Feingold *Executive Vice President and Chief Operating Officer*	• **Executive Management**
Philip H. Hunke, DDS, MSD *Plan President*	• **Executive Management**
[redacted]	[redacted]
[redacted]	
Carlos A. Lacasa, JD *Senior Vice President and General Counsel*	• **Executive Management**
Edward A. Strongin, CPA *Chief Financial Officer*	• **Executive Management** • **Accounting and Budgeting**
Daniel Salama, BSE *Chief Information and Security Officer*	• **Executive Management** • **Management Information Systems**
Mayre Thompson, MHA *Chief Compliance and Privacy Officer*	• **Executive Management** • **Compliance** • **Program Integrity**

Shannon Turner, JD *Vice President of Operations*	• **Executive Management** • **Administrator**
DeDe Davis *Vice President of Dental Management and Quality Improvement*	• **Executive Management** • **Dental Management** • **Quality Assurance / Utilization Review**
Martha Abadilla *Associate Vice President of Administration and Operations*	• **Member Services** • **Provider Services**
Oteasa Townsend-Hardy, BHSA *Director of Quality Improvement and Risk Management*	• **Quality Assurance** • **Risk Management**
Meghan Henkel, LPN *Director of Utilization Management and Case Management*	• **Utilization Review/Management**
Carol Raspa *Director of Claims Management*	• **Claims Administration** • **Claims Processing**
Diana Davis *Director of Grievances and Appeals*	• **Grievances** • **Appeals** • **State Fair Hearings**
René Canales *Director of Network Development*	• **Network Development** • **Provider Services**
Aldwin Gomez *Director of Call Center Operations*	• **Member Services** • **Provider Services**
Sophia Wallen *Director of Credentialing*	• **Credentialing**
Jeanette Logan, MBA *Senior Manager of Client Services*	• **Management Information Systems**

The following is an overview of the Key Personnel roles and responsibilities, and MCNA's qualified candidates for these roles. Resume forms for all Key Personnel candidates are attached to this RFP as **Attachment 2-1**, and set forth the experience and qualifications of each team member.

Administrator: Shannon Turner, JD

- MCNA's Vice President of Operations, Shannon Turner, JD is responsible for managing the day-to-day operations of all MCNA departments, staff, and functions to ensure that performance measures and requirements are met. Shannon will be the primary point of contact with DHCFP

for all operational issues. She is based in our Texas office and reports directly to MCNA's Plan President, Dr. Philip Hunke.

Chief Financial Officer: Edward Strongin, CPA

- MCNA's Chief Financial Officer, Edward Strongin, CPA is responsible for oversight of all MCNA financial-related activity including all audit activities, accounting systems, financial reporting and budgeting. Edward is based in our corporate office in Florida and reports to MCNA's Board of Directors with a dotted line to our CEO, Dr. Jeffrey Feingold.

Provider Services Manager and Member Services Manager: Martha Abadilla

- MCNA's Associate Vice President of Administration and Operations, Martha Abadilla, is responsible for oversight of Member and Provider Services. Martha will be the primary manager of MCNA's Provider Relations Department and is responsible for the development and implementation of our plan-related policies, procedures, processes and staff activities. As the Member Services Manager, she is responsible for coordinating communications between MCNA and Nevada Medicaid members. Martha will ensure there are sufficient member services representatives, including staff members with the skills to deliver culturally and linguistically appropriate services in the Medicaid managed care program. Martha works out of our Regional office in Texas and reports to MCNA's Vice President of Operations (Administrator), Shannon Turner.

Grievance and Appeals Coordinator: Diana Davis

- Diana Davis, MCNA's Director of Grievances and Appeals, is responsible for managing/adjudicating member grievances, appeals, and requests for fair hearings and provider grievances and appeals for the State of Nevada. She will ensure issues are resolved within the mandatory guidelines as established by State and federal regulatory agencies, accrediting organizations standards, and in accordance with MCNA's Grievance and Appeals Department policies and procedures. Diana is based in Florida and reports to MCNA's Chief Compliance and Privacy Officer, Mayre Thompson.

Claims Administrator: Carol Raspa

- MCNA's Director of Claims, Carol Raspa, will serve in the role of Claims Administrator. She is responsible for developing, implementing, and administering a comprehensive Nevada Medicaid Managed Care claims processing system capable of paying claims in accordance with State and federal requirements and the terms of the contract. Carol is based in Florida and reports to MCNA's Vice President of Operations (Administrator), Shannon Turner.

MCNA has hired (or will recruit) Nevadans to fill the following roles:

[redacted]

Provider Relations Representatives

- MCNA's Provider Relations (PR) Representatives are responsible for the development and implementation of ongoing strategies to increase provider participation. PR Representatives conduct provider orientation, training and ongoing education, and assist with claims inquiries and issue resolution.

Member Advocate Outreach Specialists (MAOS)

- MCNA's MAOS are primarily responsible for the development and implementation of MCNA's ongoing strategies to increase utilization of dental services, perform member outreach and education, and execute initiatives to work with non-compliant members.

Staffing Plan [§3.14.3.1]

MCNA understands a successful program in Nevada will require additional clinical and support staff to ensure operations are efficient and effective. Meeting contractual performance goals and providing world-class customer-service to our members, providers, and DHCFP stakeholders is very important to MCNA. We know that having the right amount of resources allocated to Nevada will significantly impact response times and customer satisfaction.

[redacted]

Subcontractors [§3.14.4]

MCNA Insurance Company (MCNA) will comply with the requirements of the DHCFP contract by underwriting the cost of the dental benefits, ensuring all Provider Relations and Outreach responsibilities are fulfilled, providing a skilled team of general and specialty dentists to provide clinical review services, managing a robust network of general dentists and specialists, and overseeing our affiliated subcontractor who will provide additional administrative services.

MCNA Insurance Company (the bidder) utilizes our affiliate subcontractor, MCNA Dental Plans, as our third party administrator for all current and planned business operations. **MCNA agrees to comply with all requirements related to subcontractors outlined in the Nevada RFP.**

Subcontractor Oversight

MCNA's subcontract contains rigorous performance standards designed to ensure compliance with DHCFP requirements. These performance standards will be monitored on a day-to-day basis by:

- Shannon Turner, Vice President of Operations.

MCNA also oversees the subcontractor's performance through our Quality Improvement Committee process. The Quality Improvement Committee evaluates the subcontractor's ability to perform the activities to be delegated; monitors the subcontractor's performance on an ongoing basis; subjects the subcontractor to formal review on an annual basis; identifies deficiencies or areas for improvement; and takes corrective action as necessary.

MCNA's Quality Improvement (QI) Department continuously monitors plan operations to identify areas for improvement. [redacted]

MCNA will not allow any subcontractor to commence work until all required insurance information is provided. Additionally, we will provide proof of payment to any subcontractors used for this contract upon request by the State, and we agree to notify the State via their choice of mail, email, or fax within five (5) business days of receipt of the request. MCNA will remain fully responsible for the obligations, services, and functions performed by our subcontractor to the same extent as if such obligations, services, and functions were performed by MCNA Insurance Company.

Project Work Plan [§3.14.5, §3.14.5.1]

Flawless implementations are critical to ensuring client success. **MCNA will submit a detailed implementation plan to DHCFP within one month of being awarded the DBA contract.** Please see **Attachment 3-9** for MCNA's draft implementation plan for Nevada.

The work plan will outline the key activities necessary to successfully assume Medicaid and CHIP dental program operations. It includes the establishment of MCNA's Nevada Project Implementation Team and the identification of the project office toolset to be utilized to manage the implementation project. Our team utilizes our Program Management Office (PMO) to enable continuous information flow among key personnel responsible for the implementation and monitoring of deliverables.

MCNA's project plan includes key milestones and activities needed in order to be ready to assume plan operations on July 1, 2017. All timeframes including those for network development are included along with an estimate of person hours for the identified tasks. Finally, the plan takes into account dependencies and DHCFP related components.

Resource Allocation

The project work plan commences when the PMO assigns a minimum of one (1) project manager (PM) and two (2) subject matter experts (SMEs) to determine the scope and breadth of the project. The PM

and SMEs provide a report of the project requirements and preliminary findings to the project PMO to assess its resource allocation needs for the project. Once the PMO is able to ascertain the needs, a set of team members is assigned to the project. These team members are brought in at various phases of the project in order to contribute their expertise and skills.

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

- **Static Project Team**
  - Is assigned from the inception of the project
  - Remains with the project throughout its life cycle
  - Remains in place after the project has concluded to provide training and support
- **Dynamic Project Team**
  - Is brought in during the project kickoff
  - Remains with the project throughout its lifecycle
  - Are released from the project at its conclusion

Requirements Gathering

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

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

Kickoff

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

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

Blueprinting

The blueprinting session is conducted by the PM and the SMEs in order to understand the full scope of the project. This assists with compiling the Project Charter to log all deliverables necessary at the

conclusion of the implementation. During the blueprinting session, any deficiencies in information provided are identified and listed within the Action Log for further clarification. Issues found are logged within a Risk Register and assigned a Mitigation Plan. Both the log and the register are assigned a primary owner who ensures their continuous monitoring and status adjustments. The log and register are also made available to all team members in order to review items assigned to their ownership.

Project Charter

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

The development of the Project Charter is a Risk Management strategy that reduces the need for Change Management. Unexpected challenges are inevitable with any project, but MCNA's experience has taught us that a robust Charter allows both the stakeholder and the project team to understand the project requirements thoroughly, and vet solutions prior to issues arising as the project reaches an advanced stage.

Project Planning

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

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

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

The plan is meticulously maintained and all team members update the plan on a daily basis to ensure there is no impact to the planned timeline. MCNA maintains several distinct tasks within its project

plans. Sub-plans may be developed for each department or stakeholder in order to expedite delivery and prevent confusion or mistakes.

Implementation Process

Checkpoint Meetings

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

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

Risk Assessment

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

Acceptance Criteria

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

Action Item Log

In addition to the project plan, MCNA maintains an Action Log for items requiring attention from everyone involved in the project. These items can be as simple as scheduling a one-on-one call to completing documentation approval. The purpose is to prevent the project plan from being inundated with tasks not critical for the implementation and yet maintaining a log of activities that must be performed in order for it to succeed. The log outlines the activity in detail, assigns ownership to a team member and allocates a due date by which it must be completed. The log is maintained in a Microsoft Excel® format and is housed in our secure document management system for accessibility and collaboration amongst the project team.

Project Status Review

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

Training Plan

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

Testing

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

Readiness Review Approach [§3.14.5.2]

To showcase our efforts applied during the implementation, MCNA plans and prepares for a readiness review by ensuring all of the deliverables have been met and project tasks achieved prior to the go-live date. MCNA's project plan includes key milestones and activities needed to be ready to assume plan operations on July 1, 2017. All timeframes including those for network development are included along with an estimate of person hours for the identified tasks.

Presentation of Findings [§3.14.6]

MCNA understands and agrees to obtain the DHCFP's approval prior to publishing or making formal presentations of statistical or analytical material that includes information about enrolled participants. Any material proposed will protect specific individual member privacy and confidentiality to the extent required by federal and state laws and regulations.

Marketing [§3.14.7]

MCNA and its subcontractors do not intend to market or advertise to potential enrollees. However, should we decide to develop any marketing or advertising materials, we will submit them to DHCFP for approval at least 60 days prior to the next scheduled Medical Care Advisory Committee (MCAC) meeting. All materials will comply with applicable State and federal rules, regulations, and requirements. We understand that DHCFP has the sole authority to approve marketing materials.

Program Integrity [§3.15]

MCNA's Fraud and Abuse Program [§3.15.1, §3.15.6 - §3.15.7]

Combating fraud and abuse is an essential part of the business ethos of MCNA. Our CEO and Board of Directors oversee the Fraud, Waste, and Abuse Compliance Plan (known as the Fraud and Abuse Program) and provide the Chief Compliance Officer with the resources needed to execute the program. MCNA's program incorporates all program integrity requirements and combines prevention, vigilant monitoring, investigation, enforcement, training and communication to foster a culture of ethics and compliance in our provider networks, the plans we serve, and our workplace.

Our Nevada Fraud and Abuse Program will adhere to all requirements outlined in §3.15 of the RFP, and includes all required components of the plan outlined in §3.15.6 and §3.16.7. Our Fraud and Abuse Program will also comply with all applicable State and federal requirements, including:

- §§1128, 1156, and 1902(a)(68) of the Social Security Act
- 42 CFR §438.1 - §438.812 (Subpart H)
- 42 CFR §455 Subpart A, B, and E
- 42 CFR §1000-1008
- 42 CFR §§456.3, 456.4, and 456.23
- 42 CFR §457.950(a)(2)
- Section 6032 of the Federal Deficit Reduction Act of 2005
- Nevada Revised Statutes, Chapter 422
- Nevada DHCFP Medicaid Services Manual
- Nevada DHCFP Medicaid Billing Guides

Our Fraud and Abuse Program includes our policies, procedures, and standards of conduct. It also outlines the methods that members, providers, and employees can use to report suspected fraud, waste, or abuse (FWA).

MCNA's Special Investigations Unit (SIU) serves as our program integrity unit (PIU), and is responsible for the day-to-day implementation of the Fraud and Abuse Program. We require all subcontractors and providers to be compliant with our Fraud and Abuse Program, and will fully cooperate and coordinate with the DHCFP, its Surveillance and Utilization Review (SUR) unit, and the Nevada Attorney General's Office and its Medicaid Fraud Control Unit (MFCU). Our Fraud and Abuse Program outlines our training process, program goals and objectives, program enforcement processes, how to report suspected FWA, and communication protocols with State agencies, employees, providers, and subcontractors.

We will submit our Fraud and Abuse Program to DHCFP annually for review and approval. After the initial year of program operations, the program will include a report on the successes of the goals and objectives from the previous year.

Our Special Investigations Unit (SIU) [§3.15.10 - §3.15.13, §3.15.16]

MCNA's SIU Leaders

Mayre Thompson, MHA
Chief Compliance and Privacy Officer

Former Program Analyst for the Bureau of Managed Care at the Florida Agency for Health Care Administration overseeing Medicaid Managed Care health plan operations.

Vicki Grudzinski, CLEA
SIU Manager

Former Senior Medicaid Fraud Analyst with the Florida Office of Attorney General Medicaid Fraud Control Unit (MFCU). Former Special Auditor Investigator for the New York Medicaid Fraud Control Unit (MFCU). Certified Law Enforcement Analyst (CLEA) through the Florida Department of Law Enforcement.

Christian Fondeur, CFE
Senior Fraud and Profiling Analyst

Former Senior Fraud Analyst for MBNA America. Former Fraud Analyst for Mercantil Commerce Bank. Lean Six Sigma, Green Belt.

The SIU addresses the identification, review, recovery, prevention, and reporting of improper payments, including FWA. Our SIU monitors program utilization of members, claims data, and internal staff and vendor transactions to monitor for FWA indicators and to detect criminal activity such as embezzlement or theft. Any evidence of criminal activity such as theft or embezzlement will be reported to the appropriate authorities and the DHCFP SUR unit within five (5) business days.

Additionally, MCNA has a process in place to verify whether members received services billed by providers in accordance with 42 CFR §455.20 (Beneficiary Verification Procedures). SIU selects a random sample of no less than 500 members to survey each month. The verification process is conducted by sending members a copy of their Explanation of Benefits (EOB) or by member phone interviews. MCNA will report all member verification activities to:

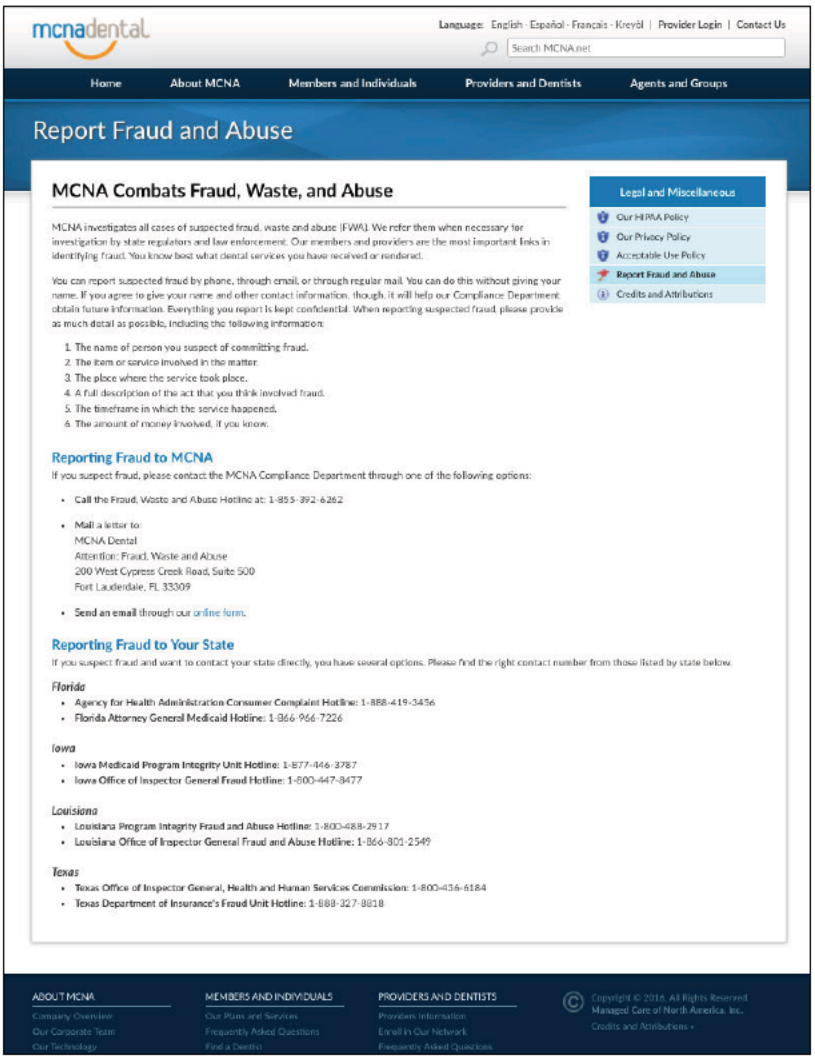
- MCNA's Fraud, Waste and Abuse Committee on a quarterly basis; and
- To DHCFP in the frequency required by the Agency.

MCNA may send additional verification of services letters to members and conduct member phone interviews in connection with targeted provider investigations, provider profiling activities, and other program integrity undertakings. The following situations may warrant attempting to contact a member by phone to ascertain whether the billed services were rendered:

- Excessive visits or services
- A questionable service
- A recurring billing pattern

SIU will request dental records for discrepancies identified during the verification process. Those records will be evaluated and if the billed services are not listed in the record, a full investigation will be opened and funds will be recouped.

MCNA maintains a toll-free hotline and web page to enable members of the public, recipients, and providers to report all allegations of waste, fraud, abuse, or improper payments. Our Nevada website will have a stand-alone highlighted button or link on the front page to enable anyone to report Medicaid fraud, waste, or abuse. Please see above MCNA's FWA information area on our corporate website.



Training for Employees and Subcontractors [§3.15.8.1]

The training of employees at all levels is an essential component of an effective Fraud and Abuse Program. All information required for compliance with Section 6032 of the Deficit Reduction Act of 2005 is incorporated into our training materials and information provided to MCNA's employees, subcontractors, and providers. All MCNA employees receive FWA training within 30 days of initial hiring, upon adoption of updates to the Fraud and Abuse Program, and annually as a condition of employment. Thirty days before an employee's anniversary, our Human Resources Department begins the process of reminding all employees of their upcoming annual training. Members of the Board of Directors also receive compliance training annually. All subcontractors are educated about their responsibilities regarding FWA and erroneous payments. Information about the Fraud and Abuse Program is part of all provider contracts and MCNA's Provider Manual.

The training is web-based and employees access the content in the Learning Management module of DentalTrac™. Employees are trained to be cognizant of all applicable state and federal laws and regulations that apply to MCNA's operations and competitive practices, as well as the day-to-day activities of the company and its employees. If an employee has not completed scheduled training within the required timeframe, the Human Resources Director notifies the employee's supervisor of his or her non-compliance, and the employee may be removed from his or her duties until training is complete. Ongoing training is provided to departments affected by a material change in policies or procedures, and state and federal regulations.

Screening for Excluded or Disbarred Entities [§3.15.5]

MCNA recognizes that we are prohibited from entering into or maintaining relationships with any person or entity who is debarred, suspended, or excluded from participation in a federal healthcare program as described in 42 CFR §438.610. Our Fraud and Abuse Program provides written policies and procedures that outline MCNA's commitment to comply with all state and federal requirements and to use established protocols to identify debarred individuals or excluded providers. The Credentialing and Human Resources departments are responsible for ensuring that MCNA does not hire, or enter into contracts with individuals or entities that are listed as debarred, suspended, excluded or otherwise ineligible for participation in state and federal health care programs including both Medicaid and Medicare. Upon initial employment and contracting, and monthly thereafter, the following websites are monitored to ensure that prospective and current employees, providers, subcontractors, and other individuals affiliated with MCNA are not listed:

- The Office of the Inspector General's (OIG) List of Excluded Individuals and Entities database
- Federal System for Award Management (SAM) sanctions and debarment reports
- Nevada Medicaid Excluded Providers list and Nevada Board of Dental Examiners
- Healthcare Integrity and Protection Data Bank (HIPDB)

If MCNA discovers that any owner, employee, network provider, subcontractor, or subcontractor's employee has been excluded, suspended, or debarred from any state or federal healthcare program or any program listed in Executive Order 12549, the Chief Compliance and Privacy Officer will report such information to the SUR unit of DHCFP within three (3) business days. **MCNA will immediately initiate efforts to sever the relationship with the debarred or excluded individual or entity.**

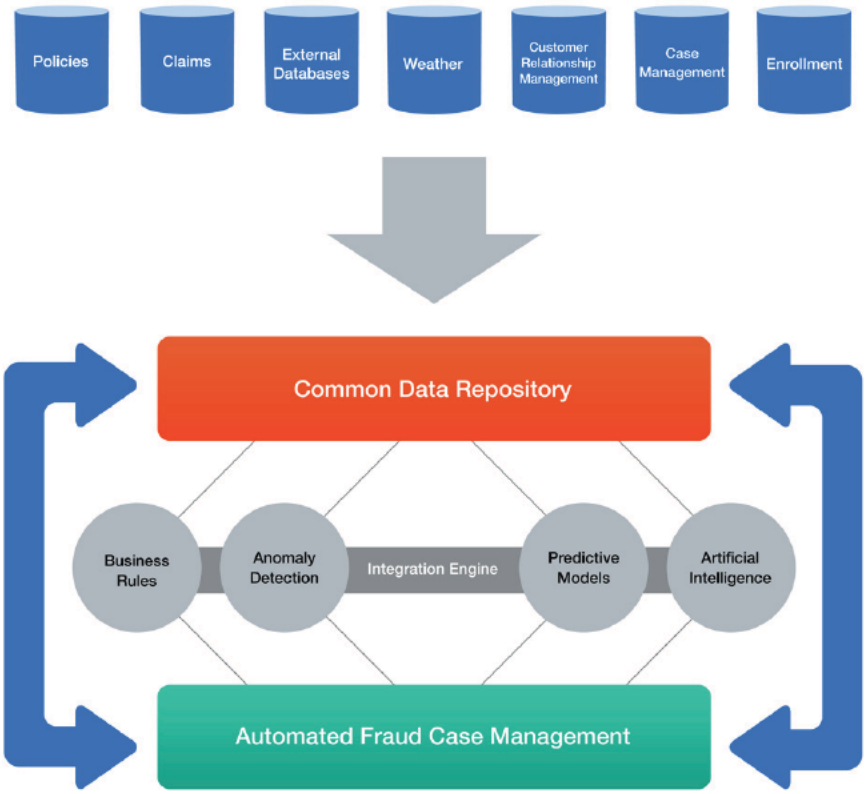
Fraud Prevention and Detection Measures [§3.15.17, §3.15.22 - §3.15.23]

MCNA's advantage in detecting fraud and abuse activities lies in our ability to perform sophisticated analysis of claims data and provider profiles. The sophistication, flexibility and modularity of MCNA's proprietary management information system (MIS), DentalTrac™, allows for powerful, **data-driven predictive analytics.** Our system generates trends and predictive models that are critical indicators used on a daily basis by our SIU for combating fraud and abuse. DentalTrac™'s extensive fraud identification and detection tactics include:

- Proprietary database-driven technology that analyzes providers with suspect billing activity
- Consistent data mining that flags qualified cases for investigation

- Data-driven predictive analytics (algorithm and statistical)
- Custom rules and alerts that drive contract-specific workflow and payment policies
- Supplemental clinical code edits, updated in real-time
- National Correct Coding Initiative rules and methodologies

MCNA performs provider compliance reviews to identify FWA issues. The diagram to the right outlines our comprehensive detection approach.



Every claim is passed through a series of intelligent filters in DentalTrac™ for a complete profiling analysis. Our MIS applies the proven algorithms in real-time throughout the lifecycle of the claims:

- Prior to adjudication
- Post-adjudication but prior to payment
- Post-payment (retrospective)

Once the analyses are complete, business rules determine whether our MIS should automatically deny the claim, flag the claim for possible fraud, notify our SIU, or other actions defined by the company. MCNA's profiling analysis takes into account all claims data including new, resubmitted, and adjusted claims (for items such as date of service or procedure code). Also included in the profiling analysis are both paid and denied claims. Denied claims, although they pose no monetary loss, can indicate the intent to defraud.

In addition to the approaches outlined above, MCNA also investigates reports of fraud and abuse from DHCFP and those received by our employees, Member and Provider Hotline customer service representatives, and employees of provider offices (whistleblowers) via our confidential fraud and abuse tip line and through our website.

MCNA will identify and report provider preventable conditions (PPC) that are associated with claims for Medicaid members to the DHCFP's SUR unit. We will all require our providers and subcontractors to identify and report PPC.

MCNA will refer all credible allegations of fraud to the Nevada DHCFP's SUR unit within two (2) business days. The referral will include all elements required in section 3.15.14.4 of this RFP. A full-scale investigation will then commence including, but not limited to:

Corrective Actions [§3.15.15]

Corrective actions are implemented to safeguard against the delivery of unnecessary services, monitor quality, and ensure services and payments are appropriate according to MCNA's policies and guidelines, and State and federal regulations. MCNA takes the necessary corrective measures and implements one or more actions to address suspected or confirmed fraud and abuse. Corrective actions include, but are not limited to, member and provider education, pre-payment or prior authorization review, payment recovery (recoupment), State-authorized payment suspension, and the

suspension or termination of the provider. MCNA understands that failure to implement State-authorized payment suspension can result in penalties.

Payment Recovery [§3.15.19 - §3.15.20]

If any overpayments are identified as a result of an SIU investigation, we will provide notification to the provider. This notice will include, at a minimum, the amount of the overpayment, a detailed listing of the claims involved, citations and information to support the findings, options for repayment, appeal rights, and the provider's right to an Administrative Fair Hearing through the DHCFP after MCNA's appeals process is exhausted.

The SIU will collect and retain all overpayments resulting in an FWA investigation or audit, and all affected encounters will be adjusted or voided within 60 calendar days following the identification of the overpayments, regardless of whether MCNA is able to recover the overpayment from the provider.

We understand that any monetary recoveries made by a government entity including the Attorney General's Office, belongs exclusively to the State of Nevada and MCNA has no claim to any portion of this recovery. MCNA and its subcontractors will agree that any State of Nevada government entity or local law enforcement may opt to stand in the place of a vendor or client in the collection against a third party for all criminal, civil and administrative action recoveries undertaken by any government entity. Any funds recovered and retained by a government entity will be reported to the actuary to consider in the rate-setting process, and if any specific payments are identified as improper, MCNA must adjust or void those encounters, as appropriate.

We are committed to maintaining close relationships with the DHCFP's SUR unit, the Attorney General's MFCU, and other Nevada state agencies. In Texas, Louisiana, and Iowa, our SIU and clinical review teams routinely work with the state agencies responsible for program integrity activities to assist them with their investigation and recoupment efforts, and to participate in training sessions with the agencies' staff.

It is MCNA's mission to support and aid state agencies in their fight against fraud, waste, and abuse, and improve the integrity of their Medicaid Programs. We will cooperate and assist the SUR unit and any state or federal agency charged with identifying, investigating, sanctioning, or prosecuting suspected fraud and abuse. Access to originals and copies of all records, computer files, appropriate staff, and other information requested will be provided, and MCNA will allow access to our premises and provide records to DHCFP or its authorized agents, CMS, the U.S. DHHS, the FBI, and other units of the State or federal government. We will also participate in periodic FWA and erroneous payments training sessions, meetings, and joint reviews of network providers or members.

MCNA commits to applying the highest ethical standards and diligence to prevent the occurrence of fraud, waste, and abuse of Nevada Medicaid and CHIP resources. Every dollar saved benefits those members that are truly in need of assistance.

Provider Credentialing and Enrollment [§3.15.2 - §3.15.3, §3.15.25]

Our credentialing and recredentialing process has been NCQA certified since 2011, and URAC accredited since 2014. We hold ourselves to the highest industry standards. MCNA's written credentialing and re-credentialing policies and procedures detail the process for approval of new providers, and termination or suspension of providers. We encourage board certification as applicable. Our written credentialing and re-credentialing process complies with 42 CFR §438.12, §438.206, §438.214, §438.224, and §438.230, and governs our review of all licensed providers with whom we contract or employ. We will submit our credentialing criteria to DHCFP's Provider Enrollment unit at least 90 days prior to the start of the contract for review and approval. Changes will be submitted thereafter at least 30 days prior to the proposed effective date.

Our Credentialing Committee reviews every application received from providers seeking to participate in our network to ensure that MCNA enrolls only qualified providers who meet all requisite criteria. To join MCNA's network of Nevada dental providers, we will ensure, at a minimum, that the provider:

- Completes a credentialing application (paper, via our online electronic Credentialing Portal, or through CAQH).
- Completes the Enrollment Disclosure Form to clearly identify **ownership and control** details.
- Possesses the licenses and credentials necessary to render dental services under State law.
    - MCNA checks Dental License, DEA License, Controlled Substance Registration, and Sedation Permits at initial and re-credentialing time, and whenever the license expires mid-cycle.
- Is not suspended or excluded from federal healthcare programs, including Medicare and Medicaid.

  - MCNA queries the OIG, EPLS, and SAM databanks, and the Medicare Opt-Out List, at initial and re-credentialing, and as needed mid-cycle, to ensure that all providers identified are appropriately denied participation, or are contacted for removal from participation.
- Possesses current professional liability insurance.
  - MCNA checks documentation of insurance including limits, the provider's name, policy number, and expiration dates at initial and re-credentialing time, at the time of site audit by a Provider Relations Representative, and annually upon expiration.
- Is not under any current sanction or has a history of sanctions that would preclude them from participation in our network.
  - MCNA monitors the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank for information about sanction history and acts accordingly.
- Is enrolled to participate in the Nevada Medicaid program.
  - The provider cannot treat and bill for MCNA's Nevada members until enrollment with the Nevada fiscal agent is complete.

MCNA's Nevada Credentialing Committee will be chaired by our Dental Director, Dr. Cody Hughes. Once the verification process is complete, MCNA's staff presents a comprehensive applicant package to the Credentialing Committee for a final determination. A letter is then generated to each applicant notifying them of the approval or denial of the request for network participation. All providers are re-credentialed every 3 years.

All new MCNA providers who are not enrolled in the Nevada Medicaid program will be referred to Medicaid's fiscal agent for enrollment. Providers are not permitted to render services to MCNA's Nevada Medicaid or CHIP members until they are enrolled with Nevada Medicaid's fiscal agent.

MCNA will ensure that all network providers maintain a license in good standing. Should we enter into a Letter of Agreement (single case agreement), MCNA will report the agreement to DHCFP. We will provide DHCFP and or the MFCU credentials for providers, subcontractors, or subcontractor's providers upon request and at no charge.

We understand that MCNA may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the Title XX Services Program. On a monthly basis, no later than the 10th of the month, MCNA will report to the DHCFP a list of all providers who have been enrolled and a list of all providers who have disenrolled, deactivated, terminated, de-credentialed or been removed from the active provider enrollment. If the provider has been terminated, de-credentialed or disenrolled, the cause and all required documentation of the termination will be supplied to the DHCFP within five (5) business days of the decision to terminate.

MCNA's Contracting Approach [§3.15.4]

MCNA understands and acknowledges that we are responsible for any functions and responsibilities delegated to any subcontractor or provider. We recruit all available providers, including those who do

not currently participate in the DHCFP dental program. We provide diligent oversight of our contracted providers and maintain and implement policies and procedures for monitoring performance and providing corrective action. MCNA will submit these policies to DHCFP within 5 business days of any changes or upon request.

Our written provider contract contains requirements for participation and incorporates our Provider Manual. The contract and any necessary amendments are reviewed by MCNA's General Counsel and the Compliance Department to ensure compliance with all regulatory standards. Once contracted and properly credentialed, we train all new network providers on our policies and procedures, covered benefits and limitations, dental record keeping, quality performance and improvement practices, grievance and appeals procedures, and member rights and responsibilities. All provider contracts, subcontracts, and addenda are subject to review and approval by the DHCFP, and will be submitted for review and approval during the Readiness Review period. Any revisions to the agreement will also be submitted for DHCFP review and approval. MCNA will submit all provider contracts to the DHCFP or MFCU within five (5) business days of request.

MCNA network providers are contractually required to provide or arrange for coverage of services, consultations, or emergency dental services 24 hours per day, 7 days per week. After-hours coverage may consist of an answering service or call forwarding, but must be accessible using the office's daytime telephone number and cannot simply refer the member to the nearest Emergency Room. MCNA providers are required to arrange for the provision of primary dental services during absences due to vacation or illness. Additional key contract provisions include a prohibition against balance billing, fraud and abuse prevention standards, and dental record keeping requirements. Our provider contracts do not contain "gag" clauses, and are not structured to provide financial or other incentives for reducing or limiting medically necessary services.

Our Dental Provider Agreement will adhere to all Nevada requirements, including:

- Providers must be licensed, credentialed, and eligible to render services in the Medicaid program under applicable state and federal law before they may be reimbursed for providing covered dental care to Nevada members.
- MCNA will reimburse network providers on a fee-for-service basis.
- MCNA will reimburse FQHCs in accordance with DHCFP requirements.
- Providers must cooperate with program integrity activities, including providing access to records as necessary for audits by MCNA, or State and federal entities. MCNA may suspend payments or terminate the Provider's contract as deemed appropriate pursuant to state and federal laws.
- Providers shall not use any policy or practice that has the effect of discriminating among members on the basis of race, color, or national origin, sex, sexual orientation, gender identity, or disability.
- MCNA and all providers must abide by the prohibition on payments for provider-preventable conditions, as laid out at 42 C.F.R. §447.26.
- Providers accept reimbursement at the contracted rate as payment in full, and may not receive additional payments from other sources except as otherwise authorized by the State.
- In the event of a disputed payment between MCNA and the provider, the provider shall not attempt to recover any funds from members.

- Providers must comply with applicable state and federal laws, including Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act.
- Providers shall deliver services in a culturally competent manner to all individuals, including to individuals with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.
- Providers shall provide physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities.
- Providers shall maintain and share, as appropriate, health records for members in accordance with professional standards and applicable state and federal confidentiality protections.
- MCNA shall furnish to providers information about MCNA's grievance and appeal system, pursuant to 42 CFR §§438.414 and 438.10(g)(2)(xi).
- Providers must retain all records for at least ten (10) years following the termination of their provider agreement with MCNA.

MCNA shall take appropriate action related to dual FFS and MCNA network providers and provide all documentation related to any disciplinary action, sanction, de-credentialing, or removal from the provider panel to DHCFP in a time and manner as determined by the DHCFP as follows:

- When MCNA becomes aware through public sources of any disciplinary action, or any sanction taken against a network provider, or any suspected provider fraud or abuse, MCNA shall immediately inform the DHCFP's Provider Enrollment Unit;
- MCNA is required to check the Office of the Inspector General (OIG) website and DHCFP's excluded Provider list at least monthly to confirm our network providers have not been sanctioned by the OIG or by the DHCFP; and
- If MCNA is notified or discovers that the OIG, DHCFP or another state Medicaid agency or certification/licensing entity has taken an action or imposed a sanction against a network provider, MCNA shall review the provider's performance related to this RFP and take any action or impose any sanction, including disenrollment from the network.

Disclosure of Information on Ownership and Control [§3.15.24]

MCNA will disclose all required information regarding ownership and control, business transactions, and persons convicted of a crime to the DHCFP in accordance with the terms of this RFP. We understand that failure to disclose information required under 42 CFR §455.104 will result in any federal funds withheld or recouped from, or any penalties assessed upon, the DHCFP will be withheld and recouped from or assessed upon MCNA . We acknowledge that disclosures shall include all elements required by section 3.15 of this RFP. MCNA will submit disclosures at all of the following times:

- Upon submitting our proposal in accordance with the State's procurement process. (Please see **Attachment 3-10** for MCNA's disclosure statement.)
- Upon executing the contract with the State.

- Upon renewal or extension of this contract.
- Within five (5) calendar days after any change in ownership of MCNA.

MCNA will collect and validate information related to ownership and business transactions from our providers and subcontractors. We also collect and validate information regarding providers and subcontractors convicted of crimes in order to comply with 42 CFR §455.106.

All MCNA Dental Provider Agreements and subcontracts require information related to ownership and business transactions to be furnished to MCNA. Providers and subcontractors are also required to submit full and complete information about:

- The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and
- Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

Prior to entering into or renewing a Dental Provider Agreement, or upon written request by MCNA, the provider must disclose the identity of any person who:

- Has ownership or control interest in the provider, or is an agent or managing employee of the provider/subcontractors; and
- Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

MCNA will promptly notify the DHCFP Provider Enrollment Unit of any action it takes on the provider's application for participation in the program.

Monitoring for Over and Under-Utilization of Services [§3.15.9]

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

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

- CDT codes
- Provider authorization requests
- Frequency of claim submissions and resubmissions
- Non-compliant required documentation submission
- Non-compliant patient dental chart record keeping
- Member treatment histories

Our state-of-the-art management information system, DentalTrac™, captures and processes prior authorizations and utilization data. The claims module of DentalTrac™ collects this data and reports are generated routinely to determine utilization patterns that fall outside of the norm.

Addressing Provider Overutilization and Underutilization

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

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

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

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

Addressing Member Underutilization

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

MCNA constantly reviews our data and broader available datasets such as state specific CMS 416 data to identify barriers to care and unique populations that tend to be less compliant with the periodicity schedule. The teen population as a whole typically underutilizes routine preventive care. To increase teen adherence to the EPSDT periodicity schedule, MCNA has developed targeted interventions to educate teens on the importance of good oral health. In our Texas market, MCNA provides telephonic outreach to all teens that have not had their annual dental checkup. During these calls MCNA attempts to schedule appointments for the teen members and assists with arranging transportation services if needed. MCNA's Member Advocate and Outreach Specialists (MAOS) also attend health fairs and community outreach events targeted to teens. In 2015, MCNA participated in over 620 outreach events.

Reporting Requirements [§3.15.21]

MCNA will submit all information to the DHCFP according to the format in ***Attachment T, Forms and Reporting Guide***.

All occurrences of the following events will be promptly reported to the DHCFP in accordance with the requirements of this RFP:

- Every allegation, complaint, or referral pertaining to overpayments whether caused by fraud, waste, abuse or billing errors;
- Every credible allegation of fraud (CAF);
- Every MCNA employee who is employed by, has ownership interest in, or contracts with, any provider enrolled with Nevada Medicaid; and
- Every provider that is de-credentialed or denied credentialing for whatever reason.

MCNA will provide the DHCFP monthly reporting that details all active reviews and their status, as well as all completed reviews with a detailed reason, and the amount of each overpayment recovered from MCNA's fraud and abuse investigation or audits. Each review must be reported even if the determination was that no overpayment occurred. MCNA agrees to provide encounter data upon request to the MFCU at no cost.

Reporting [§3.16]

MCNA agrees to provide all required reports including the following categories:

- **Summary Utilization Reporting [§3.16.2]**
  - MCNA will provide DHCFP reports using quality measures identified in the DHCFP Quality Assessment and Performance Improvement Strategy (QAPIS). All reports will be submitted in a timely manner.
- **Dispute Resolution Reporting [§3.16.3]**
  - MCNA will provide reports documenting the number and types of provider disputes, member grievances, appeals and fair hearing requests received by MCNA and its subcontractors.
  - These reports are to include, but not be limited to, the total number of member grievances, the total number of notices provided to members, the total number of member and provider appeal requests, and provider disputes filed, including reporting of all subcontractor's member grievances, notices, appeals and provider disputes. The reports must identify the member grievance or appeal issue or provider dispute received; and verify the resolution timeframe for member grievances and appeals and provider disputes.
  - Comprehensive member grievance, notice, and appeal information, fair hearing requests, and provider dispute information, including, but not limited to, specific outcomes, shall be retained for each occurrence for review by the DHCFP.
- **Quality Assurance Reporting [§3.16.4]**
  - Performance Improvement Projects (PIPs) will be performed by MCNA pursuant to guidelines established jointly by MCNA, the DHCFP, and the State's External Quality Review Organization (EQRO), as well as those identified in this RFP. In addition, MCNA must provide outcome-based clinical reports and Management Reports as may be requested by the DHCFP or its EQRO. Should MCNA fail to provide such reports in a timely manner, the DHCFP will require MCNA to submit a Plan of Correction (POC) to

address contractual requirements regarding timely reporting submissions, areas of concern, or areas of noncompliance noted by the DHCFP or its EQRO.

- **Member Satisfaction Reporting [§3.16.5]**
  - MCNA shall collect and submit to DHCFP a member satisfaction survey prior to the third quarter of each contract year. The DHCFP may request a specific sample, and/or survey tool. Survey results must be disclosed to the State. Upon request by the State or a member, MCNA will disclose the results to members.
- **Financial Reporting [§3.16.6]**
  - MCNA shall meet the financial reporting requirements set forth in the Forms and Reporting Guide, including any revisions or additions to the document.
- **Sales and Transaction Reporting [§3.16.7]**
  - MCNA shall report transactions between MCNA and parties in interest that are provided to the State or other agencies to members upon reasonable request.
- **Other Reporting [§3.16.8]**
  - MCNA shall be required to comply with additional reporting requirements upon the request of the DHCFP. Additional reporting requirements may be imposed on MCNA if DHCFP identifies any area of concern with regard to a particular aspect of MCNA's performance under this contract. Such reporting would provide the DHCFP with the information necessary to better assess MCNA's performance.

MCNA agrees that unless clearly labeled as "confidential" or "trade secret," information or documents received from MCNA may be open to public disclosure and copying. The State will have the duty to disclose, unless a particular record is made confidential by law or a common law balancing of interests. This includes compensation arrangements, profit levels, audits and findings, and pertinent litigation data. MCNA agrees to indemnify and defend the State for honoring any designation of "confidential" or "trade secret" on documents submitted to the State. The failure to label any document that is released by the State shall constitute a complete waiver of any and all claims for damages caused by any release of the records. If a public records request for a labeled document is received by the State, the State will notify MCNA of the request and delay access to the material until seven (7) business days after notification to MCNA. Within that time delay, it will be the duty of MCNA to act in protection of its labeled record. Failure to act shall constitute a complete waiver by MCNA.

As part of our commitment to adhering to all DHCFP requirements referenced in this RFP, we acknowledge that we will meet and exceed all encounter data provision and submission requirements. MCNA understands that encounter data for amounts expended for providers excluded by Medicare, Medicaid, or CHIP, may not be submitted except for emergency services pursuant to 42 CFR §431.55(h) and 42 CFR §438.808. All encounters must be submitted for proper and accurate reporting. MCNA agrees to ensure submission within 90 calendar days of receipt of encounter.

Information Systems and Technical Requirements [§3.17]

[redacted]

[redacted]

[redacted] We are prepared to work closely with the DHCFP, its fiscal agent, and its MMIS to establish interfaces in accordance to the requirements in the National EDI Transaction Set Implementation Guides and in the following areas, but not limited to these areas:

- Health Plan – Encounter Data
- Health Plan – Network Data File
- Health Plan – Client Update File
- MMIS – Encounter Data Error File (HIPAA X12 837 and NCPDP)
- MMIS – Encounter Data Informational Errors File
- MMIS – Health Plan Error File
- MMIS – Third Party Liability Update File
- MMIS – Client Demographic Data
- MMIS – Daily Health Plan Recipient File
- MMIS – Health Plan Recipient File
- MMIS – Network Data Exception File
- MMIS – Network Primary Dental Provider (PDP) Updates
- MMIS – Client PDP Changes
- MMIS – Client Enrollment Updates
- MMIS – Health Plan Notification

MCNA maintains a corporate culture of exceeding the expectations of our clients and state partners. In support of this, we follow strict processes to certify the accuracy and completeness of all reporting activities. Regulatory compliance is integral to our processes, which guarantee that contractual obligations are met on time, all the time. We will comply with all reporting requirements included in the RFP along with the requirements specified in the section 1903(r)(1)(F) of the Social Security Act (42 U.S.C. 1396b(r)(1)(F)). MCNA will work closely with DHCFP to define the specific format and data elements required for each report prior to Readiness Review in order to meet all stated objectives before the program's operational start date. We understand that we are responsible for any expense incurred in the modification or creation of interfaces that may be required by CMS, including changes necessitated by HIPAA regulations.

Encounter Data Reporting [§3.17.3]

MCNA's exemplary and extensive experience in processing claims and encounter data is a direct reflection of the dedication of our staff, the quality controls we have developed and implemented, and a robust and scalable MIS that supports these important tasks. In addition to the encounter and claim record handling process described in section 3.13.4 and as part of our commitment to adhering to all DHCFP requirements referenced in this RFP, we acknowledge that we will meet and exceed all encounter data provision and submission requirements including, but not limited to:

- MCNA will ensure all contractual encounter data report files in prescribed data fields are available to DHCFP's encounter data processing agent in our SFTP server on a monthly basis.
- MCNA will ensure encounters successfully pass encounter edits with a minimum of 95% of the data successfully passing all encounter edits within the first six (6) months of submission, and with 97% or as required by federal regulation, whichever is more stringent, passing all thereafter.
- MCNA will ensure that all encounter data is complete and accurate to establish capitation rates, and will certify its completeness, accuracy, and truthfulness.

HIPAA-Compliant Transactions [§3.17.4]

DentalTrac™ is currently certified to exchange HIPAA ASC X12N 5010 standard file formats as well as proprietary file layout specifications as required by DHCFP. We support the full set of HIPAA 5010 transaction files as well as the ICD-10 code sets. All file exchanges are completed through a multitude of secure protocols including, but not limited to, secure File Transfer Protocol (FTP/SFTP) over secure connections such as a Virtual Private Network (VPN).

[redacted]

Supported File Format Standards	
HIPAA ASC X12 270/271	Hea th Care E g b ty Benef t Inqu ry and Response
HIPAA ASC X12 276/277	Hea th Care C a m Status Request and Response
HIPAA ASC X12 277CA	Hea th Care C a ms Acknow edgement
HIPAA ASC X12 277U	Hea th Care C a ms Status Response
HIPAA ASC X12 278	Hea th Care Serv ces - Request for Rev ew and Response; Hea th Care Serv ces Not f cat on and Acknow edgment
HIPAA ASC X12 820	Payro Deducted and Other Group Prem um Payment for Insurance Products
HIPAA ASC X12 834	Benef t Enro ment and Ma ntenance
HIPAA ASC X12 835	Hea th Care C a m Payment/Adv ce
HIPAA ASC X12 837D	Hea th Care C a m: Profess ona , Inst tut ona , and Denta , nc ud ng coord nat on of benef ts (COB) and subrogat on c a ms
HIPAA ASC X12 997	Funct ona Acknow edgement
HIPAA ASC X12 999	Funct ona Acknow edgement
NSF	Nat ona Standard Format
HL7	Hea th Leve Seven
XML	Extens b e Markup Language
UDF	User Def ned F e

We use a combination of thorough safeguards, policies, monitoring tools, and automated business processes to ensure systematic, ongoing, and auditable adherence to HIPAA regulations, mandates, rules and standards per HIPAA Security (45 CFR §164), HIPAA Privacy (45 CFR §160 and §164), and HIPAA Transaction & Code Set (TCS) (45 CFR §164).

MCNA understands that all electronic transactions must be accepted and transmitted in HIPAA-compliant formats. We will comply with the requirements of the National EDI Transaction Set Implementation Guide and the HIPAA-compliance technical specifications for each transaction found in the EDI Companion Guides referenced in this RFP.

Meeting NPI Transaction Requirements [§3.17.5 - §3.17.6]

MCNA Insurance Company
❖ **NPI:** 1952711780 ❖ **Taxonomy Code:** 302R00000X

MCNA is pleased to provide the DHCFP with our NPI and Taxonomy Code as required with submission of this response. We are certified by the National Committee for Quality Assurance (NCQA) in credentialing and re-credentialing. This certification underscores our continuous commitment to operating under the highest quality standards in our industry and to ensuring the best service possible for our members, providers, and clients. Our Credentialing Committee reviews every application received from providers seeking to participate in our network to ensure that MCNA enrolls qualified providers who meet all requisite criteria, including those required to have a National Provider Identifier (NPI). MCNA will contract with a sufficient number of dental providers and ensure they are registered with the DHCFP to meet the access and encounter requirements of this RFP.

The business process engine and rules management system that power our claims adjudication engine and encounter processing systems contain edits and process definitions that will allow us to enforce the presence of valid NPI and taxonomy codes in all claims submitted by providers. Paper claims are converted to electronic ASC X12N 837D files utilizing advanced Optical Character Recognition (OCR) technologies with over 99.5% accuracy. This ensures that all applicable edits, business rules, and validations we implement on electronic claims files are applied to all paper claims as well. Accurate claims data submitted by providers is critical for the proper administration of program benefits and prompt provider reimbursement, and will ultimately be used to report to DHCFP as encounter data.

DHCFP Responsibilities [§3.18]

We are committed to supporting the goals and objectives of DHCFP. MCNA acknowledges and understands that DHCFP will be responsible for: External Quality Review, Due Process, DHCFP On-Site Audits, Actuarial Services, Encounter Data Processing, Website Access, and Operation Oversight.

[redacted] e will fully cooperate with the State's external quality review organization (EQRO), and provide access and support for all audit and review activities. **We take pride in being a partner to the states we serve.**

Our Texas Experience

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

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

Dr. Meister led the effort and redrafted the criteria to be used by HHSC and all dental contractors to ensure that only medically necessary orthodontia services are eligible for coverage. These guidelines have resulted in significant savings for the Texas Medicaid and CHIP programs and changed the practice patterns of orthodontic providers across the state, **saving the Texas program over $100 million annually and reducing utilization by 72%**.

[redacted]

Cost Containment and/or Cost Avoidance Initiatives [§3.19]

Cost Containment and Avoidance

MCNA strives to ensure that Medicaid is the payor of last resort. Our policies and procedures ensure cost containment and cost avoidance through system-based edits and data analytics. These initiatives are designed to positively impact health outcomes and result in cost savings to the State. We understand that cost containment and avoidance initiatives must be provided to the DHCFP for review and approval prior to implementation.

MCNA will also demonstrate its ability to operate an effective claims processing system that minimizes payment errors and, through the effective use of system edits and audits, prevents loss of public funds to fraud, abuse, and/or waste.

Reliable, Accurate, and Knowledge Driven Claims Processing System

Understanding claims processing and adjudication requires an extensive understanding of program benefits, proper standards of care, provider practice patterns, and member needs and behaviors. In 2015, MCNA processed approximately 18 million dental claims (97.5% electronically) with an accuracy level above 99.9%. We also processed over 98% of clean claims within 20 business days of receipt. **MCNA is committed to providing Nevada with the same levels of efficiency and accuracy.**

MCNA's record of successful and prompt implementations has been flawless throughout our transitions for Medicaid and CHIP programs in Texas, Louisiana, Florida, and Iowa. Our project implementation team coordinates with all critical MCNA business units to ensure that project-specific key resources are aligned and in place for a successful implementation. Our project implementation team will apply our methodologies using our structured approach to success.

The expertise and knowledge cultivated throughout our organization ensures that MCNA operates in a cohesive manner without the "silo" effect you find in other organizations. Our claims management system, an essential component of our fully-integrated, proprietary, and enterprise-wide management information system (MIS), DentalTrac™, and our experienced staff ensure accurate, prompt payment of claims while maintaining a high degree of provider satisfaction.

MCNA's claims management system and processes are supported by well-documented policies and procedures designed specifically to address the needs of our state clients including all state and federal requirements. **In 2014, MCNA received full claims processing accreditation from URAC.** This ensures that our highly trained claims management team is able to operate efficiently and reliably against the strictest national guidelines and benchmarks without compromising quality or performance metrics.

The DentalTrac™ Claims module is designed specifically to operate public sector programs such as the Nevada Medicaid Program. DentalTrac™ enables us to deliver exceptional service levels across all of our claims capability **core competencies and integrated components** (CCIC), including:

- Administrative and financial adjudication accuracy
- Clean claims payment turnaround
- Cost avoidance and third party recovery
- Systematic detection of fraud, waste, and abuse
- Accurate, timely, and complete encounter submissions

MCNA's claims management system within DentalTrac™ is specially designed to be easily configured and re-configured to accommodate new or changing requirements, whether they arise from legal or regulatory change, or from the changing practices of our business partners. A business process-oriented methodology decouples low-level coding from process design, yielding a building-block approach to system configuration that maximizes flexibility, rapid development, and correctness.

While our system has been designed to make change easy, any such change is subject to stringent software quality assurance and change management processes. Through our modern, rules-based MIS, we rapidly create new and adapted products and business processes to meet evolving business needs. Our claims management information system capabilities are in production today managing all of our lines of business, including dental managed care programs in Florida, Louisiana, Texas, and Iowa where we have met or exceeded the performance requirements specified in this RFP.

Verification of Services Billed

MCNA has a process in place to verify whether members received services billed by providers in accordance with 42 CFR §455.20 (Beneficiary Verification Procedures). SIU selects a random sample of members to survey each month. The verification process is conducted by sending members a copy of their Explanation of Benefits (EOB) or by member phone interviews. MCNA will report all member verification activities to:

- MCNA's Fraud, Waste and Abuse Committee on a quarterly basis; and
- To DHCFP in the frequency required by the Agency.

When warranted, MCNA sends additional verification of services letters to members and conducts member phone interviews in connection with targeted provider investigations, provider profiling activities, and other program integrity undertakings. The following situations may warrant attempting to contact a member by phone to ascertain whether the billed services were rendered:

- Excessive visits or services
- A questionable service
- A recurring billing pattern

SIU will request dental records for discrepancies identified during the verification process. Those records will be evaluated and if the billed services are not listed in the record, a full investigation will be opened and funds will be recouped.

Liquidated Damages and Sanctions [§3.20]

MCNA will comply with all terms and conditions stipulated in the current Contract, the RFP, and all attachments, including the Forms and Reporting Guide. We will file accurate, timely and complete reports to DHCFP. MCNA agrees that if we fail to meet the contract requirements, liquidated damages or intermediate sanctions may be assessed. In addition to liquidated damages and intermediate sanctions, MCNA will be responsible for any fines or sanctions imposed upon the DHCFP by regulatory agencies as a result of our non-compliance.

DHCFP may refuse to enter into a contract and may suspend or terminate an existing contract if MCNA fails to provide required reports, or disclose ultimate ownership or control information and related party transactions as required by DHCFP policy.

Company Background/History [§9.4.2, §4.1.9 - §4.1.10]

Qualified Dental Benefits Administration

MCNA's response to this RFP is based on over 20 years of experience underwriting and administering dental benefits. We are currently contracted to serve **nearly 3,500,000 children and adults** in Texas, Louisiana, Florida, and Iowa. Additionally, MCNA was recently awarded the sole contract to provide dental managed care services to all of the enrollees of Idaho's Medicaid and CHIP programs on a full-risk basis with a go-live date of February 1, 2017, making MCNA **the largest underwriter of direct, full-risk Medicaid and CHIP dental managed care contracts with state agencies in the United States**.

We have gained a deep understanding of how to support children, adolescents, and adults, including individuals with disabilities or special health care needs who require comprehensive dental care. MCNA will provide choice to our members, and their families who support them, by ensuring a robust network of primary care dentists, paraprofessionals, and dental specialists. Our model focuses on the delivery of dental services in a manner that is easy to navigate, fully integrated, and tailor-made for Nevada.

We assist our members by incorporating evidence-based practices, engaging providers and stakeholders to solicit feedback, and continuously gathering and analyzing data to support our quality improvement initiatives. MCNA is dedicated to improving the oral health of our members.

MCNA is poised to offer innovative integrated care programs and services that will maximize the long-term viability, success, and value of the Nevada Medicaid and CHIP dental program. Our community-based model pairs local expertise and relationships with national resources and best practices. These solutions are the product of our years of experience in establishing commercial and state-sponsored dental programs. We successfully execute complex benefit programs for Medicaid and CHIP participants. There are multiple components to a seamless implementation and successful operation. Here is a summary of key focus areas:

1. **Development and adherence to a detailed implementation plan.**
   Our plan will include our task list, staff responsibilities, timelines, and processes that we will use to ensure services begin on the contract effective date. If awarded a contract, we are committed to implement the program in the time frames described in the plan. **MCNA has successfully passed every readiness review and met every operational start date for the programs we have launched in Texas, Florida, Louisiana, Iowa, and Kentucky.**

2. **Creation of a robust provider network.**
   As a company founded by dentists, MCNA focuses on provider inclusion. We have a strong track record of developing broad-based provider networks that are tailored to the needs of the communities we serve. In preparation for submission of this RFP response, MCNA has spent considerable time with the provider community and stakeholders in Nevada, including the Nevada Dental Association, key legislators, and the Advisory Committee on the State Program for Oral Health (AC4OH). We have familiarized ourselves extensively with the challenges of participation in the Medicaid and CHIP program and have taken into account an abundance of provider feedback. [redacted]

[redacted]

We have **over 20 years of experience increasing provider satisfaction** by removing the obstacles that prevent providers from treating Medicaid patients in an **efficient and cost-effective manner**. MCNA will introduce a robust technological platform and customer service approach to ensure that providers' concerns about timeliness of authorizations, responsiveness, and other obstacles to participation are resolved.

We are already in the process of building this network in Nevada. **MCNA reimburses providers on a fee-for-service basis.** We process claims in a timely manner and make payments on a twice weekly basis via EFT or paper check based on the preference of the provider.

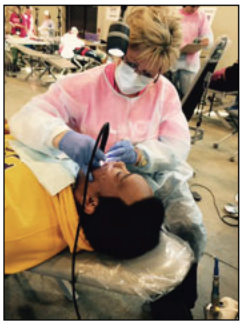
3. **Enhance provider support and service.**
MCNA not only contracts with providers, we partner with them to serve the needs of our members. Our comprehensive Provider Manual sets forth the policies and procedures that providers need to serve our Nevada members. In addition to the Provider Manual, MCNA utilizes provider bulletins, fax blasts, email, our YouTube channel, social media, and our provider newsletter, "Dental Details," to ensure that Nevada's dental community is kept abreast of program requirements and industry trends.

MCNA provides a dedicated Provider Hotline team skilled in assisting dentists and their office staff with any needs that may arise. We will employ Nevada based Provider Relations Representatives who will travel throughout the state providing education, training, and resolution of issues through face-to-face meetings with providers. MCNA's free online Provider Portal enables providers to submit prior authorization requests and claims, verify eligibility, manage patient rosters, schedule appointments, and serves as an additional method of communication between the provider and MCNA.

4. **Improve oral health outcomes of our members.**
We drive improvements in quality and oral health outcomes in many ways. MCNA implements meaningful Performance Improvement Projects (PIPs) to achieve our primary goal of increasing the utilization of preventive care services and improving the oral health outcomes and whole-person care of our members. We utilize a variety of industry standard metrics to continually measure the number of members who see the dentist and receive exams, sealants, fluoride, and prophylaxis

services. Our main goal for children is to drive adherence to the periodicity schedule. MCNA utilizes multiple channels to outreach to members who are in need of care, including outbound calls through our dedicated Care Connections Team. MCNA Member Advocate Outreach Specialists will be deployed across Nevada to engage members in their communities through participation in health fairs and community events.

5. **Provide dental services in a highly coordinated manner.**
We are pleased that Nevada has chosen to keep the dental program separate and carved-out from medical plan services. This enables the dental insurer to be responsive to the needs and expectations of DHCFP rather than the health plan they would serve as a subcontractor. This separation ultimately allows us to better integrate dental services into our members' care and assure that our approach is tailored to meet the needs of individuals with special health care needs, disabilities, language barriers, or other challenges. We leverage specialized clinicians, clinical practices, and guidelines that address the unique physical, behavioral health, and social support needs of each of our members. This level of care coordination cannot be replicated in a situation where the dental plan is a subordinate to the medical plan and does not have the independence needed to address issues in care delivery.



MCNA believes in holistic care. In full recognition of the nexus between oral health and physical health, we developed a comprehensive case management program for members with special health care needs, pregnant women, individuals with chronic conditions, and members in need of targeted care coordination, focused on maintaining the connection between each member's health plan case manager, medical providers, and our team of skilled professionals. Our Case Management team outreaches to physicians and other providers who serve our members to ensure coordination of care. This high-touch approach is particularly useful in assisting members with cranio-facial anomalies that often require surgery and medical care in addition to complex dental services.

6. **Decrease healthcare costs through the reduction of unnecessary, inappropriate, and duplicative services.**
MCNA ensures our members receive the right care, in the right setting, at the right time. Our utilization management program uses evidence-based guidelines to ensure services are medically necessary and provided in the amount, duration, and scope required for each patient. All clinical decisions, both approvals and denials, are made by licensed dentists. Our sophisticated, proprietary management information system, DentalTrac™, includes edits to identify duplicative services and ensure that benefit plan requirements are followed.

7. **Identify and eliminate waste, fraud, and abuse.**
Fraud, waste, and abuse represents an unnecessary and avoidable cost to state Medicaid programs. We provide high-quality care while continually monitoring data analytics to identify potential waste, fraud, and abuse. The DentalTrac™ system is designed to proactively screen claims through a complex hierarchy of rules to avoid overpayments. Additionally, MCNA's Special Investigations Unit utilizes claims data to generate provider profiling reports to identify

potential overutilization. Licensed dentists then conduct dental record reviews to validate any findings. Our effective fraud, waste, and abuse detection and prevention methods, and advanced claim edits, have enabled us to save our clients over $15 million dollars in 2015 and create a deterrent to this behavior.

8. **Enhance member satisfaction and health literacy through the use of leading edge technology.**
Members can reach MCNA via a dedicated toll-free Member Hotline from 5:00 am to 5:00 pm PST, Monday through Friday. Our call center is staffed with individuals who speak a variety of languages including English, Spanish, Tagalog, Haitian Creole, French Creole, Vietnamese, and French. Any languages not spoken by our call center staff are easily available through the use of our translation vendor, LanguageLine.

MCNA's website enables members to access resources 24 hours a day, 7 days a week. Members are able to send secure email messages to MCNA, download oral health and hygiene information, download their member handbook, and select a dentist. We also have an interactive section of the website called "MCNA Kids Zone," which contains games and videos geared toward improving the oral health literacy of our members. MCNA utilizes social media tools such as Facebook, Twitter, and YouTube to connect with members and educate them about the importance of proper oral hygiene and the need to seek timely dental care.

An Experienced Partner

MCNA has provided dental managed care services for individuals and state programs for over 20 years. We have a proven track record of successfully implementing programs in other states that are similar in scope to the Nevada Medicaid and CHIP dental program. The following lists our **active full-risk, statewide contracts with state Medicaid and CHIP agencies:**

- **Florida** – MCNA has been providing dental managed care services for Florida's CHIP Program, **since January 1, 2005**. We currently serve approximately 70,000 enrollees. In early 2016, MCNA was awarded its fourth consecutive contract by the Florida Healthy Kids Corporation (FHKC) to continue managing this program. MCNA scored first in FHKC's most recent dental HEDIS results.

- **Texas** – MCNA has been providing dental managed care services for the Texas Health and Human Services Commission Medicaid and CHIP dental programs **since March 1, 2012**. We currently serve approximately 1,500,000 enrollees.

- **Louisiana** – MCNA was **ranked first** in the Louisiana procurement to serve as the **sole dental benefits program manager** with a go-live date of July 1, 2014. We currently serve the State's

1,450,000 Medicaid and CHIP members under a contract with the Louisiana Department of Health.

- **Iowa** – MCNA was awarded a contract by the Iowa Medicaid Enterprise to serve adult members enrolled in the State's Dental Wellness Plan. We commenced operations on August 1, 2016, and have a current enrollment of approximately 13,000 members.

- **Idaho** – MCNA was recently **ranked first** in the Idaho Smiles procurement and awarded the **sole contract** by the Idaho Department of Health and Welfare to provide dental managed care services to the State's 280,000 Medicaid and CHIP enrollees with a go-live date of February 1, 2017.

We maintain a commercial plan in the State of Florida, and we serve Medicaid, ACA, and long term care members under various subcontracts with Medicaid managed care plans in Florida, Indiana, and West Virginia.

From 2009 to 2014, MCNA served Florida's Medicaid enrollees under a direct contract with the Florida Agency for Health Care Administration. The program began as a demonstration project in Miami-Dade County and was so successful that the Legislature expanded it statewide in 2012. Throughout the life of the contract, MCNA's enrollment for both programs peaked at over 600,000 members.

Additionally, MCNA was subcontracted by Centene Corporation's Florida affiliate, Sunshine Health, to provide all dental benefits administration services for its Florida Medicaid and Long Term Care members from 2008 through 2014. Over the life of the contract, enrollment increased from 100,000 to approximately 400,000 members.

If awarded the opportunity to serve the Medicaid and CHIP members and dental providers of Nevada, we will work hard every day to ensure that MCNA's services, cost controls, and quality standards will exceed the expectations of the DHCFP.

Section 4: Redacted Technical Proposal [§9.5]

MCNA's response to this RFP contains proprietary trade secret information in the form of a compilation, pattern, method, technique, or process that derives economic value to the company and is not generally known or readily ascertainable by the general public. Accordingly, MCNA asserts Trade Secret protection over the content of this RFP response as detailed below, pursuant to NRS 333.333 and other applicable Nevada laws. If released, this information would give a competitive advantage to our business competitors and serve no public purpose.

Response		
Section	**Page(s)**	**Rationale**
2	19	Conf dent a , non-pub c nformat on that shou d be protected from compet tors.
2	23	Conf dent a , non-pub c nformat on that shou d be protected from compet tors.
2	25-27	Conf dent a , non-pub c f nanc a nformat on. Compet t ve d fferent ator.
2	32-36	Conf dent a , non-pub c methodo ogy for comp et ng project de verab es. Compet t ve d fferent ator.
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3	63	Conf dent a , non-pub c methodo ogy for comp et ng project de verab es. Compet t ve d fferent ator.
3	65	Conf dent a , non-pub c f nanc a nformat on. Compet t ve d fferent ator.
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3	76	Conf dent a , non-pub c methodo ogy for comp et ng project de verab es. Compet t ve d fferent ator.
3	83	Conf dent a , non-pub c nformat on that shou d be protected from compet tors.
3	87-88	Conf dent a , non-pub c methodo ogy for comp et ng project de verab es. Compet t ve d fferent ator.
3	100	Conf dent a , non-pub c, propr etary nformat on techno ogy or software, and methodo ogy for comp et ng project de verab es. Compet t ve d fferent ator.
3	103-105	Conf dent a , non-pub c methodo ogy for comp et ng project de verab es. Compet t ve d fferent ator.
3	107-108	Conf dent a , non-pub c methodo ogy for comp et ng project de verab es. Compet t ve d fferent ator.
3	110-112	Conf dent a , non-pub c methodo ogy for comp et ng project de verab es. Compet t ve d fferent ator.
3	116	Conf dent a , non-pub c methodo ogy for comp et ng project de verab es. Compet t ve d fferent ator.
3	120	Conf dent a , non-pub c methodo ogy for comp et ng project de verab es. Compet t ve d fferent ator.
3	124	Conf dent a , non-pub c, propr etary nformat on techno ogy or software, and methodo ogy for comp et ng project de verab es. Compet t ve d fferent ator.
3	130-132	Conf dent a , non-pub c methodo ogy for comp et ng project de verab es. Compet t ve d fferent ator.
3	133	Conf dent a , non-pub c, propr etary nformat on techno ogy or software, and methodo ogy for comp et ng project de verab es. Compet t ve d fferent ator.

3	136-138	Conf dent a , non-pub c methodo ogy for comp et ng project de verab es. Compet t ve d fferent ator.
3	139	Conf dent a , non-pub c, propr etary nformat on techno ogy or software, and methodo ogy for comp et ng project de verab es. Compet t ve d fferent ator.
3	140-141	Conf dent a , non-pub c methodo ogy for comp et ng project de verab es. Compet t ve d fferent ator.
3	143-146	Conf dent a , non-pub c methodo ogy for comp et ng project de verab es. Compet t ve d fferent ator.
3	149-150	Conf dent a , non-pub c methodo ogy for comp et ng project de verab es. Compet t ve d fferent ator.
3	154	Conf dent a , non-pub c, propr etary nformat on techno ogy or software, and methodo ogy for comp et ng project de verab es. Compet t ve d fferent ator.
3	156	Conf dent a , non-pub c nformat on that shou d be protected from compet tors.
3	158-159	Conf dent a , non-pub c methodo ogy for comp et ng project de verab es. Compet t ve d fferent ator.
3	163	Conf dent a , non-pub c, propr etary nformat on techno ogy or software, and methodo ogy for comp et ng project de verab es. Compet t ve d fferent ator.
3	164	Conf dent a , non-pub c nformat on that shou d be protected from compet tors.
3	167	Conf dent a , non-pub c nformat on that shou d be protected from compet tors.
3	168	Conf dent a , non-pub c f nanc a nformat on. Compet t ve d fferent ator.
3	172-176	Conf dent a , non-pub c, propr etary nformat on techno ogy or software, and methodo ogy for comp et ng project de verab es. Compet t ve d fferent ator.
3	179	Conf dent a , non-pub c f nanc a nformat on. Compet t ve d fferent ator.
3	184	Conf dent a , non-pub c, propr etary nformat on techno ogy or software, and methodo ogy for comp et ng project de verab es. Compet t ve d fferent ator.
3	186-188	Conf dent a , non-pub c, propr etary nformat on techno ogy or software, and methodo ogy for comp et ng project de verab es. Compet t ve d fferent ator.
3	191	Conf dent a , non-pub c methodo ogy for comp et ng project de verab es. Compet t ve d fferent ator.
3	193-195	Conf dent a , non-pub c, propr etary nformat on techno ogy or software, and methodo ogy for comp et ng project de verab es. Compet t ve d fferent ator.
3	196	Conf dent a , non-pub c methodo ogy for comp et ng project de verab es. Compet t ve d fferent ator.
3	197-205	Conf dent a , non-pub c, propr etary nformat on techno ogy or software, and methodo ogy for comp et ng project de verab es. Compet t ve d fferent ator.
3	208-211	Conf dent a , non-pub c, propr etary nformat on techno ogy or software, and methodo ogy for comp et ng project de verab es. Compet t ve d fferent ator.
3	212-214	Conf dent a , non-pub c methodo ogy for comp et ng project de verab es. Compet t ve d fferent ator.
3	217-220	Conf dent a , non-pub c methodo ogy for comp et ng project de verab es. Compet t ve d fferent ator.
3	227	Conf dent a , non-pub c methodo ogy for comp et ng project de verab es. Compet t ve d fferent ator.
3	231-234	Conf dent a , non-pub c methodo ogy for comp et ng project de verab es. Compet t ve d fferent ator.
3	241-252	Conf dent a , non-pub c, propr etary nformat on techno ogy or software, and methodo ogy for comp et ng project de verab es. Compet t ve d fferent ator.
3	253	Conf dent a , non-pub c nformat on that shou d be protected from compet tors.
3	255-256	Conf dent a , non-pub c methodo ogy for comp et ng project de verab es. Compet t ve d fferent ator.

3	258-259	Conf dent a , non-pub c methodo ogy for comp et ng project de verab es. Compet t ve d fferent ator.
3	262	Conf dent a , non-pub c nformat on that shou d be protected from compet tors.
6	269-270	Conf dent a , non-pub c f nanc a nformat on. Compet t ve d fferent ator

Attachments

ID	Description	Rationale
2-1	Resumes	Th s nformat on s conf dent a and non-pub c, and shou d be protected from compet tors. MCNA's emp oyees are our greatest asset.
3-1	SOC 2 Report	Conf dent a and non-pub c ndependent aud tor's report on MCNA's Denta Trac™ secur ty, ava ab ty, and conf dent a ty contro s. Compet t ve d fferent ator.
3-2	Outreach Program	Conf dent a and non-pub c nterna outreach program that shou d be protected from compet tors.
3-5	Bond Letter	Conf dent a and non-pub c f nanc a nformat on that shou d be protected from compet tors.
3-6	MCNA Hea th Care Ho d ngs F nanc a s	Conf dent a and non-pub c f nanc a nformat on that shou d be protected from compet tors.
3-7	MCNA Insurance Company F nanc a s	Conf dent a and non-pub c f nanc a nformat on that shou d be protected from compet tors.
3-8	Aud ted F nanc a Statements	Conf dent a and non-pub c f nanc a nformat on that shou d be protected from compet tors.
3-9	Imp ementat on P an	Methodo ogy for comp et ng project de verab es. Conf dent a and non-pub c mp ementat on p an. Compet t ve d fferent ator.
3-10	D sc osure Form	Conf dent a and non-pub c ownersh p nformat on that shou d be protected from compet tors.

Section 5: Cost/Financial [§9.6, §5, §6]

Cost Schedule [§9.6.1]

MCNA is pleased to submit our initial administrative rate components as required by the RFP. We utilized the existing rates provided in Attachment P to generate a model based on an 86% MLR (medical loss ratio) with a 3.5% premium tax component.

MCNA works hard to control our administrative costs while maintaining best-in-class standards of performance, including using only licensed dentists for clinical reviews, providing comprehensive customer service with extended call center hours, dedicated member and provider hotlines, member advocates, multifaceted outreach, advanced provider and member portals, a dedicated Nevada website, and comprehensive reporting capabilities. All components are supported by our proprietary, state-of-the-art management information system, DentalTrac™.

Our team looks forward to working with the State and its actuaries to further refine our model to serve the needs of DHCFP.

Category	Rate	Provider Tax	Direct Non-Medical	Indirect Non-Medical	Medical Administration	Risk and Contingency	Profit	Total
TANF								
Males & Females; < 1yr old	**$0.63**	$0.022	$0.014	$0.009	$0.017	$0.013	$0.013	**$0.088**
Males & Females; 1 - 2 yrs old	**$6.37**	$0.223	$0.147	$0.096	$0.172	$0.127	$0.127	**$0.892**
Males & Females; 3 - 14 yrs old	**$18.25**	$0.639	$0.420	$0.274	$0.493	$0.365	$0.365	**$2.555**
Females; 15 - 18 yrs old	**$16.80**	$0.588	$0.386	$0.252	$0.454	$0.336	$0.336	**$2.352**
Males; 15 - 18 yrs old	**$14.69**	$0.514	$0.338	$0.220	$0.397	$0.294	$0.294	**$2.057**
Females; 19 - 34 yrs old	**$4.40**	$0.154	$0.101	$0.066	$0.119	$0.088	$0.088	**$0.616**
Males; 19 - 34 yrs old	**$3.82**	$0.134	$0.088	$0.057	$0.103	$0.076	$0.076	**$0.535**

Females; 35+ yrs old	**$5.81**	$0.203	$0.134	$0.087	$0.157	$0.116	$0.116	**$0.813**
Males; 35+ yrs old	**$5.93**	$0.208	$0.136	$0.089	$0.160	$0.119	$0.119	**$0.830**
Check-Up								
Males & Females; < 1yr old	**$0.54**	$0.019	$0.012	$0.008	$0.015	$0.011	$0.011	**$0.076**
Males & Females; 1 - 2 yrs old	**$9.91**	$0.347	$0.228	$0.149	$0.268	$0.198	$0.198	**$1.387**
Males & Females; 3 - 14 yrs old	**$23.79**	$0.833	$0.547	$0.357	$0.642	$0.476	$0.476	**$3.331**
Females; 15 - 18 yrs old	**$21.59**	$0.756	$0.497	$0.324	$0.583	$0.432	$0.432	**$3.023**
Males; 15 - 18 yrs old	**$19.50**	$0.683	$0.449	$0.293	$0.527	$0.390	$0.390	**$2.730**
Expansion								
Females; 19 - 34 yrs old	**$6.16**	$0.216	$0.142	$0.092	$0.166	$0.123	$0.123	**$0.862**
Males; 19 - 34 yrs old	**$4.94**	$0.173	$0.114	$0.074	$0.133	$0.099	$0.099	**$0.692**
Females; 35+ yrs old	**$10.68**	$0.374	$0.246	$0.160	$0.288	$0.214	$0.214	**$1.495**
Males; 35+ yrs old	**$10.71**	$0.375	$0.246	$0.161	$0.289	$0.214	$0.214	**$1.499**

** The figures above are rounded to three decimal places. The intent is to represent an 86% MLR 3.5% Provider Tax and the remaining 10.5% for Direct Non-Medical Indirect Non-Medical Medical Administration Risk and Contingency and Profit.*

Cost Proposal Certification of Compliance with Terms and Conditions of RFP [§9.6.2]

Attachment I

ATTACHMENT I – COST PROPOSAL CERTIFICATION OF COMPLIANCE WITH TERMS AND CONDITIONS OF RFP

I have read, understand and agree to comply with ***all*** the terms and conditions specified in this Request for Proposal.

YES ✓ I agree to comply with the terms and conditions specified in this RFP.

NO _____ I do not agree to comply with the terms and conditions specified in this RFP.

If the exception and/or assumption require a change in the terms in any section of the RFP, the contract, or any incorporated documents, vendors ***must*** provide the specific language that is being proposed in the tables below. If vendors do not specify in detail any exceptions and/or assumptions at time of proposal submission, the State will not consider any additional exceptions and/or assumptions during negotiations. ***Note: Only cost exceptions and/or assumptions should be identified on this attachment. Do not restate the technical exceptions and/or assumptions on this attachment.***

MCNA Insurance Company
Company Name

Signature

Carlos Lacasa
Print Name

November 30, 2016
Date

Vendors MUST use the following format. Attach additional sheets if necessary.

EXCEPTION SUMMARY FORM

EXCEPTION #	RFP SECTION NUMBER	RFP PAGE NUMBER	EXCEPTION (Complete detail regarding exceptions must be identified)
None			

ASSUMPTION SUMMARY FORM

ASSUMPTION #	RFP SECTION NUMBER	RFP PAGE NUMBER	ASSUMPTION (Complete detail regarding assumptions must be identified)
None			

This document must be submitted in Tab III of vendor's cost proposal.
This form MUST NOT be included in the technical proposal.
(Per the instructions in Section 9 of this RFP, this document is being submitted in Section 5 of our response.)

Dental Benefits Administrator *RFP 3290* *Page 185 of 196*

Section 6: Confidential Financial [§9.7]

MCNA Insurance Company, the offeror, is a Texas Accident and Health Insurance Company licensed in 13 states. MCNA is a wholly owned subsidiary of MCNA Health Care Holdings, LLC, and operates state-wide Medicaid and CHIP dental programs serving approximately 1.5 million children in Texas, 1.45 million children and adults in Louisiana, and approximately 13,000 adult members in Iowa. Commencing on February 1, 2017, MCNA will provide dental managed care services to over 280,000 Idaho Medicaid and CHIP enrollees on a full-risk basis. We are pleased to provide the State of Nevada with assurances of our financial solvency and strong fiscal track record. We submit herewith evidence of our financial capacity.

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

Efficient and effective contract performance has put us on a solid financial footing and positioned us to provide our high-caliber services to the DHCFP for the Medicaid and CHIP dental program. This is the business space where we excel. MCNA forges strong relationships with our members and providers, and works diligently with regulatory agencies. As noted, we are in **full compliance** with our financial solvency requirements as determined by the Texas Department of Insurance and we will continue to comply with any additional requirements that are mandated under Nevada law as a result of being awarded a contract by the DHCFP. Most importantly, we will deliver quality access to dental care for DHCFP enrollees.

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

- Current year interim, unaudited, GAAP-basis 2016 quarterly **balance sheets and profit and loss statements** for MCNA Health Care Holdings, LLC, and subsidiaries **(Attachment 3-6).**
- Current year interim, unaudited, GAAP-basis 2016 quarterly **balance sheets and profit and loss statements** for MCNA Insurance Company **(Attachment 3-7)**.

- Audited, GAAP-basis 2015 and 2014 financial statements with footnote disclosures for both the Offeror and the Consolidated Parent Company **(Attachment 3-8)**.

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

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

MCNA (including MCNA's parent organization, affiliates, and subsidiaries) is not a publicly traded (stock-exchange-listed) corporation. Accordingly, there have been no publicly available financial filings with the United States Securities and Exchange Commission (SEC). There have been no SEC investigations involving MCNA or any of its affiliated companies, nor are there any other current or pending investigations, civil or criminal, involving MCNA.

[redacted]

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

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

- MCNA has been in business for approximately 25 years.
- Office locations are currently in Fort Lauderdale, Florida, San Antonio, Texas, and New Orleans, Louisiana.
- Staff exceeding 550 individuals.

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

Dun and Bradstreet Number [§9.7.1.1, §4.1.11.1]

MCNA Insurance Company's Dun and Bradstreet Number is **080277476**.

Federal Tax Identification Number [§9.7.1.2, §4.1.11.2]

MCNA Insurance Company's Federal Tax Identification Number is **52-2459969**.

Profit and Loss, and Balance Statements [§9.7.1.3, §4.1.11.3]

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

- Current year interim, unaudited, GAAP-basis 2016 quarterly **balance sheets and profit and loss statements** for MCNA Health Care Holdings, LLC, and subsidiaries **(Attachment 3-6).**
- Current year interim, unaudited, GAAP-basis 2016 quarterly **balance sheets and profit and loss statements** for MCNA Insurance Company **(Attachment 3-7)**.