Managed Care Program Annual Report (MCPAR) for Nevada: Nevada Dental Benefits Administrator (DBA) Program

Due date	Last edited	Edited by	Status
06/29/2023	06/29/2023	Jaimie Evins	Submitted

	Indicator	Response
	Exclusion of CHIP from MCPAR Enrollees in separate CHIP programs funded under Title XXI should not be reported in the MCPAR. Please check this box if the state is unable to remove information about Separate CHIP enrollees from its reporting on this program.	Selected

Section A: Program Information

Point of Contact

Number	Indicator	Response
A1	State name Auto-populated from your account profile.	Nevada
A2a	Contact name First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	Maria Curiel

A2b	Contact email address Enter email address. Department or program-wide email addresses ok.	m.curiel@dhcfp.nv.gov
A3a	Submitter name CMS receives this data upon submission of this MCPAR report.	MARIA CURIEL
A3b	Submitter email address CMS receives this data upon submission of this MCPAR report.	m.curiel@dhcfp.nv.gov
A4	Date of report submission CMS receives this date upon submission of this MCPAR report.	06/29/2023

Reporting Period

Number	Indicator	Response
A5a	Reporting period start date Auto-populated from report dashboard.	01/01/2022
A5b	Reporting period end date Auto-populated from report dashboard.	12/31/2022
A6	Program name Auto-populated from report dashboard.	Nevada Dental Benefits Administrator (DBA) Program

Add plans (A.7)

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

	Indicator	Response

	Plan name	LIBERTY Dental Plan

Add BSS entities (A.8)

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

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

	Indicator	Response
	BSS entity name	Nevada Medicaid District Office

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	Statewide Medicaid enrollment Enter the total number of individuals enrolled in Medicaid as of the first day of the last month of the reporting year. Include all FFS and managed care enrollees, and count each person only once, regardless of the delivery system(s) in which they are enrolled.	210,433
BI.2	Statewide Medicaid managed care enrollment Enter the total, unduplicated number of individuals enrolled in any type of Medicaid	673,148

	managed care as of the first day of the last month of the reporting year. Include enrollees in all programs, and count each person only once, even if they are enrolled in more than one managed care program or more than one managed care plan.	

Topic III. Encounter Data Report

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

Topic X: Program Integrity

Number	Indicator	Response
BX.1	Payment risks between the state and plans Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific	In accordance with 42 CFR 438.608(a), the State performs a managed care Annual Compliance Plan Review of DBA reports 315 and 316, which are submitted by the DBAs on July 1st. The State provides educational guidance to managed care plans through the quarterly PI network calls and the annual trainings. Guidance is also given to the plans during the year on an ad hoc basis. In CY2022, the State started an managed care-initiated provider payment suspension process. As noted

	payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities.	in B.X.5, the State is developing a report to verify identified and recovered overpayments listed on monthly DBA reports 309, 311, 312, 313.
BX.2	Contract standard for overpayments Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	State requires the return of overpayments
BX.3	Location of contract provision stating overpayment standard Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	7.10.7.2, 7.10.8.2
BX.4	Description of overpayment contract standard Briefly describe the overpayment standard (for example, details on whether the state allows plans to retain overpayments, requires the plans to return overpayments, or administers a hybrid system) selected in indicator B.X.2.	7.10.7.2. The Contractor will recover and retain all Overpayments resulting from a Contractor-initiated fraud, waste and abuse review, investigation or audit. 7.10.8.2. Any improper payments identified by the State that have not been reported by the Contractor as being under review may be recovered and retained by the State.
BX.5	State overpayment reporting monitoring Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment pieces (whether annually or promptly). This indicator is	Managed care plans submit monthly overpayment reports 312 and 313 using a template developed by the state to facilitate monitoring overpayments. DBA reports 309 and 311 also list identified overpayments. However, these four reports are insufficient in verifying compliance as detailed in the CMS 2021 MCO Audit. Currently SUR is developing a report using the State's Data Warehouse that can take the identified overpayment claims from the manged care plans and verify that the adjustments have been made in MMIS. The State will reach out to the

	asking the state how it monitors that reporting.	individual plans for clarification and/or data issues as they arise.
BX.6	Changes in beneficiary circumstances Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).	MIT is used to correctly reflect current eligibility status posted by Welfare. Any updates to a clients eligibility due to incarceration, DOD, switch of plans, that are not picked up by the system will be reported and sent to MIT to be updated manually to bring the clients eligibility in line.
BX.7a	Changes in provider circumstances: Monitoring plans Does the state monitor whether plans report provider “for cause” terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	Yes
BX.7b	Changes in provider circumstances: Metrics Does the state use a metric or indicator to assess plan reporting performance? Select one.	Yes
BX.7c	Changes in provider circumstances: Describe metric Describe the metric or indicator that the state uses.	The MCOs submit 302 termination reports on a weekly basis per contract section 7.6.2.5.12.1; this reporting encompasses all reasons to include "for cause," terminations. Plan performance is evaluated based upon timely submission of this report.
BX.8a	Federal database checks: Excluded person or entities During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and	No

	determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	
BX.9a	Website posting of 5 percent or more ownership control Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to §455.104 and required by 42 CFR 438.602(g)(3).	No
BX.10	Periodic audits If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, what is the link(s) to the audit results? Refer to 42 CFR 438.602(e).	This information is reported by the plans as described per B.X.8b, but is not posted within the public-facing website.

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C1I.1	Program contract Enter the title of the contract between the state and plans participating in the managed care program.	DBA RFP 3425

N/A	Enter the date of the contract between the state and plans participating in the managed care program.	01/01/2018
C1I.2	Contract URL Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://purchasing.nv.gov/Public/
C1I.3	Program type What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Prepaid Ambulatory Health Plan (PAHP)
C1I.4a	Special program benefits Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	Dental
C1I.4b	Variation in special benefits What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable.	Managed care in Nevada is limited to Urban and Washoe Counties. Through EPSDT benefits, individuals under the age of 21, receive comprehensive dental care. Individuals age 21 and over who qualify for full Medicaid receive emergency services. Nevada Medicaid offers expanded services in addition to the adult dental services for Medicaid-Eligible Pregnant Women.
C1I.5	Program enrollment	673,148

	Enter the total number of individuals enrolled in the managed care program as of the first day of the last month of the reporting year.	
C1I.6	Changes to enrollment or benefits Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year.	There were no changes to the population or benefits for the reporting year.

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	Uses of encounter data For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Rate setting Quality/performance measurement Monitoring and reporting Contract oversight
C1III.2	Criteria/measures to evaluate MCP performance What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO,	Timeliness of initial data submissions Timeliness of data corrections Provider ID field complete Overall data accuracy (as determined through data validation)

	PIHP, or PAHP. 42 CFR 438.242(d).	
C1III.3	Encounter data performance criteria contract language Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	Contract 3425 DBA Section 3.17.3
C1III.4	Financial penalties contract language Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.	Contract 3425 DBA Section 3.20
C1III.5	Incentives for encounter data quality Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with "N/A" if the plan does not use incentives to award encounter data quality.	N/A
C1III.6	Barriers to collecting/validating encounter data Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting period.	No barriers

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
C1IV.1	State's definition of "critical incident," as used for reporting purposes in its MLTSS program If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for "critical incidents" within the managed care program? Respond with "N/A" if the managed care program does not cover LTSS.	N/A
C1IV.2	State definition of "timely" resolution for standard appeals Provide the state's definition of timely resolution for standard appeals in the managed care program. Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.	3.12.5.2 Standard resolution of Appeals: The Vendor is allowed no more than thirty (30) calendar days from the date of receipt of appeal.
C1IV.3	State definition of "timely" resolution for expedited appeals Provide the state's definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal.	3.12.5.3 Expedited resolution of appeals: The vendor must resolve each expedited appeal and provide notice, as expeditiously as the recipient's health condition requires, not to exceed three (3) business days after the vendor receives the expedited appeal request. The vendor is required to establish and maintain an expedited review process for appeals when the vendor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the recipient's life or health or ability to attain, maintain, or regain maximum function. The vendor must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an appeal. If the vendor denies a request for an expedited resolution of an appeal, it must transfer the appeal to the standard timeframe of no longer than thirty (30) calendar days from the day the vendor

		receives the appeal (with a possible fourteen (14) calendar day extension) for resolution of appeal and give the recipient prompt oral notice of the denial and follow up within two (2) calendar days with a written notice.
C1IV.4	State definition of "timely" resolution for grievances Provide the state's definition of timely resolution for grievances in the managed care program. Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.	3.12.5.1 Standard disposition of grievances: The vendor is allowed no more than ninety (90) calendar days from the date of receipt of the grievance.

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Number	Indicator	Response
C1V.1	Gaps/challenges in network adequacy What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting standards.	Nevada Medicaid Managed Care is currently only in urban Clark and Washoe counties. Although housing communities have grown in some of the zip codes in these counties, dental offices and services have not expanded to the same areas. Additionally, there are a few provider types, including Pediatric Specialists, Endodontists and Prosthodontists, that are just not prevalent in Nevada. Those that are in Nevada are hesitant to enroll with Nevada Medicaid due to the low reimbursement rates.
C1V.2	State response to gaps in network adequacy How does the state work with MCPs to address gaps in network adequacy?	DHCFP encourages the DBA to use value-based purchasing models and provider incentives, when possible, improve members' access to critical services. Additionally, the Nevada Legislature recently passed a rate increase for Dental Providers.

Access Measures

Describe the measures the state uses to monitor availability, accessibility, and network adequacy. Report at the program level.

Revisions to the Medicaid managed care regulations in 2016 and 2020 built on existing requirements that managed care plans maintain provider networks sufficient to ensure adequate access to covered services by: (1) requiring states to develop quantitative network adequacy standards for at least eight specified provider types if covered under the contract, and to make these standards available online; (2) strengthening network adequacy monitoring requirements; and (3) addressing the needs of people with long-term care service needs (42 CFR 438.66; 42 CFR 438.68).

42 CFR 438.66(e) specifies that the MCPAR must provide information on and an assessment of the availability and accessibility of covered services within the MCO, PHIP, or PAHP contracts, including network adequacy standards for each managed care program.

Access measure total count: 1

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

1 / 1

C2.V.2 Measure standard
30 minutes 20 miles

C2.V.3 Standard type
Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
General Dentist	Urban	Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping, Network Adequacy

C2.V.8 Frequency of oversight methods
Quarterly

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
C1IX.1	BSS website List the website(s) and/or email address that beneficiaries use to seek assistance from the BSS	dhcfp@dhcfp.nv.gov https://dhcfp.nv.gov/Members/BLU/MCOMain/

	through electronic means. Separate entries with commas.	
C1IX.2	BSS auxiliary aids and services How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2))? CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.	A statewide phone queue for Medicaid beneficiaries operates 8am-5pm Monday-Friday, all business days. Phone numbers to this queue are posted on our contacts page at DHCFP.NV.GOV. Phone numbers to the statewide queue are: 702-668-4200, 775-687-1900, 775-753-1191, 775-684-3651, 866-569-1746, and include a TTY option. This phone line in conducted in Spanish and English. Addresses to all DHCFP offices are listed on the DHCFP website under this contact page for Carson City, Elko, Las Vegas, and Reno. There is a 'contact us' form and our dhcfp@dhcfp.nv.gov email address that accepts all Medicaid inquiries. The contact page also includes social media links to Facebook and Twitter.
C1IX.3	BSS LTSS program data How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4).	DHCFP District Office staff assists NV Medicaid beneficiaries to resolve any access to care issues, concerns or complaints. Health Care Coordinators are available to assist beneficiaries in resolving issues and record any complaints and intervene with providers if necessary. Any reports of Fraud, Waste, or Abuse is reported to our Surveillance Utilization and Review (SUR) unit to investigate. Managed Care Quality Assurance (MCQU) unit is notified of MCO concerns. Any appeals for service reduction, termination, or denial are referred to the Hearings Unit.
C1IX.4	State evaluation of BSS entity performance What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	Random call monitoring and front desk interaction monitoring takes place by the District Office supervisors and managers to ensure appropriate information is provided to beneficiaries. Regular training of all customer service and District Office staff on Medicaid processes is also in place. All District Office Care Coordination cases are reviewed by a unit supervisor for quality at the conclusion of the case. Access to care and complaints by provider type and area are tracked on a monthly basis. Customer Service queue reports

		are run weekly to review hold times and adjustments are made to staffing if needed.

Topic X: Program Integrity

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

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	Plan enrollment What is the total number of individuals enrolled in each plan as of the first day of the last month of the reporting year?	LIBERTY Dental Plan 673,144
D1I.2	Plan share of Medicaid What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid enrollment (B.I.1)	LIBERTY Dental Plan 75%
D1I.3	Plan share of any Medicaid managed care	LIBERTY Dental Plan

	What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid managed care enrollment (B.I.2)	100%

Topic II. Financial Performance

Number	Indicator	Response
D1II.1a	Medical Loss Ratio (MLR)	LIBERTY Dental Plan
	What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR.	86%
D1II.1b	Level of aggregation	LIBERTY Dental Plan
	What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.	Program-specific statewide
D1II.2	Population specific MLR description	LIBERTY Dental Plan

	Does the state require plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS or Group VIII expansion enrollees? If so, describe the populations here. Enter "N/A" if not applicable. See glossary for the regulatory definition of MLR.	N/A
D1II.3	MLR reporting period discrepancies Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	LIBERTY Dental Plan Yes
N/A	Enter the start date.	LIBERTY Dental Plan 01/01/2021
N/A	Enter the end date.	LIBERTY Dental Plan 12/31/2021

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	Definition of timely encounter data submissions Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	LIBERTY Dental Plan 180 days
D1III.2	Share of encounter data submissions that met state's timely submission requirements What percent of the plan's encounter data file submissions (submitted during the reporting	LIBERTY Dental Plan 99.94%

	period) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract period when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting period.	
D1III.3	Share of encounter data submissions that were HIPAA compliant What percent of the plan's encounter data submissions (submitted during the reporting period) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting period.	LIBERTY Dental Plan 99.94%

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Number	Indicator	Response
D1IV.1	Appeals resolved (at the plan level) Enter the total number of appeals resolved as of the first day of the last month of the reporting year. An appeal is "resolved" at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or	LIBERTY Dental Plan 154

	adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary's representative) chooses to file a request for a State Fair Hearing or External Medical Review.	
D1IV.2	Active appeals Enter the total number of appeals still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.	LIBERTY Dental Plan 6
D1IV.3	Appeals filed on behalf of LTSS users Enter the total number of appeals filed during the reporting year by or on behalf of LTSS users. Enter "N/A" if not applicable. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the appeal was filed).	LIBERTY Dental Plan N/A
D1IV.4	Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed an appeal For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter "N/A". Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting	LIBERTY Dental Plan N/A

	year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter “N/A”. The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.	
D1IV.5a	Standard appeals for which timely resolution was provided Enter the total number of standard appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	LIBERTY Dental Plan 124
D1IV.5b	Expedited appeals for which timely resolution was provided Enter the total number of expedited appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	LIBERTY Dental Plan 17

D1IV.6a	Resolved appeals related to denial of authorization or limited authorization of a service Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service. (Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	LIBERTY Dental Plan 97
D1IV.6b	Resolved appeals related to reduction, suspension, or termination of a previously authorized service Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.	LIBERTY Dental Plan 0
D1IV.6c	Resolved appeals related to payment denial Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.	LIBERTY Dental Plan 48
D1IV.6d	Resolved appeals related to service timeliness Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).	LIBERTY Dental Plan 0

D1IV.6e	Resolved appeals related to lack of timely plan response to an appeal or grievance Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	LIBERTY Dental Plan 0
D1IV.6f	Resolved appeals related to plan denial of an enrollee's right to request out-of-network care Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO).	LIBERTY Dental Plan 0
D1IV.6g	Resolved appeals related to denial of an enrollee's request to dispute financial liability Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.	LIBERTY Dental Plan 0

Appeals by Service

Number of appeals resolved during the reporting period related to various services. Note: A single appeal may be related to multiple service types and may therefore be counted in multiple categories.

Number	Indicator	Response

D1IV.7a	Resolved appeals related to general inpatient services Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter "N/A".	LIBERTY Dental Plan N/A
D1IV.7b	Resolved appeals related to general outpatient services Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter "N/A".	LIBERTY Dental Plan N/A
D1IV.7c	Resolved appeals related to inpatient behavioral health services Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter "N/A".	LIBERTY Dental Plan N/A
D1IV.7d	Resolved appeals related to outpatient behavioral health	LIBERTY Dental Plan

	services Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter "N/A".	N/A
D1IV.7e	Resolved appeals related to covered outpatient prescription drugs Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter "N/A".	LIBERTY Dental Plan N/A
D1IV.7f	Resolved appeals related to skilled nursing facility (SNF) services Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter "N/A".	LIBERTY Dental Plan N/A
D1IV.7g	Resolved appeals related to long-term services and supports (LTSS)	LIBERTY Dental Plan N/A

	Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter "N/A".	
D1IV.7h	Resolved appeals related to dental services Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter "N/A".	LIBERTY Dental Plan 154
D1IV.7i	Resolved appeals related to non-emergency medical transportation (NEMT) Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter "N/A".	LIBERTY Dental Plan N/A
D1IV.7j	Resolved appeals related to other service types Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-i, enter "N/A".	LIBERTY Dental Plan N/A

State Fair Hearings

Number	Indicator	Response

D1IV.8a	State Fair Hearing requests Enter the total number of requests for a State Fair Hearing filed during the reporting year by plan that issued the adverse benefit determination.	LIBERTY Dental Plan 1
D1IV.8b	State Fair Hearings resulting in a favorable decision for the enrollee Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	LIBERTY Dental Plan 0
D1IV.8c	State Fair Hearings resulting in an adverse decision for the enrollee Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.	LIBERTY Dental Plan 0
D1IV.8d	State Fair Hearings retracted prior to reaching a decision Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) prior to reaching a decision.	LIBERTY Dental Plan 0
D1IV.9a	External Medical Reviews resulting in a favorable decision for the enrollee If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A".	LIBERTY Dental Plan N/A

	External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	
D1IV.9b	External Medical Reviews resulting in an adverse decision for the enrollee If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	LIBERTY Dental Plan N/A

Grievances Overview

Number	Indicator	Response
D1IV.10	Grievances resolved Enter the total number of grievances resolved by the plan during the reporting year. A grievance is "resolved" when it has reached completion and been closed by the plan.	LIBERTY Dental Plan 188
D1IV.11	Active grievances Enter the total number of grievances still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.	LIBERTY Dental Plan 9
D1IV.12	Grievances filed on behalf of LTSS users Enter the total number of grievances filed during the	LIBERTY Dental Plan N/A

	reporting year by or on behalf of LTSS users. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.	
D1IV.13	Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user. If the managed care plan does not cover LTSS, the state should enter "N/A" in this field. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting	LIBERTY Dental Plan N/A

	year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.	
D1IV.14	Number of grievances for which timely resolution was provided Enter the number of grievances for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	LIBERTY Dental Plan 188

Grievances by Service

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

Number	Indicator	Response
D1IV.15a	Resolved grievances related to general inpatient services Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does	LIBERTY Dental Plan N/A

	not cover this type of service, enter "N/A".	
D1IV.15b	Resolved grievances related to general outpatient services Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Do not include grievances related to outpatient behavioral health services — those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	LIBERTY Dental Plan N/A
D1IV.15c	Resolved grievances related to inpatient behavioral health services Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	LIBERTY Dental Plan N/A
D1IV.15d	Resolved grievances related to outpatient behavioral health services Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	LIBERTY Dental Plan N/A
D1IV.15e	Resolved grievances related to coverage of outpatient prescription drugs Enter the total number of grievances resolved by the plan	LIBERTY Dental Plan N/A

	during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".	
D1IV.15f	Resolved grievances related to skilled nursing facility (SNF) services Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter "N/A".	LIBERTY Dental Plan N/A
D1IV.15g	Resolved grievances related to long-term services and supports (LTSS) Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".	LIBERTY Dental Plan N/A
D1IV.15h	Resolved grievances related to dental services Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter "N/A".	LIBERTY Dental Plan 188
D1IV.15i	Resolved grievances related to non-emergency medical transportation (NEMT) Enter the total number of grievances resolved by the plan	LIBERTY Dental Plan N/A

	during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter "N/A".	
D1IV.15j	Resolved grievances related to other service types Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-i, enter "N/A".	LIBERTY Dental Plan N/A

Grievances by Reason

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

Number	Indicator	Response
D1IV.16a	Resolved grievances related to plan or provider customer service Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	LIBERTY Dental Plan 0
D1IV.16b	Resolved grievances related to plan or provider care management/case management Enter the total number of grievances resolved by the plan	LIBERTY Dental Plan 0

	during the reporting year that were related to plan or provider care management/case management. Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	
D1IV.16c	Resolved grievances related to access to care/services from plan or provider Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	LIBERTY Dental Plan 20
D1IV.16d	Resolved grievances related to quality of care Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care. Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.	LIBERTY Dental Plan 109
D1IV.16e	Resolved grievances related to plan communications Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications.	LIBERTY Dental Plan 0

	Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.	
D1IV.16f	Resolved grievances related to payment or billing issues Enter the total number of grievances resolved during the reporting period that were filed for a reason related to payment or billing issues.	LIBERTY Dental Plan 0
D1IV.16g	Resolved grievances related to suspected fraud Enter the total number of grievances resolved during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	LIBERTY Dental Plan 0
D1IV.16h	Resolved grievances related to abuse, neglect or exploitation	LIBERTY Dental Plan 0

	Enter the total number of grievances resolved during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	
D1IV.16i	Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals) Enter the total number of grievances resolved during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	LIBERTY Dental Plan 0
D1IV.16j	Resolved grievances related to plan denial of expedited appeal Enter the total number of grievances resolved during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.	LIBERTY Dental Plan 0
D1IV.16k	Resolved grievances filed for other reasons Enter the total number of grievances resolved during the	LIBERTY Dental Plan 59

reporting period that were filed for a reason other than the reasons listed above.

Topic VII: Quality & Performance Measures

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

Quality & performance measure total count: 8

Complete

D2.VII.1 Measure Name: Annual Dental Visit (ADV)-2-3 Years

1 / 8

D2.VII.2 Measure Domain
Dental and oral health services

D2.VII.3 National Quality Forum (NQF) number
1388

D2.VII.4 Measure Reporting and D2.VII.5 Programs
Program-specific rate

D2.VII.6 Measure Set
HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range
No, 01/01/2021 - 12/31/2021

D2.VII.8 Measure Description
NA

Measure results

LIBERTY Dental Plan
33.19%

Complete

D2.VII.1 Measure Name: Annual Dental Visit (ADV)-4-6 Years

2 / 8

D2.VII.2 Measure Domain
Dental and oral health services

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

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

1388

Program-specific rate

D2.VII.6 Measure Set
HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range
No, 01/01/2021 - 12/31/2021

D2.VII.8 Measure Description
NA

Measure results

LIBERTY Dental Plan
49.91%

Complete

D2.VII.1 Measure Name: Annual Dental Visit (ADV)-7-10 Years

D2.VII.2 Measure Domain
Dental and oral health services

D2.VII.3 National Quality Forum (NQF) number
1388

D2.VII.4 Measure Reporting and D2.VII.5 Programs
Program-specific rate

D2.VII.6 Measure Set
HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range
No, 01/01/2021 - 12/31/2021

D2.VII.8 Measure Description
NA

Measure results

LIBERTY Dental Plan
55.85%

Complete

D2.VII.1 Measure Name: Annual Dental Visit (ADV)-11-14 Years

D2.VII.2 Measure Domain
Dental and oral health services

D2.VII.3 National Quality Forum (NQF) number
1388

D2.VII.4 Measure Reporting and D2.VII.5 Programs
Program-specific rate

D2.VII.6 Measure Set
HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range
No, 01/01/2021 - 12/31/2021

D2.VII.8 Measure Description
NA

Measure results

LIBERTY Dental Plan
51.60%

Complete

D2.VII.1 Measure Name: Annual Dental Visit (ADV)-15-18 Years

D2.VII.2 Measure Domain
Dental and oral health services

D2.VII.3 National Quality Forum (NQF) number
1388

D2.VII.4 Measure Reporting and D2.VII.5 Programs
Program-specific rate

D2.VII.6 Measure Set
HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range
No, 01/01/2021 - 12/31/2021

D2.VII.8 Measure Description
NA

Measure results

LIBERTY Dental Plan
43.90%

D2.VII.1 Measure Name: Annual Dental Visit (ADV)-19-20 Years

Complete

D2.VII.2 Measure Domain
Dental and oral health services

D2.VII.3 National Quality Forum (NQF) number
1388

D2.VII.4 Measure Reporting and D2.VII.5 Programs
Program-specific rate

D2.VII.6 Measure Set
HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range
No, 01/01/2021 - 12/31/2021

D2.VII.8 Measure Description
NA

Measure results

LIBERTY Dental Plan
28.25%

Complete

D2.VII.1 Measure Name: Annual Dental Visit (ADV)-Total 2-20 Years

D2.VII.2 Measure Domain
Dental and oral health services

D2.VII.3 National Quality Forum (NQF) number
1388

D2.VII.4 Measure Reporting and D2.VII.5 Programs
Program-specific rate

D2.VII.6 Measure Set
HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range
No, 01/01/2021 - 12/31/2021

D2.VII.8 Measure Description
NA

Measure results

LIBERTY Dental Plan
46.86%

Complete

D2.VII.1 Measure Name: Percentage of Eligibles Who Received Preventive Dental Services (PDENT) 8 / 8

D2.VII.2 Measure Domain
Dental and oral health services

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

D2.VII.4 Measure Reporting and D2.VII.5 Programs
Program-specific rate

D2.VII.6 Measure Set
Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range
No, 01/01/2021 - 12/31/2021

D2.VII.8 Measure Description
NA

Measure results

LIBERTY Dental Plan
37.81%

Topic VIII. Sanctions

Describe sanctions that the state has issued for each plan. Report all known actions across the following domains: sanctions, administrative penalties, corrective action plans, other. Include any pending or unresolved actions.

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

Sanction total count: 1

Complete

D3.VIII.1 Intervention type: Corrective action plan 1 / 1

D3.VIII.2 Intervention topic
Compliance Review

D3.VIII.3 Plan name
LIBERTY Dental Plan

D3.VIII.4 Reason for intervention

During the 2022 Compliance Review, Liberty Dental received a score of Not Met in 5 elements across 2 Standards. Liberty Dental has since successfully remediated all 5 non-compliant elements.

Sanction details

D3.VIII.5 Instances of non-compliance
5

D3.VIII.6 Sanction amount
$0

D3.VIII.7 Date assessed
09/16/2022

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 05/11/2023

D3.VIII.9 Corrective action plan
No

Topic X. Program Integrity

Number	Indicator	Response
D1X.1	Dedicated program integrity staff Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	LIBERTY Dental Plan 14.3
D1X.2	Count of opened program integrity investigations How many program integrity investigations have been opened by the plan in the past year?	LIBERTY Dental Plan 6
D1X.3	Ratio of opened program integrity investigations to enrollees What is the ratio of program integrity investigations opened by the plan in the past year per 1,000 beneficiaries enrolled in the plan on the first day of the	LIBERTY Dental Plan 6:681

	last month of the reporting year?	
D1X.4	Count of resolved program integrity investigations How many program integrity investigations have been resolved by the plan in the past year?	LIBERTY Dental Plan 3
D1X.5	Ratio of resolved program integrity investigations to enrollees What is the ratio of program integrity investigations resolved by the plan in the past year per 1,000 beneficiaries enrolled in the plan at the beginning of the reporting year?	LIBERTY Dental Plan 3:657
D1X.6	Referral path for program integrity referrals to the state What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	LIBERTY Dental Plan Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently
D1X.7	Count of program integrity referrals to the state Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of unduplicated referrals	LIBERTY Dental Plan 6
D1X.8	Ratio of program integrity referral to the state What is the ratio of program integrity referral listed in the previous indicator made to the state in the past year per 1,000 beneficiaries, using the plan's total enrollment as of the first day of the last month of the reporting year (reported in indicator D1.I.1) as the denominator.	LIBERTY Dental Plan 6:681

D1X.9	Plan overpayment reporting to the state Describe the plan's latest annual overpayment recovery report submitted to the state as required under 42 CFR 438.608(d)(3). Include, for example, the following information: The date of the report (rating period or calendar year). The dollar amount of overpayments recovered. The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR reporting under 438.8(f)(2).	LIBERTY Dental Plan .07%
D1X.10	Changes in beneficiary circumstances Select the frequency the plan reports changes in beneficiary circumstances to the state.	LIBERTY Dental Plan Weekly

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

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

Number	Indicator	Response
EIX.1	BSS entity type What type of entity was contracted to perform each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	Nevada Medicaid District Office State Government Entity
EIX.2	BSS entity role	Nevada Medicaid District Office Enrollment Broker/Choice Counseling

What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	Beneficiary Outreach LTSS Complaint Access Point LTSS Grievance/Appeals Education