Fiscal Year 2019–2020 Site Review Report

for

DentaQuest

February 2020

This report was produced by Health Services Advisory Group, Inc., for the Colorado Department of Health Care Policy and Financing.

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Introduction

In accordance with its authority under Colorado Revised Statute 25.5-1-101 et seq. and pursuant to Request for Proposal (RFP) 2019000147, the Department of Health Care Policy and Financing (the Department) executed a new contract with **DentaQuest USA Health Insurance Company** (**DentaQuest**), a prepaid ambulatory health plan (PAHP), effective July 1, 2019. The PAHP is responsible for providing a statewide oral healthcare network and services under Colorado's Child Health Plan *Plus* (CHP+) Oral Health Care Benefits Program. Public Law 111-3, Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, requires that each state's Children's Health Insurance Program (CHIP) apply several provisions of Section 1932 of the Social Security Act in the same manner as the provisions apply under Title XIX of the Act. This requires PAHPs to comply with provisions of the Code of Federal Regulations (CFR), Title 42—federal Medicaid managed care regulations published May 6, 2016. Revisions to federal Medicaid managed care regulations published May 6, 2016, became applicable to CHIP effective July 1, 2018. The CFR requires that states conduct a periodic evaluation of their PAHPs to determine compliance with federal healthcare regulations and managed care contract requirements. The Department of Health Care Policy and Financing (the Department) has elected to complete this requirement for the CHP+ PAHP by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

In order to evaluate the PAHP's compliance with federal managed care regulations and State contract requirements, the Department determined that the review period for fiscal year (FY) 2019–2020 was July 1, 2019 (contract effectiveness date) through December 31, 2019. This report documents results of the FY 2019–2020 site review activities for **DentaQuest**. For each of the standard areas reviewed this year, this section contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 2 describes the background and methodology used for the 2019–2020 compliance monitoring site review. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the denials of authorization of services (denials), grievances, and appeals record reviews. Appendix C lists HSAG, dental plan, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process the dental plan will be required to complete for FY 2019–2020 and the required template for doing so. Appendix E contains a detailed description of HSAG's site review activities consistent with the Centers for Medicare & Medicaid Services (CMS) final protocol.

Summary of Results

Based on conclusions drawn from the review activities, HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. HSAG assigned required actions to any requirement receiving a score of *Partially Met* or *Not Met*. HSAG also identified opportunities for improvement with associated recommendations for some elements, regardless of the score.

Table 1-1 presents the scores for **DentaQuest** for each of the standards. Findings for all requirements are summarized in this section. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* follow in Appendix A—Compliance Monitoring Tool.

Table 1-1—Summary of Scores for the Standards

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
I. Coverage and Authorization of Services	17	16	11	5	0	1	69%
II. Access and Availability	13	13	9	1	3	0	69%
VI. Grievances and Appeals	30	30	4	14	12	0	13%
Totals	**60**	**59**	**24**	**20**	**15**	**1**	**41%**

*The overall score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements from the standards in the compliance monitoring tool.

Table 1-2 presents the scores for **DentaQuest** for the denials, grievances, and appeals record reviews. Details of the findings for the record reviews are in Appendix B—Record Review Tools.

Table 1-2—Summary of Scores for the Record Reviews

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Denials	90	60	39	21	30	65%
Grievances	42	35	24	11	7	69%
Appeals	60	39	6	33	21	15%
Totals	**192**	**134**	**69**	**65**	**58**	**51%**

*The overall score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements from the record review tools.

Standard I—Coverage and Authorization of Services

Summary of Strengths and Findings as Evidence of Compliance

DentaQuest provided HSAG with policies, procedures, and its 2019 Utilization Management Program Description as evidence of compliance with coverage and authorization requirements. Within its policies, **DentaQuest** included guidelines and clinical criteria for dental benefit determination. **DentaQuest** based its criteria on State Medicaid guidelines, best practices, industry guidelines, American Medical Association guidelines, and various specialty association standards. **DentaQuest** further developed a decision model of algorithms based on the American Dental Association's Code of Dental Terminology (CDT) in order to provide additional consistency and equity in the clinical decisions. **DentaQuest**'s Peer Review Committee, a group of licensed dental professionals, reviewed the clinical guideline algorithms and with their recommendation, the algorithms were approved by Clinical Quality Oversight Committee. **DentaQuest** stated in its policies that it does not incentivize its decision makers to make denial decisions or influence decisions that result in underutilization.

DentaQuest made its clinical coverage criteria available to its providers through the Provider Office Reference Manual (ORM). Within policies and procedures, **DentaQuest** indicated that any affected party may be privy to any decision-making criteria applied.

During the on-site interview, **DentaQuest** described processes for the review of prior authorization requests, which aligned with the processes defined in policy and procedure. **DentaQuest** described the process for clinically-based decisions beginning with an authorization request review by the clinical review specialist, who approved requests based on the clinical algorithm. If the request did not align with an approval based on the algorithm, the request was forwarded to a licensed dental consultant who had the authority to deny services based on clinical criteria. **DentaQuest** staff members reported that all clinical denials were made by individuals with appropriate clinical expertise. The process, as defined in the 2019 Utilization Management Program Description, included mechanisms to consult with the requesting provider when appropriate. **DentaQuest** had processes in place to extend decision-making time frames by up to 14 calendar days if additional information is needed to make a determination. **DentaQuest** had a policy for providing written notification to the member in the case that the time frame for determining benefits is extended.

Within its policies, **DentaQuest** outlined time frames for urgent and standard prior authorization decisions, consistent with regulations. **DentaQuest** had policies and procedures to provide a written notice of adverse benefit determination (NABD), referred to by **DentaQuest** as a notice of action, to the member when services were denied in whole or in part.

Summary of Findings Resulting in Opportunities for Improvement

During the on-site interviews, **DentaQuest** staff members struggled to answer questions regarding the authorization process, time frames for processing urgent prior authorization requests, and what constitutes an emergency medical condition. During the interviews, the **DentaQuest** staff members often consulted policies and procedures to respond to questions or were evidently not familiar with Medicaid managed care regulations or the Code of Colorado Regulations (CCRs) pertaining to the CHP+ dental contract. HSAG recommends that **DentaQuest** develop a plan to identify the regulations that pertain to CHP+ managed care (42 CFR Part 438 and 10 CCR 2505-10 8.200) and create training materials for staff members both locally and in other offices that work with Colorado CHP+ members.

HSAG recommends that **DentaQuest** refer to its Notice of Action letter as the NABD to be consistent with CMS definitions at CFR 438.400(b).

Upon review of **DentaQuest**'s 2019 Utilization Management Program Description, HSAG found that **DentaQuest** stated claims from an emergent situation "are reviewed retrospectively for medical necessity." HSAG recommends **DentaQuest** ensure that policies and procedures are revised to ensure the retrospective review is conducted based on the prudent layman standard, as outlined in the federal regulations and as described by **DentaQuest** staff members during the on-site interview as being the actual process in practice.

Summary of Required Actions

Although policies and procedures articulated processes to monitor the provision of services to ensure the services are sufficient to respond to the needs of members, during the on-site review, it was evident that organizational practices were not in place to effectively implement these policies and procedures. HSAG found that many grievances, denials, and appeals were related to an insufficient network of providers and **DentaQuest** staff members stated that Denver-based staff members were not informed of the type or number of grievances or appeals. Communication between the grievance and appeal staff members and the provider network staff members is imperative so the provider network staff members have an understanding of the extent of network issues, allowing them the ability to work with providers and members to solve the members' issues related to the insufficiency of the network. **DentaQuest** must develop a mechanism for interdepartmental communication so member grievances and appeals can be addressed in a way that meets the members' needs and meets the terms of the CHP+ contract.

During the review of denial records, HSAG found that, for one record, **DentaQuest** indicated the denial of service was due to the service being not medically necessary (as described in the letter to the member: the member was not in enough pain), when in fact, it is not a service authorized by **DentaQuest** to provide to members (the use of nitrous oxide in dental procedures) and the reason for the denial should have been listed as "not a covered benefit." **DentaQuest** must ensure that the reasons for denying services in part or in whole are stated accurately to members and providers.

During the on-site record review, although HSAG found that all denial decisions reviewed were made within the required time frames, **DentaQuest**'s Authorization Review policy stated that, "unless

specified differently by the Plan or regulation" standard decisions are made within 14 calendar days. The policy had no Colorado-specific addendum to specify Colorado-specific time frames. Colorado's required time frame for standard pre-service authorization decisions is 10 calendar days following the receipt of the request for service. **DentaQuest** must revise its Authorization Review policy and any other applicable policies and documents to depict Colorado-specific time frames for determinations related to a standard request for service.

In the denial letters sent the members (NABD), HSAG found that **DentaQuest** listed a general CCR citation as criteria used in making the decision to deny the request for services, which was not specific to the denial in the member letter. Within the letter, **DentaQuest** did not explain the citation or the criteria in easy-to-understand language. However, **DentaQuest** did include language informing the member that the criteria used in making the decision is available, if requested. **DentaQuest** must either remove the CCR citation or provide additional language that is easy for the member to understand.

HSAG reviewed **DentaQuest**'s denial letter (NABD) and found that template language describing the appeal and State fair hearing processes included inaccurate time frames. Specifically, the time frame **DentaQuest** would acknowledge an appeal request was stated as five days instead of two working days, the time frame for **DentaQuest** to make an appeal decision was stated as 20 days instead of 10 working days, and it was not clear that the time frame for a member to submit a request for a State fair hearing must start at the appeal decision letter date and not the NABD date. **DentaQuest** must review the template language in its NABD to ensure that the information and timelines provided to members are accurate.

Standard II—Access and Availability

Summary of Strengths and Findings as Evidence of Compliance

Per **DentaQuest** policy, **DentaQuest** made available a range of dental services for its members and monitored its network to evaluate the availability of providers, service locations, and service types. **DentaQuest** used a quarterly CO CHIP Access Analysis report to determine whether target standards were met.

In developing and maintaining the network, **DentaQuest** considered providers with the capacity to serve members who are not proficient in English or those who may have physical or mental disabilities or require special accommodations. Members were able to use the provider directory to establish which providers in their area spoke a foreign language, had accommodations for mobility limitations, and had the capacity to treat members with neurobehavior diagnoses, such as autism. Providers were directed, through the provider agreement, to accept CHP+ members during the same hours of operation offered to members with other insurance.

DentaQuest had a policy and process in place to provide a second opinion for its members at no cost, when indicated. **DentaQuest** also had a process to provide services outside of the network, limited to urgent and emergent care, when needed.

DentaQuest provided an annual cultural competency and diversity training to its providers. **DentaQuest** also used a telephonic language service to assist members who may be proficient in a variety of languages other than English.

Summary of Findings Resulting in Opportunities for Improvement

HSAG had no findings that resulted in opportunities for improvement.

Summary of Required Actions

At the time of the compliance review, **DentaQuest** described credentialing issues that were preventing the credentialing of a sufficient quantity of providers to meet the needs of the members. **DentaQuest** described efforts to forego credentialing efforts temporarily for providers that were previously aligned with Delta Dental's CHP+ line of business in order to expedite their privileges to provide dental care with **DentaQuest**. **DentaQuest** also described efforts to prioritize credentialing providers that were in the greatest demand, such as periodontists and oral surgeons in rural and frontier regions. Despite these efforts, grievances and appeals reviewed on-site indicated that members were not getting needed services despite indication that they were experiencing dental pain. Further, Colorado-based **DentaQuest** staff members stated that they were not apprised of grievances or appeals that had been filed, which indicated a lack of cohesion between the departments or oversight and monitoring of the provision of care to ensure Colorado CHP+ members were receiving covered services. **DentaQuest** must ensure that providers are available in sufficient number, type, and specialty to furnish contracted services.

Although **DentaQuest**'s policies and procedures allowed for use of out-of-network providers, several grievances, denials, and appeals were due to out-of-network providers requesting the service. During the on-site interviews, **DentaQuest** staff members acknowledged difficulty with credentialing providers from the previous Delta Dental network in a timely manner. Many cases reviewed on-site were members that had been previously seen by Delta Dental providers under the CHP+ program. In addition, there was no evidence provided of direction given to the utilization management staff members to allow out-of-network providers to furnish services until such time that the **DentaQuest** provider network is sufficient. **DentaQuest** must develop a mechanism to allow out-of-network providers to furnish services under the CHP+ contract with the Department for as long as it is unable to provide the services.

DentaQuest provided no evidence of having a mechanism to make arrangements with out-of-network providers for claims submissions and payment or to ensure that members are not charged more than if the services are provided by the network. **DentaQuest** must develop a mechanism to coordinate with the out-of-network providers for payment and to ensure that the cost to the member is no greater than it would be if the services were furnished within the network. For example, a single case agreement contract template could be developed to inform out-of-network providers of claims and payment procedures as well as the prohibition of balance billing members.

DentaQuest had a process in place for monitoring compliance with timely access standards for other states; however, **DentaQuest** had not yet begun monitoring its Colorado CHP+ market to ensure providers were compliant with timely access standards. **DentaQuest** must ensure timely access by: establishing mechanisms to ensure compliance with access (e.g., appointment) standards by network providers, monitoring network providers regularly to determine compliance, and taking corrective action if there is failure to comply.

Standard VI—Grievances and Appeals

Summary of Strengths and Findings as Evidence of Compliance

On-site, HSAG found evidence of the intent to have a grievance system in place. HSAG found that **DentaQuest** had staffing resources to process grievances and appeals and had developed policies, procedures, and templates in an effort to provide direction to staff members in how to process grievances and appeals. On-site record reviews demonstrated that **DentaQuest**'s documentation system used to document grievances and appeals had fields to capture the required information.

Summary of Findings Resulting in Opportunities for Improvement

HSAG found that **DentaQuest** Complaints and Grievance Department staff members were unaware of the federal managed care regulations released in May 2016 and were using outdated and inaccurate desktop procedures and protocols. In addition, staff members were implementing outdated rules and, in some cases, rules that did not apply to the case being processed. During the on-site interviews, staff members were not only unable to articulate that they understood the regulations clearly but were also unable to clearly articulate processes being followed by **DentaQuest** staff members when processing grievances and appeals. In two appeal records reviewed, the letter stated that **DentaQuest** would not process the appeal due to untimely filing. In one of these cases, the filing time frame was depicted in the letter as 10 days (the time frame is actually 60 days to file an appeal). In the other case, the letter to the member stated, "you filed untimely, you must have filed within 60 days of the original denial letter." This member had filed the appeal in 44 days following the original denial letter. **DentaQuest** staff members also were unable to articulate understanding of the distinct processes required under the Medicaid fee-for-service program vs. its CHP+ managed care program.

Resolutions of grievances and appeals reviewed on-site were not consistently responsive to the members' needs. Denver-based staff members reported being unaware of grievances or appeals filed and reported no interaction between themselves and the Complaints and Grievance Department based in Milwaukee. Of the 10 appeal records reviewed on-site, five denials were due to the member not having met the waiting period for the service, and two were due to the provider being out of network. In none of these cases did **DentaQuest** Complaints and Grievance Department staff members interact with Denver-based staff members to investigate whether the denial was related to transition issues (the **DentaQuest** contract not being active for the full year, but the member was active with CHP+; or lack of ability to

accomplish contracting in the short period of time) and should have, therefore, been provided. In two cases, the members' parent provided statements of how long the member had been receiving CHP+, which did not appear to be considered when deciding the appeal case. All appeals were processed administratively (including those cases in which the original decision was based on medical necessity, the appeal decision was based on an out-of-network provider making the request, or the waiting period for the service had not been met). Given the effective date of **DentaQuest**'s contract, consideration for these transition issues should be given. In none of the 10 appeal cases reviewed was the original denial decision overturned.

HSAG strongly recommends that **DentaQuest** reevaluate and reprocess each denial and appeal that was received since July 1, 2019, allowing for visits to out-of-network providers until such time the **DentaQuest** Network is sufficient. HSAG also recommends that, when processing or reprocessing appeals or denials related to the waiting period for a particular service, **DentaQuest** develop a mechanism to determine the length of eligibility for the CHP+ program, rather than denying services based on eligibility for **DentaQuest** program participation. HSAG also recommends that **DentaQuest** Complaints and Grievance Department staff members attend basic customer service training.

Summary of Required Actions

Although **DentaQuest**'s policies and procedures regarding the Grievance and Appeal System addressed some of the requirements at 42 CFR 438.400–424, many required provisions were missing, and the policies contained inaccuracies and contradictions within the same policy and between policies. **DentaQuest** staff members struggled to answer questions regarding the process for sending NABDs and the processes for addressing grievances and appeals. Staff members often consulted policies and procedures to respond to questions and were, at times, unable to describe internal processes related to addressing grievances and appeals. Complaints and Grievance Department staff members were unable to clearly articulate an understanding of the difference between a grievance, a member appeal, and a provider reconsideration (based on technical issues, i.e., coding or timeliness of claims). The policies and on-site record reviews also demonstrated organizational confusion regarding time frames for receiving and resolving grievances and appeals. Staff members reported using internal documents and protocols; however, it was clear that these documents were not consistent with the federal managed care regulations or Colorado's regulations for implementing the federal rules.

DentaQuest's Provider ORM included no information about the **DentaQuest** internal appeal process for CHP+ members. In addition, the ORM stated that reconsiderations must be requested within 10 calendar days from the notice of action; however, given the confusion within **DentaQuest**'s policies of the terms "appeal" and "reconsideration," it was unclear whether this refers to the reconsideration of provider payment disputes or member appeals. The member handbook included incomplete and inaccurate information about filing and processing grievances and appeals.

On-site record reviews revealed that incorrect reasons for denying service and upholding the original decision upon appeal were provided to members. Several grievance records contained resolution letters that were unresponsive to the members' needs. No consideration was given to continuity of care for

orthodontia services members had been receiving prior to July 1, 2019. There was no evidence that consideration of **DentaQuest**'s inadequate network allowed authorization of out-of-network providers and there was no evidence of appeals staff members' communication with the Colorado-based provider staff members so that specific providers who had been serving CHP+ members could be contacted for recruitment and contracting.

Of the 10 appeal records reviewed on-site, five denials were due to the member not having met the waiting period for the service, and two were due to the provider being out of network. In none of these cases did **DentaQuest** Complaints and Grievance Department staff members interact with Denver-based staff members to investigate whether the denial was related to transition issues (the **DentaQuest** contract not being active for the full year, but the member was active with CHP+; or lack of ability to accomplish contracting in the short period of time) and should have, therefore, been provided. In two cases, the members' parent provided statements of how long the member had been receiving CHP+ when filing the appeal, which did not appear to be considered when deciding the appeal case.

All appeals were processed administratively (including those cases in which the original decision was based on medical necessity, the appeal decision was based on an out-of-network provider making the request, and the waiting period for the service had not been met). Given the effective date of **DentaQuest**'s contract, consideration for these transition issues should be given. In none of the 10 appeal cases reviewed was the original denial decision overturned.

DentaQuest must revise its policies, procedures, member and provider informational materials, and organizational processes to:

- Ensure that, if there is an expression of dissatisfaction, the interaction is treated and logged as a grievance to assure accurate information for quality improvement purposes.
- Adequately address the requirement that providers and authorized representatives may file an appeal or grievance and may request a State fair hearing on behalf of the member with the member's written consent.
- Ensure that members are afforded the right to provide consent for authorized representatives to file an appeal on their behalf.
- Ensure consistently providing members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, as well as providing interpreter services and toll-free numbers that have adequate teletypewriter/telecommunications device for the deaf (TTY/TDD) and interpreter capabilities.
- Ensure that members understand that grievances are not required to be in writing to expect a response.
- Ensure communication to members regarding the requirement to follow oral appeals with a written signed appeal is clear and does not require a second communication to inform the member that a written signed appeal is required.

- Track appeal resolutions sent to ensure that members are provided accurate information in appeal resolution letters.
- Include the provisions that oral inquiries seeking to appeal an adverse benefit determination (ABD) are treated as appeals (to establish the earliest possible filing date).
- Include the provisions that parties to the appeal and the State fair hearing include the representative of a deceased member's estate.
- Include all required provisions related to extending the time frames for resolution of grievances and appeals and ensure that if the PAHP requires additional information and time to effectively process the appeal, a notice that includes the required content is provided to the member.
- Accurately describe all required provisions of expedited review of appeals
- Accurately describe the internal appeals process.
- Accurately describe grievance resolution content.
- Clearly differentiate between the provider reconsideration process, Medicaid member appeal processes, and CHP+ member appeals processes.

DentaQuest must develop and implement effective processes to:

- Ensure that members are afforded the right to provide additional evidence or testimony and to receive documents and records upon request at no charge.
- Ensure that all comments, documents, records, and other information submitted by the member or the member's representative is considered when deciding the appeal without regard to whether such information was submitted or considered in the initial ABD.
- Ensure compliance with the time frames for sending written grievance acknowledgement and resolution.
- Ensure that acknowledgement letters are sent within the two-working day required time frame.
- Track content of member communications for accuracy.
- Ensure that written notice of the resolution of an expedited appeal is sent within 72 hours and that reasonable efforts to provide oral notice of the resolution also occurs within the 72-hour time frame.
- Accurately inform members that the request for a State fair hearing must be in writing and is due within 120 days from the **DentaQuest** internal appeal notice of resolution.

DentaQuest must develop and implement effective training for Complaints and Grievance Department staff members to ensure that staff understand the federal managed care regulations at 42 CFR Part 438 and Colorado's state-specific grievance and appeal time frames at 10 CCR 2505-10 8.209 so that members receive accurate information and may execute their rights to receive services.

2. Overview and Background

Overview of FY 2019–2020 Compliance Monitoring Activities

For the FY 2019–2020 CHP+ site review process, the Department requested a review of two areas of performance. HSAG developed a review strategy and monitoring tools consisting of two standards for reviewing the performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. FY 2019–2020 represents the initial year of reviewing **DentaQuest** for compliance with federal and state CHP+ managed care regulations; therefore, the Department requested an additional one-time focus activity, Standard VI—Grievances and Appeals, to ensure that **DentaQuest** processes and procedures were in place to comply with grievance and appeal managed care regulations. Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of the three standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the three standards, HSAG used the dental plan's contract requirements and regulations specified by the federal Medicaid/CHP+ managed care regulations published May 6, 2016. HSAG conducted a desk review of materials submitted prior to the on-site review activities: a review of records, documents, and materials provided on-site; and on-site interviews of key dental plan personnel to determine compliance with federal managed care regulations and contract requirements. Documents submitted for the desk review and on-site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and administrative records related to PAHP denials, grievances, and appeals.

HSAG also reviewed a sample of the dental plan's administrative records related to PAHP denials, grievances, and appeals to evaluate implementation of federal healthcare regulations. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records (to the extent that a sufficient number existed) for each of denials, grievances, and appeals. Using a random sampling technique, HSAG selected the sample from all PAHP denial records, all grievance records, and all appeals records that occurred between July 1, 2019, and December 31, 2019. For the record reviews, the dental plan received a score of *M* (met), *NM* (not met), or *NA* (not applicable) for each required element. Results of record reviews were considered in the review of applicable requirements in Standard I—Coverage and Authorization of Services and Standard VI—Grievances and Appeals. HSAG separately calculated a record review score for each record and an overall record review score.

The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[2-1] Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The three standards chosen for the PAHP FY 2019–2020 site review represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VI—Grievances and Appeals, Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontracts and Delegation, and Standard X—Quality Assessment and Performance Improvement.

Objective of the Site Review

The objective of the site review was to provide meaningful information to the Department and the dental plan regarding:

- The dental plan's compliance with federal healthcare regulations and managed care contract requirements in the three areas selected for review.
- Strengths, opportunities for improvement, and actions required to bring the dental plan into compliance with federal healthcare regulations and contract requirements in the standard areas reviewed.
- The quality and timeliness of, and access to, services furnished by the dental plan, as assessed by the specific areas reviewed.
- Possible interventions recommended to improve the quality of the dental plan's services related to the standard areas reviewed.

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Aug 5, 2019.

Appendix A. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Compliance Monitoring Tool
for DentaQuest

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor ensures that the services are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the services are furnished. *42 CFR 438.210(a)(3)(i)* Contract: Amendment 1—Exhibit G	Please see UM08-INS-Authorization Review Please see UM01-INS-Establishment and Adoption of Utilization Review Criteria and Clinical Guidelines Section A	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: Although policies and procedures articulated processes to monitor the provision of services to ensure the services are sufficient to respond to the needs of members, during the on-site review, it was evident that organizational practices were not in place to effectively implement these policies and procedures. HSAG found that many grievances, denials, and appeals were related to an insufficient network of providers and DentaQuest staff members stated that Denver-based staff members were not informed of the type or number of grievances or appeals.		
Required Actions: Communication between the grievance and appeal staff members and the provider network staff members is imperative so the provider network staff members have an understanding of the extent of network issues, allowing them the ability to work with providers and members to solve the members' issues related to the insufficiency of the network. DentaQuest must develop a mechanism for interdepartmental communication so member grievances and appeals can be addressed in a way that meets the members' needs and meets the terms of the CHP+ contract.		
2. The Contractor does 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. *42 CFR 438.210(a)(3)(ii)* Contract: Amendment 1—Exhibit G	Please see UM08-INS-Authorization Review, Policy Section	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
3. The Contactor may place appropriate limits on services— • On the basis of criteria applied under the State plan (such as medical necessity). • For the purpose of utilization control, provided that: – The services furnished can reasonably achieve their purpose.	Please see UM01-INS-Establishment and Adoption of Utilization Review Criteria and Clinical Guidelines Section A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.210(a)(4) *42 CFR 441.20* Contract: Exhibit B—4.3.1.2.1 (bullet #1)		
4. The Contractor specifies what constitutes "medically necessary" as: • A program, good, or service that will, or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, injury, or disability and must meet all of the following: – Is provided in accordance with generally accepted standards of medical practice in the United States. – Is clinically appropriate in terms of type, frequency, extent, site, and duration. – Is not primarily for the economic benefit of the provider or for the convenience of the member, caretaker, or provider. – Is performed in a cost effective and most appropriate setting required by the member's condition. • A course of treatment that includes mere observation or no treatment at all. Contract: Exhibit B—1.1.47	Please see UM Program Description 2019, Page 5- top paragraph defines medical necessity	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor and its subcontractors have in place and follow written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42 CFR 438.210(b)(1)* Contract: Exhibit B—4.3.12.1	"Please see UM Program Description 2019, Page 5- Prior Auth Review. Please see UM08-INS-Authorization Review Please see UM17-INS-Continuation of Care"	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
6. The Contractor and its subcontractors have in place mechanisms to ensure consistent application of review criteria for authorization decisions. *42 CFR 438.210(b)(2)(i)* Contract: Amendment 1—Exhibit G	"Please see UM Program Description 2019, Page 3-4 Description of Utilization Management Programs Please see UM01-INS-SOP-Clinical Algorithms Development and Implementation"	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: During the review of denial records, HSAG found that, for one record, DentaQuest indicated the denial of service was due to the service being not medically necessary (as described in the letter to the member: the member was not in enough pain), when in fact, it is not a service authorized by DentaQuest to provide to members (the use of nitrous oxide in dental procedures) and the reason for the denial should have been listed as "not a covered benefit."		
Required Actions: DentaQuest must ensure that the reasons for denying services in part or in whole are indicated accurately and consistently to members and providers.		
7. The Contractor and its subcontractors have in place mechanisms to consult with the requesting provider for medical services when appropriate. *42 CFR 438.210(b)(2)(ii)* Contract: Exhibit B—None	Please see UM Program Description 2019, Page 5 Last Paragraph	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
8. The Contractor ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by an individual who has appropriate expertise in treating the member's dental health needs. *42 CFR 438.210(b)(3)* Contract: Exhibit B—4.3.7.1.2	Please see UM Program Description 2019, Page 1-3 Organizational Structure and Resources Please see UM08-INS-Authorization Review Section A.1.b	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor notifies the requesting provider and gives the member written notice of any decision by the contractor to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. *Note: Notice to the provider may be oral or in writing.* *42 CFR 438.210(c)* Contract: Amendment 1—Exhibit G	Please see UM04-INS Section A Approval Notification And Section B Denial Notification	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
10. The Contractor adheres to the following time frames for making standard and expedited authorization decisions: • For standard authorization decisions—as expeditiously as the member's condition requires and not to exceed 10 calendar days following the receipt of the request for service. • If the provider indicates, or the Contractor determines, that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization determination and provides notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service. *42 CFR 438.210(d)(1–2)* Contract: Exhibit B—4.3.7.2.1.2 & 4.3.7.2.1.3	Please see UM08-INS-Authorization Review, Section A.2 – 3 Please note language in Section A.2: *unless specified differently by the Plan or regulation*	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: During the on-site record review, although HSAG found that all denial decisions reviewed were made within the required time frames, DentaQuest's Authorization Review policy stated that, "unless specified differently by the Plan or regulation" standard decisions are made within 14 calendar days. The		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
policy had no Colorado-specific addendum to specify Colorado-specific time frames. Colorado's required time frame for standard pre-service authorization decisions is 10 calendar days following the receipt of the request for service.		
Required Actions: DentaQuest must revise its Authorization Review policy and any other applicable policies and documents to depict Colorado-specific time frames for determinations related to a standard request for service.		
11. The Contractor may extend the time frame for making standard or expedited authorization decisions by up to 14 additional calendar days if: • The member or the provider requests an extension, or • The Contractor justifies a need for additional information and how the extension is in the member's interest. *42 CFR 438.210(d)(1)(i–ii) and (d)(2)(ii)* Contract: Amendment 1—Exhibit G	Please see UM08-INS-Authorization Review, Section A.2 – 3	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The notice of adverse benefit determination must be written in language easy to understand, available in prevalent non-English languages in the region, and available in alternative formats for persons with special needs. *42 CFR 438.404(a)* *42 CFR 438.10(c)* Contract: Exhibit B—None Reference: 10 CCR 2505-10 8.209	Inform health plan on-site that proposed federal rule changes include eliminating the 18-point requirement for taglines on denial notices. (Reviewed in Member Information standard.) Please see UM04-INS- Notice of Action Letters, Section B	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: In the denial letters sent the members (NABD), HSAG found that DentaQuest listed a general CCR citation as criteria used in making the decision to deny the request for services, which was not specific to the denial in the member letter. Within the letter, DentaQuest did not explain the citation or the criteria in easy-to-understand language.		
Required Actions: DentaQuest must either remove the CCR citation or provide additional language that is easy for the member to understand.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The notice of adverse benefit determination must explain the following: • The adverse benefit determination the Contractor has made or intends to make. • The reasons for the adverse benefit determination, including the right of the member to be provided upon request (and free of charge), reasonable access to and copies of all documents, and records relevant to the adverse benefit determination (includes medical necessity criteria and strategies, evidentiary standards, or processes used in setting coverage limits). • The member's (or member's designated representative's) right to request one level of appeal with the Contractor and the procedures for doing so. • The member's right to request a State review after receiving an appeal resolution notice from the Contractor that the adverse benefit determination is upheld. • The procedures for exercising the right to request a State review. • The circumstances under which an appeal process can be expedited and how to make this request. *42 CFR 438.404(b)* Contract: Exhibit B—None Reference: 10 CCR 2505-10 8.209	Please see UM04-INS- Notice of Action Letters, Section B	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: HSAG reviewed DentaQuest's denial letter (NABD) and found that template language describing the appeal and State fair hearing processes included inaccurate time frames. Specifically, the time frame DentaQuest would acknowledge an appeal request was stated as five days instead of two days, the time frame for DentaQuest to make an appeal decision was stated as 20 days instead of 15 days, and it was not clear that the time frame for a member to submit a request for a State fair hearing started at the appeal decision letter date and not the NABD date.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: DentaQuest must review the template language in its NABD to ensure that the information and timelines provided to members are accurate.		
14. The Contractor mails the notice of adverse benefit determination within the following time frames: • For termination, suspension, or reduction of previously authorized Medicaid-covered services, as defined in 42 CFR 431.211, 431.213, and 431.214 (see below). • For denial of payment, at the time of any denial affecting the claim. • For standard service authorization decisions that deny or limit services, no later than 10 calendar days after receipt of request for service. • For expedited service authorization decisions, no later than 72 hours after receipt of request for service. • For extended service authorization decisions, no later than the date the extension expires. • For service authorization decisions not reached within the required time frames, on the date the time frames expire. *42 CFR 438.404(c)* Contract: Exhibit B—None Reference: 10 CCR 2505-10 8.209	Please see UM08-INS-Authorization Review, Section C Please note language in Section A.2: unless specified differently by the Plan or regulation	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. For reduction, suspension, or termination of a previously authorized Medicaid-covered service, the Contractor gives notice at least ten (10) days before the intended effective date of the proposed adverse benefit determination except: • The Contractor gives notice on or before the intended effective date of the proposed adverse benefit determination if: – The Agency has factual information confirming the death of a member. – The Agency receives a clear written statement signed by the member that he/she no longer wishes services or gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information. – The member has been admitted to an institution where he/she is ineligible under the plan for further services. – The member's whereabouts are unknown, and the post office returns Agency mail directed to him/her indicating no forwarding address. – The Agency establishes that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth. – A change in the level of medical care is prescribed by the member's physician. – The notice involves an adverse benefit determination made with regard to the preadmission screening requirements.	NA- DentaQuest does not terminate, suspend or reduce previously approved services	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• If probable member fraud has been verified, the Contractor gives notice five (5) calendar days before the intended effective date of the proposed adverse benefit determination. *42 CFR 438.404(c)* *42 CFR 431.211* *42 CFR 431.213* *42 CFR 431.214* Contract: Exhibit B—None Reference: 10 CCR 2505-10 8.209		
16. If the Contractor extends the time frame for standard authorization decisions, it must give the member written notice of the reason for the extension and inform the member of the right to file a grievance if he or she disagrees with that decision. *42 CFR 438.404(c)(4)* Contract: Exhibit B—None Reference: 10 CCR 2505-10 8.209	Please see UM08-INS-Authorization Review, Section A.4	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
17. The Contractor provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42 CFR 438.210(e)* Contract: Amendment 1—Exhibit G	Please see HR15-ENT-Staff De-Incentives Please see UM Program Description 2019, Page 4- last paragraph	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	11	X	1.00	=	11.00
	Partially Met	=	5	X	.00	=	0.00
	Not Met	=	0	X	.00	=	0.00
	Not Applicable	=	1	X	NA	=	NA
Total Applicable		=	16	**Total Score**		=	11.00
				Total Score ÷ Total Applicable		=	69%

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor maintains and monitors a network of providers sufficient to provide access to all covered services to all members, including those with limited English proficiency or physical or mental disabilities. *42 CFR 438.206(b)(1)* Contract: Amendment 1—Exhibit G	Please see NET05-INS Procedure Section DentaQuest does not have insight to member disabilities or language proficiency and therefore this is not included in the network analysis or standards.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: At the time of the compliance review, DentaQuest described credentialing issues that were preventing the credentialing of a sufficient quantity of providers to meet the needs of the members. DentaQuest described efforts to forego credentialing efforts temporarily for providers that were previously aligned with Delta Dental's CHP+ line of business in order to expedite their privileges to provide dental care with DentaQuest. DentaQuest also described efforts to prioritize credentialing providers that were in the greatest demand, such as periodontists and oral surgeons in rural and frontier regions. Despite these efforts, grievances and appeals reviewed on-site indicated that members were not getting needed services despite indication that they were experiencing dental pain. Further, Colorado-based DentaQuest staff members stated that they were not apprised of grievances or appeals that had been filed, which indicated a lack of cohesion between the departments or oversight and monitoring of the provision of care to ensure Colorado CHP+ members were receiving covered services." **Required Actions:** DentaQuest must ensure that providers are available in sufficient number, type, and specialty to furnish contracted services.		
2. In establishing and maintaining the network adequacy standards, the Contractor considers: • The numbers, types, and specialties of network providers required to furnish the contracted CHP+ services. • The geographic location of providers in relationship to where CHP+ members live, considering distance, travel time, and means of transportation. *42 CFR 438.206(a); 438.68(c)(iv) and (vi)* Contract: Exhibit B—4.1.2.1-4.1.2.2	Please see Report 191115 CO CHIP Network Analysis in Which DentaQuest monitors access according to specialist and enrollment. Please see NET05-INS Procedure Section A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. In establishing and maintaining the network adequacy standards, the Contractor considers: • The anticipated CHP+ enrollment. • The expected utilization of services, taking into consideration the characteristics and healthcare needs of specific CHP+ populations represented in the Contractor's service area. • The number of network providers accepting/not accepting new CHP+ members. • The ability of providers to communicate with limited-English-proficient members in their preferred language. • The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for members with physical or mental disabilities. • The availability of triage lines or screening systems, as well as use of telemedicine, e-visits, and/or other technology solutions. *42 CFR 438.206(a); 438.68(c)(i)–(iii), (v), and (vii)–(ix)* Contract: Exhibit B—None	Please see NET05-INS Procedure Section A. Please see 191115 CO CHIP Network Analysis in which the network is analyzed by specialty and enrollment. Please see Provider Directory which monitors providers by those accepting, language, physical access etc. Please see NET01-INS Section 9 Directories DentaQuest outlines the directory requirements.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
4. The Contractor provides for a second opinion from a network provider or arranges for the member to obtain one outside the network (if there is no qualified provider within the network), at no cost to the member. *42 CFR 438.206(b)(3)* Contract: Amendment 1—Exhibit G	Please see CGA06-INS Section D Page 4	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. If the provider network is unable to provide necessary covered services to a particular member in network, the Contractor must adequately and in a timely manner cover the services out of network for as long as the Contractor is unable to provide them. *42 CFR 438.206(b)(4)* Contract: Amendment 1—Exhibit G	Please see UM15-INS Section Procedure B. where DentaQuest indicates the use of out of network providers.	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: Although DentaQuest's policies and procedures allowed for use of out-of-network providers, several grievances, denials, and appeals were due to out-of-network providers requesting the service. During the on-site interviews, DentaQuest staff members acknowledged difficulty with credentialing providers from the previous Delta Dental network in a timely manner. Many cases reviewed on-site were members that had been previously seen by Delta Dental providers under the CHP+ program. In addition, there was no evidence provided of direction given to the utilization management staff members to allow out-of-network providers to furnish services until such time that the DentaQuest provider network is sufficient.		
Required Actions: DentaQuest must develop a mechanism to allow out-of-network providers to furnish services under the CHP+ contract with the Department for as long as it is unable to provide the services.		
6. The Contractor requires out-of-network providers to coordinate with the Contractor for payment and ensures that the cost to the member is no greater than it would be if the services were furnished within the network. *42 CFR 438.206(b)(5)* Contract: Amendment 1—Exhibit G	Please see UM15-INS Section D States DentaQuest shall follow all applicable policies to ensure the Enrollee is not liable for costs greater than would be expected for in-network services, including a prohibition on balance billing as required in the Medicaid Provider Manual.	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: DentaQuest provided no evidence of having a mechanism to make arrangements with out-of-network providers for claims submissions and payment or to ensure that members are not charged more than if the services are provided by the network.		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: DentaQuest must develop a mechanism to coordinate with the out-of-network providers for payment and to ensure that the cost to the member is no greater than it would be if the services were furnished within the network. For example, a single case agreement contract template could be developed to inform out-of-network providers of claims and payment procedures as well as the prohibition of balance billing members.		
7. The Contractor must meet, and require its providers to meet, the State standards for timely access to care and services, taking into account the urgency of the need for services. The Contractor ensures that services are available as follows: • Emergency dental services— – Immediately, during normal dental office business hours. – A taped telephone message shall instruct members to go directly to an emergency room if the member needs emergency care after normal business hours. • Urgent care is available within 24 hours from the initial identification of need. • Non-urgent symptomatic care visit within 7 days after member request. • Well-care visit within one month after member request. *42 CFR 438.206(c)(1)(i)* Contract: Exhibit B—4.3.1.5.2, 4.3.1.3.1	Please see Provider Survey Tool DentaQuest Conducts routine Provider Appointment Availability Surveys via phone call to ensure providers are abiding by applicable appointment availability time frames. Please see NET01-INS Section 6.a.v DentaQuest conducts office verification checks to include appointment availability.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor and its providers offer hours of operation that are no less than the hours of operation offered to commercial members or Medicaid members. *42 CFR 438.206(c)(1)(ii)* Contract: Amendment 1—Exhibit G	Please see 190515 CO CHP+ MC Section B. Telephone Line Operation and Maintenance Page 2	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor makes services included in the contract available 24 hours a day, 7 days a week, when medically necessary. *42 CFR 438.206(c)(1)(iii)* Contract: Amendment 1—Exhibit G	Please see CS03-INS-DENT Section B.2 DentaQuest does not limit the hours or days in which a covered service is available.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
10. The Contractor ensures timely access by: • Establishing mechanisms to ensure compliance with access (e.g., appointment) standards by network providers. • Monitoring network providers regularly to determine compliance. • Taking corrective action if there is failure to comply. *42 CFR 438.206(c)(1)(iv)–(vi)* Contract: Amendment 1—Exhibit G	Please see Provider Survey Tool DentaQuest Conducts routine Provider Appointment Availability Surveys via phone call to ensure providers are abiding by applicable appointment availability time frames. Please see NET01-INS Section 6.a.v DentaQuest conducts office verification checks to include appointment availability.	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: DentaQuest had a process in place for monitoring compliance with timely access standards for other states; however, DentaQuest had not yet begun monitoring its Colorado CHP+ market to ensure providers were compliant with timely access standards.		
Required Actions: DentaQuest must ensure timely access by: establishing mechanisms to ensure compliance with access (e.g., appointment) standards by network providers, monitoring network providers regularly to determine compliance, and taking corrective action if there is failure to comply.		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. This includes: • Developing and implementing a strategy to recruit and retain qualified, diverse, and culturally responsible oral health practitioners. • Accessing a universal language line for providing oral translation and interpretation services in all non-English languages to members. *42 CFR 438.206(c)(2)* Contract: Exhibit B—4.1.4.5.2, 4.4.3.4	Please see NET01-INS Section 5.a.v Page 2 DentaQuest provides Cultural Diversity Training Please see NET01-INS Page 1 states that DentaQuest does discriminate against providers Please see Colorado Child Health Plan Plus (CHP+) ORM Page 7 discusses language services	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The Contractor must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities. *42 CFR 438.206(c)(3)* Contract: Exhibit B—None	Please see 190515 CO CHP+ MC Section 3.d Page 2	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
13. The Contactor submits to the State (in a format specified by the State) documentation to demonstrate that the Contractor offers an appropriate range of preventive, primary care, and specialty services that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. *42 CFR 438.207(b)* Contract: Amendment 1—Exhibit G	Please see NET01-INS Section 9 Please see Provider Directory	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard II—Access and Availability							
Total	Met	=	9	X	1.00	=	9.00
	Partially Met	=	1	X	.00	=	0
	Not Met	=	3	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	13	**Total Score**		=	9.00
			Total Score ÷ Total Applicable			=	69%

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an internal grievance and appeal system in place for members. A grievance and appeals system means the processes the Contractor implements to handle grievances and appeals of an adverse benefit determination, as well as processes to collect and track information about grievances and appeals. *42 CFR 438.400(b)* *42 CFR 438.402(a)* Contract: Exhibit B—~~4~~.4.1.2	Please see CGA09-INS-MCDCHIP, Exhibit B This exhibit discusses Member Reconsiderations (Appeals) specifically to CO Please see CGA06-INS Discusses DentaQuest Grievance (complaint) process	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor defines "adverse benefit determination" as: • The denial or limited authorization of a requested service, including determinations based on the type or level of service; requirements for medical necessity; and the appropriateness, setting, or effectiveness of a covered benefit. • 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, as defined by the State. • The failure to act within the time frames defined by the State for standard resolution of grievances and appeals. • The denial of a member's request to dispute a member financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other member financial liabilities). *42 CFR 438.400(b)* Contract: Exhibit B—None Reference: 10 CCR 2505-10 8.209	Please see CGA09-INS-MCDCHIP, Exhibit B-Definitions: Adverse Benefit Determination	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor defines an "appeal" as a review by the Contractor of an adverse benefit determination. *42 CFR 438.400(b)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	Please see CGA09-INS-MCDCHIP, Page 1 Definitions: Appeal	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: Although the definitions section of the *Member Appeals* policy depicted the correct definition of "appeal," the rest of the policy interchanged the terms "appeal," "reconsideration," and "grievance." During the on-site interview, Complaints and Grievance Department staff members were unable to clearly articulate an understanding of the difference between a grievance, a member appeal, and a provider reconsideration (based on technical issues, i.e., coding or timeliness of claims).		
Required Actions: DentaQuest must develop and implement a grievance and appeal staff training module that accurately reflects federal definitions related to the Grievance and Appeal System.		
4. The Contractor defines a "grievance" as an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. A grievance includes a member's right to dispute an extension of time proposed by the Contractor to make an authorization decision. *42 CFR 438.400(b)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	Please see CGA06-INS, Page 1 Definitions: "Complaint" (Grievance)	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: Although the definitions section of the *Member Complaints/Grievances* policy depicted the correct definitions of "complaints" and "grievances," the policy also referred to appeals as "grievances" and, during the on-site interview, Complaints and Grievance Department staff members were unable to clearly articulate an understanding of the difference between a grievance and an appeal. In addition, the policy indicated that, if the matter was resolved within the initial call, it would be considered an inquiry rather than a grievance.		
Required Actions: DentaQuest must develop and implement a grievance and appeal staff training module that accurately reflects federal definitions related to the Grievance and Appeal System. DentaQuest must also ensure that, if there is an expression of dissatisfaction, the interaction must be treated and logged as a grievance to ensure accurate information for quality improvement purposes.		
5. The Contractor has provisions for who may file: • A member may file a grievance or a Contractor-level appeal and may request a State fair hearing. • With the member's written consent, a provider or authorized representative may file a grievance or a Contractor-level appeal and may request a State fair hearing on behalf of a member. *42 CFR 438.402(c)* Contract: Exhibit B—4.3.8.3.2, 4.4.1.2 Reference: 10 CCR 2505-10 8.209	Please see CGA09-INS-MCDCHIP Page 12, Section D.-Member Fair Hearing Page 12 Section D.2 Discusses how a representative can be authorized by a member in writing Page 8 Section A.1-a.i States the member is only offered 1 level of appeal and written consent to authorize a representative Please see CGA06-INS Page 2 Section A.1 and A.2 Discusses that a representative must be authorized by the member	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The authority to file appeals and request State fair hearings was adequately addressed in the *Member Appeals* policy. The authority to file grievances was adequately addressed in the *Member Complaints/Grievances* policy. The requirement of member written consent to file on behalf of the member was addressed within the *Member Appeals* policy, but not adequately addressed within the *Member Complaints/Grievances* policy. During the on-site review, DentaQuest staff members stated that DentaQuest does not require the member's written consent for providers or other authorized representatives to file on the member's behalf.		

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: DentaQuest must revise the *Member Complaints/Grievances* policy to address the requirement that providers and authorized representatives may file an appeal or grievance and may request a State fair hearing on behalf of the member with the member's written consent. DentaQuest must also develop and implement an effective mechanism to ensure that members are afforded the right to provide consent for authorized representatives to file an appeal on their behalf.		
6. In handling grievances and appeals, the Contractor must give members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, as well as providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability. *42 CFR 438.406(a)(1)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	Please see CO CHP grievance acknowledgement Page 4 Please see CO CHP verbal appeal acknowledgement Page 4	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: Neither the *Member Appeals* policy nor the *Member Complaints/Grievances* policy addressed member assistance in filing grievances or appeals. The grievance acknowledgement template letter offered TTY assistance. The Non Discrimination notice attached to the appeal and grievance acknowledgement letter templates offered language assistance, sign language, and written information in other formats, then refers to the website to get the phone number to ask for these services. It is important to note, however, that only three of the seven grievances reviewed, and zero of the 10 appeal records reviewed contained evidence that an acknowledgement letter was sent. The Notice of Action (NABD) letters reviewed contained the Non Discrimination notice.		
Required Actions: DentaQuest must revise applicable policies and procedures and develop and implement effective mechanisms to provide members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, as well as providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability.		

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor ensures that the individuals who make decisions on grievances and appeals are individuals who: • Were not involved in any previous level of review or decision-making nor a subordinate of any such individual. • Have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if deciding any of the following: – An appeal of a denial that is based on lack of medical necessity. – A grievance regarding the denial of expedited resolution of an appeal. – A grievance or appeal that involves clinical issues. *42 CFR 438.406(b)(2)* Contract: Exhibit B—4.3.8.3.3, 4.4.1.2Reference: 10 CCR 2505-10 8.209	Please see CGA09-INS-MCDCHIP Section B.6 Page 4 Discussed that the clinical Consultant was not involved in the initial review Please see CGA06-INS Section B.5 Page 2 Discussed that the clinical Consultant was not involved in the initial review	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: Both the *Member Appeals* policy and *Member Complaints/Grievances* policy stated the requirement that the individuals who make decisions on grievances and appeals are individuals who have the appropriate clinical expertise and were not involved in a previous level of review. In the appeals record review, however, there were cases in which the original denial was a clinical review, but the appeal was denied inappropriately for untimely filing rather than providing a clinical review to decide the appeal.		
Required Actions: DentaQuest must develop and implement effective training for Complaints and Grievance Department staff members to ensure that staff members understand the federal managed care regulations and Colorado's State-specific time frames so members receive accurate information and may execute their rights to receive services.		

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor ensures that the individuals who make decisions on grievances and appeals: • Take into account all comments, documents, records, and other information submitted by the member or the member's representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. *42 CFR 438.406(b)(2)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	Please see CGA06-INS Section B-3.c-d Page 2 Discusses items taken into account Please see CGA09-INS-MCDCHIP Section B-3.c-d Page 3 Discusses items taken into account	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: Both the *Member Appeals* policy and *Member Complaints/Grievances* policy included language that DentaQuest will ensure all comments, records, and documents will be considered when deciding the appeal. During the on-site interview, staff members described a process whereby any information is placed in a folder for the decision maker to access. However, in several appeal records reviewed, there was evidence that the parent provided information to the Complaints and Grievance specialist that was not acknowledged or considered during the administrative processing of the appeal.		
Required Actions: DentaQuest must develop and implement a process to ensure that all comments, documents, records, and other information submitted by the member or the member's representative is considered when deciding the appeal without regard to whether such information was submitted or considered in the initial ABD.		

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor accepts grievances orally or in writing. *42 CFR 438.402(c)(3)(i)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	Please see CGA06-INS Section A.3 Page 2 States request can verbal	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: While the *Member Complaints/Grievances* policy included the provision that DentaQuest accepts grievances orally or in writing, the member handbook was misleading by stating that, if the customer relations department is unable to address the problem, the member can write a detailed letter and can expect prompt action if the information is submitted in writing.		
Required Actions: DentaQuest must revise member communications to ensure that members understand that grievances are not required to be in writing to expect response.		
10. Members may file a grievance at any time. *42 CFR 438.402(c)(2)(i)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	Please see CGA06-INS Section A.1 Page 2 States grievance (complaint) can be filed at any time	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11. The Contractor sends the member written acknowledgement of each grievance within two (2) working days of receipt. *42 CFR 438.406(b)(1)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	Please see CGA06-INS Section B.2 Page 2	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: The *Member Complaints/Grievances* policy stated that grievance acknowledgement would be sent within the "specified regulatory time frame." During the on-site interviews, staff members reported that internal desktop procedures state that acknowledgements are sent within five days. The on-site record review revealed that acknowledgement letters were sent in only three of seven cases reviewed.		

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: DentaQuest must develop and implement effective training for Complaints and Grievance Department staff members to ensure that staff members understand the federal managed care regulations and Colorado's State-specific time frames for sending written acknowledgement of grievances. DentaQuest must also develop and implement an effective tracking mechanism to ensure compliance with the time frames for sending written grievance acknowledgement.		
12. The Contractor must resolve each grievance and provide notice as expeditiously as the member's health condition requires, and within 15 working days of when the member files the grievance. • Notice to the member must be in a format and language that may be easily understood by the member. *42 CFR 438.408(a) and (b)(1) and (d)(1)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	Please see CGA06-INS Section C.2 page 3 Discusses A resolution to the complaint will be rendered and communicated to the Member or Authorized Representative within: 1. No later than one (1) business day from the date of receipt for items when a delay would significantly increase risk to the Member's health; or 2. No later than thirty (30) days from the date of the receipt of the complaint Please see CO CHP grievance resolution	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: The *Member Complaints/Grievances* policy stated that grievance resolution would be sent within 30 calendar days from the receipt of the grievance. During the on-site interviews, staff members reported following internal desktop procedures. The on-site record review revealed that four of seven grievance resolutions were sent within the required time frame.		
Required Actions: DentaQuest must develop and implement effective training for Complaints and Grievance Department staff members to ensure that staff members understand the federal managed care regulations and Colorado's State-specific time frames for sending grievance resolution notices. DentaQuest must also develop and implement an effective tracking mechanism to ensure compliance with the time frames for sending grievance resolution notices.		

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The written notice of grievance resolution includes: • Results of the disposition/resolution process and the date it was completed. Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	Please see CO CHP grievance resolution	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The *Member Complaints/Grievances* policy adequately described requirements for the content of grievance resolution notices; however, it also described other content more appropriate for an appeal resolution letter. During the on-site record review, HSAG found that the notices did not consistently include information that was responsive to the members' needs.		
Required Actions: DentaQuest must revise its policies and procedures to accurately describe the content of the grievance resolution notices. DentaQuest must also develop and implement effective training for Complaints and Grievance Department staff members to ensure understanding of grievance resolution content requirements. HSAG recommends that Complaints and Grievance Department staff members be required to attend basic customer service training.		
14. The Contractor may have only one level of appeal for members. *42 CFR 438.402(b)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	Please see CGA09-INS-MCDCHIP Section A.1 Page 5 States members have only one level of appeal	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: Although the *Member Appeals* policy included requirement language about one level of appeal, the policy and the member handbook also indicated that a second-level appeal could be requested.		
Required Actions: DentaQuest must revise its policies and procedures to accurately describe the internal appeals process. DentaQuest must also develop and implement effective training for Complaints and Grievance Department staff members to ensure understanding of the regulations at 42 CFR 438.400–424 and 10 CCR 2505-10 8.209.		

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. A member may file an appeal with the Contractor within 60 calendar days from the date on the adverse benefit determination notice. *42 CFR 438.402 (c)(2)(ii)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	Please see CGA09-INS-MCDCHIP Section A Page 8 States the member or Auth Rep has 60 days after receipt to file reconsideration (appeal)	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: While the *Member Appeals* policy stated that members have 60 days to file an appeal, the on-site record review revealed that staff members did not consistently operationalize this standard. In two appeal cases, the communication to the member stated that DentaQuest would not process the appeal due to untimely filing. In one letter, the filing time frame was stated as 10 days. In another letter, the filing time frame was accurately depicted as 60 days; however, the member had filed the appeal in 44 days and the appeal was denied for untimely filing. In both cases, the member had filed the appeal within the required time frame.		
Required Actions: DentaQuest must develop and implement effective training for Complaints and Grievance Department staff members to ensure understanding of the regulations at 42 CFR 438.400–424 and 10 CCR 2505-10 8.209.		
16. The member may file an appeal either orally or in writing and must follow the oral request with a written, signed appeal (unless the request is for expedited resolution). *42 CFR 438.402(c)(3)(ii)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	Please see CGA09-INS-MCDCHIP Section A Page 8 States: The reconsideration can be verbal or written however, verbal requests must be followed by a written request. Written reconsideration policies and procedures are available, upon request, to any patient, provider, or facility rendering service.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: Although the *Member Appeals* policy included the required provision that members must follow an oral appeal with a written appeal, the Notice of Action letters reviewed on-site we unclear and stated, "we may ask you to also send it in writing." During the on-site interview, DentaQuest's Complaints and Grievance Department staff members were unable to clearly articulate the requirement, or what is being done in practice by DentaQuest.		

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: DentaQuest must develop and implement effective training for Complaints and Grievance Department staff members to ensure understanding of the regulations at 42 CFR 438.400–424 and 10 CCR 2505-10 8.209. In addition, communication to members regarding the requirement to follow an oral appeal with a written signed appeal must be clear and not require a second communication to inform the member that a written signed appeal is required.		
17. The Contractor sends written acknowledgement of each appeal within two (2) working days of receipt, unless the member or designated client representative requests an expedited resolution. *42 CFR 438.406(b)(1)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	Please see CGA09-INS-MCDCHIP Section A Page 8 States that upon the receipt of the Member reconsideration, an Acknowledgement Letter will be forwarded to the Member and Provider, or Authorized Representative within 5 business days from receipt	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: The *Member Appeals* policy stated that appeal acknowledgement letters will be sent by DentaQuest within five business days of the receipt of the appeal. In addition, HSAG found no appeal acknowledgement letters in the 10 appeal records reviewed on-site.		
Required Actions: DentaQuest must develop and implement a mechanism to track and ensure that acknowledgement letters are sent within the two-working day required time frame.		
18. The Contractor's appeal process must provide: • That oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date) and must be confirmed in writing unless the member or provider requests expedited resolution. • That if the member orally requests an expedited appeal, the Contractor shall not require a written, signed appeal following the oral request. • That included, as parties to the appeal, are: – The member and his or her representative, or	Please see CGA09-INS-MCDCHIP Section A Page 8 Section B.2-d Page 9 SectionA.1-b Page 8	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– The legal representative of a deceased member's estate. *42 CFR 438.406(b)(3) and (6)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209		
Findings: The *Member Appeals* policy did not address the provision that oral inquiries seeking to appeal an ABD are treated as appeals (to establish the earliest possible filing date), or that parties to the appeal include the representative of a deceased member's estate. During the on-site interview, staff members were unable to clearly articulate which date the Complaints and Grievance specialist uses to calculate compliance with the time frame for resolution of the appeal.		
Required Actions: DentaQuest must revise policies and procedures to include the provisions that oral inquiries seeking to appeal an ABD are treated as appeals (to establish the earliest possible filing date), and that parties to the appeal include the representative of a deceased member's estate. DentaQuest must also develop and implement effective staff training to ensure that staff members responsible for processing appeals understand the federal managed care requirements at 42 CFR 438.400–424 and 10 CCR 2505-10 8.209.		
19. The Contractor's appeal process must provide: • The member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. (The Contractor must inform the member of the limited time available for this sufficiently in advance of the resolution time frame in the case of expedited resolution.) • The member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional documents considered, relied upon, or generated by the Contractor in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the appeal resolution time frame.	Please see CO CHP written appeal acknowledgement Page 2 Please see CGA09-INS-MCDCHIP Section C.5-c)vii Section D Page 12	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.406(b)(4-5) Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209		
Findings: The *Member Appeals* policy addressed the provision to allow the member the right to review documents and records and present evidence or testimony; however, there was no provision in the policy that addressed informing the member of the limited time available to do so in the case of an expedited review. During the on-site review, there was no clear process articulated to provide evidence of operationalizing this provision. The policy stated that the case file is sent with the acknowledgement letter; however, DentaQuest staff members confirmed on-site that this did not occur. The appeal acknowledgement template included language to inform the member of the right to provide additional information and to review records; however, in practice, HSAG found that no appeal acknowledgement letters were sent in any of the 10 cases reviewed for the record review.		
Required Actions: DentaQuest must develop a mechanism to ensure that members are afforded the right to provide additional evidence or testimony and to receive documents and records upon request at no charge.		
20. The Contractor maintains an expedited review process for appeals when the Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life; physical or mental health; or ability to attain, maintain, or regain maximum function. The Contractor's expedited review process includes that: • The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. *42 CFR 438.410(a–b)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	Please see CGA09-INS-MCDCHIP Section B.5 Page 9	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The *Member Appeals* policy described an expedited appeal process; however, it did not include the provision to ensure that punitive action cannot be taken against providers who request an expedited resolution or support a member's appeal.		

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: DentaQuest must revise its policies and procedures to accurately describe all required provisions of expedited review of appeals as required at 42 CFR 438.410 and 10 CCR 2505-10 8.209.4.R.		
21. If the Contractor denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the time frame for standard resolution. • Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and within two (2) calendar days provide the member written notice of the reason for the decision and inform the member of the right to file a grievance if he or she disagrees with that decision. *42 CFR 438.410(c)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	Please see CGA09-INS-MCDCHIP Section B.5-b-d States DentaQuest will notify the member or rep orally for expedited requests	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The *Member Appeals* policy did not address denial of expedition. None of the appeals reviewed on-site were processed as expedited.		
Required Actions: DentaQuest must revise its policies and procedures to accurately describe all required provisions of expedited review of appeals as required at 42 CFR 438.410 and 10 CCR 2505-10 8.209.4.S.		
22. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. Written notice of appeal resolution must be in a format and language that may be easily understood by the member.	According to Client Required Documents (CRD) the standard appeal TAT is 20 days Please see CGA09-INS-MCDCHIP Section C.2 Page 11 Outlines tat as 20 days	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.408(b)(2) *42 CFR 438.408(d)(2)* *42 CFR 438.10* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209		
Findings: The *Member Appeals* policy depicted the appeal resolution time frame as 20 calendar days. Six of the 10 appeal records reviewed on-site were resolved with notice sent within the required time frame.		
Required Actions: DentaQuest must develop and implement an effective training to ensure staff members who process appeals understand the federal managed care regulations and State-required timelines at 10 CCR 2505-10 8.209. Policies and procedures and associated template member communications must be revised to reflect the required time frame. DentaQuest must also develop and implement an effective mechanism to track content of member communications for accuracy.		
23. For expedited appeal, the Contractor must resolve the appeal and provide written notice of disposition to affected parties within 72 hours after the Contractor receives the appeal. • For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. *42 CFR 438.408(b)(3) and (d)(2)(ii)* Contract: Exhibit B—4.3.8.3.4, 4.4.1.2	Please see CGA09-INS-MCDCHIP Section C.1 Page 11	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The *Member Appeals* policy stated that a verbal notice would be provided to members within 72 hours of a request for expedited review of an appeal and that a written notice would be sent within 24 hours following the verbal notice.		
Required Actions: DentaQuest must develop a mechanism to ensure that written notice of the resolution of an expedited appeal is sent within 72 hours and that reasonable efforts to provide oral notice of the resolution also occurs within the 72-hour time frame.		

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
24. The Contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if: • The member requests the extension; or • The Contractor shows (to the satisfaction of the Department, upon request) that there is a need for additional information and how the delay is in the member's interest. *42 CFR 438.408(c)(1)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	Please see CGA09-INS-MCDCHIP Section C.4	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: Although the *Member Appeals* policy included extension language, the provision in the policy was inadequate, and staff members, during the on-site review, were unable to articulate whether this policy provision was operationalized. For grievance extensions, HSAG found no policy provisions and during the on-site interview, Complaints and Grievance Department staff members reported that they believed no extension was allowed for grievances.		
Required Actions: DentaQuest must revise its policies and procedures to include all required provisions related to extending the time frames for resolution of grievances and appeals. DentaQuest must also develop and implement an effective training to ensure staff members who process appeals understand the federal managed care regulations and State-required timelines at 10 CCR 2505-10 8.209.		
25. If the Contractor extends the time frames, it must—for any extension not requested by the member: • Make reasonable efforts to give the member prompt oral notice of the delay. • Within two (2) calendar days, give the member written notice of the reason for the delay and inform the member of the right to file a grievance if he or she disagrees with that decision.	Please see CGA09-INS-MCDCHIP Section C.4	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. *42 CFR 438.408(c)(2)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209		
Findings: The *Member Appeals* policy did not include the provision that, if requested by DentaQuest, DentaQuest would give the member written notice within two business days of the reason for the delay and inform the member of the right to file a grievance if he or she disagrees with that decision. During the on-site record review, HSAG found one appeal case and two grievance cases in which the staff member processing the cases requested internally that an extension be allowed; however, no response from the supervisor was found in the documentation and no extension notice was provided the member.		
Required Actions: DentaQuest must develop and implement an effective mechanism to ensure, if the PAHP requires additional information and time to effectively process the appeal, a notice that includes the required content is provided to the member.		
26. The written notice of appeal resolution must include: • The results of the resolution process and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing, and how to do so. *42 CFR 438.408(e)* Contract: Exhibit B—4.3.8.3.5	Please see CO CHP appeal resolution - overturn	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: Although the appeal resolution letters reviewed on-site had language to address the required elements, the information (time frames and description of processes) was inaccurate and did not provide the members with the information needed.		
Required Actions: DentaQuest must develop and implement an effective mechanism to track appeal resolutions sent to ensure that members are provided accurate information in appeal resolution letters.		

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
27. The member may request a State fair hearing after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of resolution. • If the Contractor does not adhere to the notice and timing requirements regarding a member's appeal, the member is deemed to have exhausted the appeal process and may request a State fair hearing. *42 CFR 438.408(f)(1–2)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	Please see CGA09-INS-MCDCHIP Section D.4 Page 12	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: Although the policy language regarding the time frame for requesting a State fair hearing was accurate, in practice, members are not provided accurate information; therefore, this policy provision was not adequately operationalized. The Notice of Action (NABD) letter stated that the State fair hearing request is due 120 days following "this letter", i.e. the ABD. The member handbook stated that the State fair hearing is due 60 days following the ABD. In addition, the provision for deemed exhaustion is not addressed in the policy and the policy stated that a State fair hearing may be requested "by telephone, fax, or on-line."		
Required Actions: DentaQuest must revise policies, procedures, member and provider informational materials, and member communications templates to accurately inform members that the request for a State fair hearing must be in writing and is due within 120 days from the DentaQuest internal appeal notice of resolution.		
28. The parties to the State fair hearing include the Contractor as well as the member and his or her representative or the representative of a deceased member's estate. *42 CFR 438.408(f)(3)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	Please see CGA09-INS-MCDCHIP Section D.2	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The *Member Appeals* policy did not include the provision that parties to the State fair hearing include the representative of a deceased member's estate.		
Required Actions: DentaQuest must revise its policy and procedure to include the provision that parties to the State fair hearing include the representative of a deceased member's estate.		
29. The Contractor maintains records of all grievances and appeals. The records must be accurately maintained in a manner accessible to the State and available on request to CMS. The record of each grievance and appeal must contain, at a minimum, all of the following information: • A general description of the reason for the grievance or appeal. • The date received. • The date of each review or, if applicable, review meeting. • Resolution at each level of the appeal or grievance. • Date of resolution at each level, if applicable. • Name of the person for whom the appeal or grievance was filed. *42 CFR 438.416* Contract: 4.3.15.18.2 Reference: 10 CCR 2505-10 8.209	Please see CGA09-INS-MCDCHIP Section B.1 Page 9	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
30. The Contractor provides the information about the grievance, appeal, and State fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals.	Please see NET01-INS Section 7.a Page 3 Refers Providers to ORM for specified information Please see Office Reference Manual Page 4 States members rights and responsibilities	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. *42 CFR 438.414* *42 CFR 438.10(g)(xi)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209		
Findings: DentaQuest's Provider ORM included no information about the DentaQuest internal appeal process for CHP+ members. In addition, the ORM stated that reconsiderations must be requested within 10 calendar days from the Notice of Action; however, given the interchange within DentaQuest policies of the terms "appeal" and "reconsideration," it was unclear whether this refers to reconsideration of provider payment disputes or member appeals.		
Required Actions: DentaQuest must revise the ORM to clearly differentiate between provider processes, Medicaid member processes, and CHP+ member processes for appeals.		

Results for Standard VI—Grievances and Appeals							
Total	Met	=	4	X	1.00	=	4
	Partially Met	=	14	X	.00	=	0
	Not Met	=	12	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	30	**Total Score**		=	4
				Total Score ÷ Total Applicable		=	13%

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Denials Record Review Tool
for DentaQuest

Review Period:	January 1, 2019–December 31, 2019
Date of Review:	December 10–11, 2019
Reviewer:	Barbara McConnell and Gina Stepuncik
Participating Plan Staff Member(s):	Erica Monroe and Michaelle Schrank

Requirements	File 1	File 2	File 3	File 4	File 5
Member ID	****	****	****	****	****
Date of initial request	7/31/19		8/12/19	10/1/19	10/3/19
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR		NR	NR	NR
(Standard [S], Expedited [E], or Retrospective [R])	S		S	S	S
Date notice of adverse benefit determination (NABD) sent	8/6/19		8/16/19	10/2/19	10/6/19
Notice sent to provider and member? (M or NM)*	M		M	M	M
Number of days for decision/notice	6		4	1	3
Notice sent within required time frame? (M or NM) (S = 10 Cal days after; E = 72 hours after; T = 10 Cal days before)*	M		M	M	M
Was authorization decision timeline extended? (Y or N)	N		N	N	N
If extended, extension notification sent to member? (M, NM, or NA)*	NA		NA	NA	NA
If extended, extension notification includes required content? (M, NM, or NA)*	NA		NA	NA	NA
NABD includes required content? (M or NM)*	NM		NM	NM	NM
Authorization decision made by qualified clinician? (M, NM, or NA)*	M		M	M	M
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (M, NM, or NA)*	NA		NA	NA	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (M or NM)*	NM		M	M	M
Was correspondence with the member easy to understand? (M or NM)*	NM		NM	NM	NM
Total Applicable Elements	**6**		**6**	**6**	**6**
Total Met Elements	**3**		**4**	**4**	**4**
Score (Number Met / Number Applicable) = %	**50%**		**67%**	**67%**	**67%**

***** = Reference Denial Record Review Instructions for Corresponding Requirement in Compliance Monitoring Tool

M = Met, **NM** = Not Met, **NA** = Not Applicable, **Cal** = Calendar, **Y** = Yes, **N** = No (Yes and No = not scored—informational only)

**** = Redacted Member ID

Appendix B. Colorado Department of Health Care Policy and Financing FY 2019–2020 Denials Record Review Tool for DentaQuest

Requirements	File 6	File 7	File 8	File 9	File 10
Member ID	****	****	****	****	****
Date of initial request	10/15/19	10/17/19		11/6/19	11/13/19
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	NR		NR	NR
(Standard [S], Expedited [E], or Retrospective [R])	S	S		S	S
Date notice of adverse benefit determination (NABD) sent	10/16/19	10/22/19		11/10/19	11/13/19
Notice sent to provider and member? (M or NM)*	M	M		M	M
Number of days for decision/notice	1	5		4	0
Notice sent within required time frame? (M or NM) (S = 10 Cal days after; E = 72 hours after; T = 10 Cal days before)*	M	M		M	M
Was authorization decision timeline extended? (Y or N)	N	N		N	N
If extended, extension notification sent to member? (M, NM, or NA)*	NA	NA		NA	NA
If extended, extension notification includes required content? (M, NM, or NA)*	NA	NA		NA	NA
NABD includes required content? (M or NM)*	NM	NM		NM	NM
Authorization decision made by qualified clinician? (M, NM, or NA)*	M	M		M	M
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (M, NM, or NA)*	NA	NA		NA	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (M or NM)*	M	M		M	M
Was correspondence with the member easy to understand? (M or NM)*	NM	NM		NM	NM
Total Applicable Elements	**6**	**6**		**6**	**6**
Total Met Elements	**4**	**4**		**4**	**4**
Score (Number Met / Number Applicable) = %	**67%**	**67%**		**67%**	**67%**

***** = Reference Denial Record Review Instructions for Corresponding Requirement in Compliance Monitoring Tool

M = Met, **NM** = Not Met, **NA** = Not Applicable, **Cal** = Calendar, **Y** = Yes, **N** = No (Yes and No = not scored—informational only)

**** = Redacted Member ID

Appendix B. Colorado Department of Health Care Policy and Financing FY 2019–2020 Denials Record Review Tool for DentaQuest

Requirements	OS 1	OS 2	OS 3	OS 4	OS 5
Member ID	****	****			
Date of initial request	8/24/19	9/11/19			
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	NR			
(Standard [S], Expedited [E], or Retrospective [R])	S	S			
Date notice of adverse benefit determination (NABD) sent	8/27/19	9/11/19			
Notice sent to provider and member? (M or NM)*	M	M			
Number of days for decision/notice	3	0			
Notice sent within required time frame? (M or NM) (S = 10 Cal days after; E = 72 hours after; T = 10 Cal days before)*	M	M			
Was authorization decision timeline extended? (Y or N)	N	N			
If extended, extension notification sent to member? (M, NM, or NA)*	NA	NA			
If extended, extension notification includes required content? (M, NM, or NA)*	NA	NA			
NABD includes required content? (M or NM)*	NM	NM			
Authorization decision made by qualified clinician? (M, NM, or NA)*	M	M			
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (M, NM, or NA)*	NA	NA			
Was the decision based on established authorization criteria (i.e., not arbitrary)? (M or NM)*	M	M			
Was correspondence with the member easy to understand? (M or NM)*	NM	NM			
Total Applicable Elements	**6**	**6**			
Total Met Elements	**4**	**4**			
Score (Number Met / Number Applicable) = %	**67%**	**67%**			

***** = Reference Denial Record Review Instructions for Corresponding Requirement in Compliance Monitoring Tool

M = Met, **NM** = Not Met, **NA** = Not Applicable, **Cal** = Calendar, **Y** = Yes, **N** = No (Yes and No = not scored—informational only)

**** = Redacted Member ID

Comments:

All denial notices included the statement, "This decision about your benefits was based on 10 CCR 2505-3 (W)." A CHP+ member would not understand that this refers to Colorado regulations or understand how to look it up. 10 CCR 2505-3 (W) are regulations regarding CHP+ eligibility and a high-level list of covered and non-covered services. A simple statement that the criteria used are regulations regarding which services are covered by the CHP+ program would accomplish the goal in a manner more understandable for the member. In addition, all notices erroneously told the member that, if the member filed an appeal, the resolution time would be 20 calendar days (Colorado requirement is 10 working days). In addition, all records stated that, if the member is unhappy with the appeal decision, the filing time frame for a State fair hearing is 120 days from the notice of denial (NABD). The Colorado requirement for requesting a State fair hearing is 120 days from the appeal resolution letter. Finally, all notices told the member that an appeal of the decision would be acknowledged in writing in five business days; whereas, the Colorado requirement for acknowledging grievances and appeals is two business days.

File 1: The reason for the denial described in the NABD was that the member did not meet the medical necessity criteria. The benefit (nitrous oxide), however, was not a covered service under the CHP+ plan; therefore, an inaccurate reason for denial was given to the member.

File 2: This record was removed from the sample as DentaQuest did not provide the denial/ABD documentation. Records indicated that this member was not eligible for CHP+ services at the time of the request for services.

File 8: This record was removed from the sample as the file was not provided for review.

Total Record Review Score*	Total Applicable Elements:	Total Met Elements:	Total Record Review Score:
	60	39	65%

* Only requirements with an "*" in the tool were used to calculate the score. The total record review score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements.

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Grievance Record Review Tool
for DentaQuest

Review Period:	January 1, 2019–December 31, 2019
Date of Review:	December 10–11, 2019
Reviewer:	Barbara McConnell and Gina Stepuncik
Participating Health Plan Staff Member(s):	Erica Monroe and Michaelle Schrank

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame*	Decision Maker Not Previous Level	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
1	****	7/22/19	M ☒ N ☐ N/A ☐	7/31/19	9	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: The acknowledgement letter had an incorrect time frame for resolving the grievance. The acknowledgement letter informed the member that a decision would be made in 10 calendar days. The time frame allotted in Colorado is 15 working days. The member was frustrated because she was told by DentaQuest that the service requested was covered by DentaQuest; however, the dental office was requesting payment. The resolution letter stated that the payment had been denied because the provider was not in the DentaQuest network.										
2	****	8/15/19	M ☐ N ☒ N/A ☐	8/20/19	5	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☐ N ☒ N/A ☐	M ☒ N ☐ N/A ☐
Comments: No acknowledgement letter was sent. This was a grievance related to the perceived rudeness of the dental office staff members. The resolution letter stated that the complaints and grievance specialist spoke with the dental office and was told that no one was rude. The resolution was unresponsive to the member's needs.										
3	****	8/20/19	M ☐ N ☒ N/A ☐	9/18/19	15w + 8c	M ☐ N ☒	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: The acknowledgement letter was sent 8/23/19. This was three working days and out of compliance with the two-working day time frame. The resolution letter was sent past the 15-working day requirement, and no extension letter was sent.										
4	****	8/26/19	M ☐ N ☒ N/A ☐	9/5/19	10	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: There was no written acknowledgement.										
5	****	9/10/19	M ☒ N ☐ N/A ☐	9/18/19	8	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☐ N ☒ N/A ☐	M ☐ N ☒ N/A ☐
Comments: This member was having difficulty with the Web portal. The resolution letter quoted directions given to grievance staff members about directing members how to navigate the portal, which included the statement, "If you continue to have issues creating an account, our Customer Services Department will be able to assist you further." This was unresponsive to the member's needs as the member was calling to receive assistance. The directions provided were confusing and involved too many steps to provide in writing. In addition, the member grieved about not receiving their member ID and this was not addressed in the response to the member.										
6	****	9/27/19	M ☒ N ☐ N/A ☐	11/8/19	15w + 21c	M ☐ N ☒	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: The resolution letter was sent past the 15-working day required time frame. There was documentation in the record that an extension was requested internally, but no extension letter was sent to the member.										

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame*	Decision Maker Not Previous Level	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
7	****	11/5/19	M ☐ N ☒ N/A ☐	12/3/19	15w + 7c	M ☐ N ☒	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☐ N ☒ N/A ☐	M ☒ N ☐ N/A ☐
Comments: No acknowledgment letter was sent. The resolution letter was sent past the 15-working day required time frame. There was documentation in the record that an extension was requested internally, but no extension letter was sent to the member. This member was having trouble finding an in-network orthodontist in the area. The resolution letter was unresponsive to the member's needs. The letter indicated that, after a search was completed, no in-network orthodontist was found in the area. No alternatives (such as offer services out of network, or slightly farther away) were offered to meet the member's needs.										
General Comments: The full sample provided included seven records.										
Do not score shaded columns below.										
Column Subtotal of Applicable Elements			**7**			**7**	**7**	**0**	**7**	**7**
Column Subtotal of Compliant (Met) Elements			**3**			**4**	**7**	**NA**	**4**	**6**
Percent Compliant (Divide Met by Applicable)			**43%**			**57%**	**100%**	**NA**	**57%**	**86%**

Key: M = Met; N = Not Met
N/A = Not Applicable

Total Applicable Elements	**35**
Total Compliant (Met) Elements	**24**
Total Percent Compliant	**69%**

* Grievance timeline for resolution and notice sent is 15 working days (unless extended).
**Grievance resolution letter required content includes (1) results of the disposition/resolution process and (2) the date the disposition/resolution process was completed.

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Appeals Record Review Tool
for DentaQuest

Review Period:	January 1, 2019–December 31, 2019
Date of Review:	December 10–11, 2019
Reviewer:	Barbara McConnell and Gina Stepuncik
Participating Health Plan Staff Member(s):	Erica Monroe and Michaelle Schrank

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame*	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
1	****		M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments: This record was not provided. An oversample case was reviewed to replace it.											
2	****	8/27/19	M ☐ N ☐ N/A ☒	M ☐ N ☐ N/A ☒	M ☐ N ☐ N/A ☒	Yes ☐ No ☒	Yes ☐ No ☒	8/28/19	M ☒ N ☐	M ☐ N ☒	M ☐ N ☒
Comments: A separate appeal acknowledgement letter was not required as the resolution letter was sent within the two-working day acknowledgement time frame. The reason for the denial was that the waiting period for the service was not met. DentaQuest should have explained what the waiting period is and what that means. A member would not know this. The original denial letter included a description. HSAG recommends using similar language in the appeal resolution. This was handled as an administrative appeal; therefore, no clinical staff member was used for the decision. The resolution letter addressed the required elements; however, the time frames for acknowledgement and resolution were inaccurate.											
3	****	9/6/19	M ☐ N ☒ N/A ☐	M ☐ N ☐ N/A ☒	M ☐ N ☐ N/A ☒	Yes ☐ No ☒	Yes ☐ No ☒	9/11/19	M ☒ N ☐	M ☐ N ☒	M ☐ N ☒
Comments: No resolution letter was sent. The reason for the denial was that the waiting period for the service was not met. DentaQuest should have explained what the waiting period is and what that means. A member would not know this. The original denial letter included a description. HSAG recommends using similar language in the appeal resolution. This appeal was marked as a clinical appeal in the system, but was handled as an administrative appeal; therefore, no clinical staff member was used for the decision. The resolution letter addressed the required elements; however, the time frames for acknowledgement and resolution were inaccurate.											
4	****	9/9/19	M ☐ N ☒ N/A ☐	M ☐ N ☐ N/A ☒	M ☐ N ☐ N/A ☒	Yes ☐ No ☒	Yes ☐ No ☒	10/7/19	M ☐ N ☒	M ☐ N ☒	M ☐ N ☒
Comments: No resolution letter was sent. The reason for the denial was that the provider "is not active or no provider contract is in effect." These could be two different reasons and should be explained further. The description of the request and the reason contained a CPT code and description rather than an explanation in layman's terms and did not meet the 6th grade reading level requirement. The Colorado requirement for resolution of an appeal is 10 working days; DentaQuest did not meet this standard. This was handled as an administrative appeal. The resolution letter addressed the required elements; however, the time frames for acknowledgement and resolution were inaccurate.											
5	****	9/9/19	M ☐ N ☐ N/A ☒	M ☐ N ☐ N/A ☒	M ☐ N ☐ N/A ☒	Yes ☐ No ☒	Yes ☐ No ☒	9/11/19	M ☒ N ☐	M ☐ N ☒	M ☐ N ☒
Comments: The resolution date in the system was 9/11/19; however, the appeal resolution letter was dated 8/28/19 (prior to filing the appeal). The appeal was resolved within two working days of the receipt of the appeal; therefore, no separate acknowledgement letter was required. The reason for the denial was that the dentist was out of network; therefore, this was handled as an administrative denial. The description of the request and the reason contained a CPT code and description rather than an explanation in layman's terms and did not meet the 6th grade reading level requirement. The resolution letter addressed the required elements; however, the time frames for acknowledgement and resolution were inaccurate.											

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Appeals Record Review Tool
for DentaQuest

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame*	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
6	****	9/16/19	M ☐ N ☒ N/A ☐	M ☐ N ☐ N/A ☒	M ☐ N ☐ N/A ☒	Yes ☐ No ☒	Yes ☐ No ☒	9/19/19	M ☒ N ☐	M ☐ N ☒	M ☐ N ☒
Comments: No resolution letter was sent. The reason for the original denial was that the waiting period had not been met. The date of the original denial was 8/25/19 and the letter accurately informed the member that he had 60 calendar days to file the appeal. The appeal was filed in writing on 9/11/19. The member (parent) specifically indicated that the child had been a CHP+ member for three years without interruption in coverage. The reason for upholding the denial stated in the resolution letter was that the member did not appeal within 10 days of the original denial. The letter required the member to ask the provider to submit a new authorization request with documentation for review. The resolution letter addressed the required elements; however, the time frames for acknowledgement and resolution were inaccurate.											
7	****	9/26/19	M ☐ N ☒ N/A ☐	M ☐ N ☒ N/A ☐	M ☐ N ☒ N/A ☐	Yes ☐ No ☒	Yes ☐ No ☒	10/3/19	M ☒ N ☐	M ☐ N ☒	M ☐ N ☒
Comments: No acknowledgement letter was sent. The reason for the original denial was that the time period of anesthesia requested was not medically necessary and that the teeth removed did not need to be removed. The original decision was made by a D.D.S. The reason for the appeal decision (denial upheld) was "Untimely Appeal Submission." The appeal resolution letter stated that the member has 60 days to appeal and that the initial decision was 8/12/19 (original denial letter sent 8/13/19) and that the appeal was received 9/26/19; therefore, it was untimely and denied. The field for the DentaQuest staff member to enter the number of days was left blank. This appeal was filed 44 days following the date of the original denial letter; therefore, this was an inappropriate reason for denial. In addition, this appeal was processed administratively and did not receive a clinical review. The description of the request and the reason contained a CPT code and description rather than an explanation in layman's terms and did not meet the 6th grade reading level requirement. The resolution letter addressed the required elements; however, the time frames for acknowledgement and resolution were inaccurate.											
8	****	10/15/19	M ☐ N ☐ N/A ☒	M ☐ N ☐ N/A ☒	M ☐ N ☐ N/A ☒	Yes ☐ No ☒	Yes ☐ No ☒	10/17/19	M ☒ N ☐	M ☐ N ☒	M ☐ N ☒
Comments: A separate appeal acknowledgement letter was not required as the resolution letter was sent within the two-working day acknowledgement time frame. The reason for the original denial was that the member had not met the waiting period requirement. The written appeal from the member stated that the member had been receiving orthodontia services through CHP+ and that she found a CHP+ provider to perform the maintenance needed. The reason for the appeal decision (denial upheld) was that the provider was out of network. This appeal was processed administratively. The resolution letter addressed the required elements; however, the time frames for acknowledgement and resolution were inaccurate.											
9	****	10/28/19	M ☐ N ☒ N/A ☐	M ☐ N ☐ N/A ☒	M ☐ N ☐ N/A ☒	Yes ☐ No ☒	Yes ☐ No ☒	12/9/19	M ☐ N ☒	M ☐ N ☒	M ☐ N ☒
Comments: No acknowledgement letter was sent. The reason for the denial as stated in both the original denial letter and the appeal resolution letter was that the benefit is not covered under the benefit plan. This case was processed administratively; therefore, no clinical expertise was required. The Colorado requirement for resolution of an appeal is 10 working days. DentaQuest did not meet this standard. The resolution letter addressed the required elements; however, the time frames for acknowledgement and resolution were inaccurate. There was documentation in the record that the complaints and grievance specialist indicated to a supervisor that he would like to request an extension; however, no response from the supervisor was found and no extension letter was sent to the member. The description of the request and the reason contained a CPT code and description rather than an explanation in layman's terms and did not meet the 6th grade reading level requirement. The resolution letter addressed the required elements; however, the time frames for acknowledgement and resolution were inaccurate.											
10	****	11/13/19	M ☐ N ☒ N/A ☐	M ☐ N ☐ N/A ☒	M ☐ N ☐ N/A ☒	Yes ☐ No ☒	Yes ☐ No ☒	12/9/19	M ☐ N ☒	M ☐ N ☒	M ☐ N ☒
Comments: No acknowledgement letter was sent. The original reason for the denial was that the member had not met the waiting period. The member (guardian) stated in the appeal request that the member had been on CHP+ with Delta Dental and felt that a change in administrator should not trigger a denial for the wait requirement. The reason the denial was upheld was that the appeal request was untimely. The original denial was 7/31/19. The Colorado requirement for resolution of an appeal is 10 working days. DentaQuest did not meet this standard. The description of the request and the reason contained a CPT code and description rather than an explanation in layman's terms and did not meet the 6th grade reading level requirement. The resolution letter addressed the required elements; however, the time frames for acknowledgement and resolution were inaccurate.											

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Appeals Record Review Tool
for DentaQuest

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame*	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
OS1	****	9/9/19	M ☐ N ☒ N/A ☐	M ☐ N ☐ N/A ☒	M ☐ N ☐ N/A ☒	Yes ☐ No ☒	Yes ☐ No ☒	10/7/19	M ☐ N ☒	M ☐ N ☒	M ☐ N ☒
Comments: No resolution letter was sent. The reason for the original decision was that the provider was not in the network. The appeal resolution only stated as the reason the denial was upheld was "provider participation." This is not worded in a way that a member would understand. The description of the request and the reason contained a CPT code and description rather than an explanation in layman's terms and did not meet the 6th grade reading level requirement. The resolution letter addressed the required elements; however, the time frames for acknowledgement and resolution were inaccurate. The Colorado requirement for resolution of an appeal is 10 working days; DentaQuest did not meet this standard.											
Do not score shaded columns below.											
Column Subtotal of Applicable Elements			**7**	**1**	**1**				**10**	**10**	**10**
Column Subtotal of Compliant (Met) Elements			**0**	**0**	**0**				**6**	**0**	**0**
Percent Compliant (Divide Met by Applicable)			**0%**	**0%**	**0%**				**60%**	**0%**	**0%**

Key: M = Met; N = Not Met
N/A = Not Applicable
Yes; No = Not scored—information only

Total Applicable Elements	**39**
Total Compliant (Met) Elements	**6**
Total Percent Compliant	**15%**

***Appeal resolution letter time frame** does not exceed 10 working days from the day the health plan receives the appeal (unless expedited—three calendar days; or unless extended—+14 calendar days).

****Appeal resolution letter required content** includes (1) the result of the resolution process; (2) the date the resolution was completed; (3) if the appeal is not resolved wholly in favor of the member, the right to request a State fair hearing and how to do so; (4) if the appeal is not resolved wholly in favor of the member, the right to request that benefits/services continue while the hearing is pending, and how to make that request.

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2019–2020 site review of **DentaQuest**.

Table C-1—HSAG Reviewers and DentaQuest and Department Participants

HSAG Review Team	Title
Barbara McConnell	Executive Director
Gina Stepuncik	Associate Director
DentaQuest Participants	**Title**
Ashley Bergman	Utilization Management Auditing Coordinator
Erica Monroe	Quality Program Manager
Jeanine Rank	Operations Auditor Coordinator II
Jon Janovec	Manager of Business Processes, Quality Assurance
Lisa Larkin	Provider Relation Supervisor
Maureen Hartlaub	Contract Manager
Michaelle Schrank	Manager of Utilization Management, Appeal and Compliance
Rick Spencer	CHP+ Project Manager
Stacy Gammon	Utilization Management Auditing Coordinator
Department Observers	**Title**
Michelle Kohler	Dental Contract Plan Manager
Russ Kennedy	Quality and Compliance Specialist

Appendix D. Corrective Action Plan Template for FY 2019–2020

If applicable, the dental plan is required to submit a CAP to the Department for all elements within each standard scored as *Partially Met* or *Not Met*. The CAP must be submitted within 30 days of receipt of the final report. For each required action, the dental plan should identify the planned interventions and complete the attached CAP template. Supporting documents should not be submitted and will not be considered until the CAP has been approved by the Department. Following Department approval, the dental plan must submit documents based on the approved timeline.

Table D-1—Corrective Action Plan Process

Step	Action
Step 1	**Corrective action plans are submitted**
	If applicable, the dental plan will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final compliance site review report via email or through the file transfer protocol (FTP) site, with an email notification to HSAG and the Department. The dental plan must submit the CAP using the template provided. For each element receiving a score of *Partially Met* or *Not Met*, the CAP must describe interventions designed to achieve compliance with the specified requirements, the timelines associated with these activities, anticipated training and follow-up activities, and documents to be sent following the completion of the planned interventions.
Step 2	**Prior approval for timelines exceeding 30 days**
	If the dental plan is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing.
Step 3	**Department approval**
	Following review of the CAP, the Department and HSAG will: • Approve the planned interventions and instruct the dental plan to proceed with implementation, or • Instruct the dental plan to revise specific planned interventions and/or documents to be submitted as evidence of completion and also to proceed with implementation.
Step 4	**Documentation substantiating implementation**
	Once the dental plan has received Department approval of the CAP, the dental plan will have a time frame of 90 days (three months) to complete proposed actions and submit documents. The dental plan will submit documents as evidence of completion one time only on or before the three-month deadline for all required actions in the CAP. (If necessary, the dental plan will describe in the CAP document any revisions to the planned interventions that were required in the initial CAP approval document or determined by the dental plan within the intervening time frame.) If the dental plan is unable to submit documents of completion for any required action on or before the three-month deadline, it must obtain approval in writing from the Department to extend the deadline.

Step	Action
Step 5	**Technical Assistance**
	At the dental plan's request, HSAG will schedule an interactive, verbal consultation and technical assistance session during the three-month time frame. The session may be scheduled at the dental plan's discretion at any time the dental plan determines would be most beneficial. HSAG will not document results of the verbal consultation in the CAP document.
Step 6	**Review and completion**
	Following a review of the CAP and all supporting documentation, the Department or HSAG will inform the dental plan as to whether or not the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements. Any documentation that is considered unsatisfactory to complete the CAP requirements at the three-month deadline will result in a continued corrective action with a new date for completion established by the Department. HSAG will continue to work with the dental plan until all required actions are satisfactorily completed.

The CAP template follows.

Table D-2—FY 2019–2020 Corrective Action Plan for DentaQuest

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
1. The Contractor ensures that the services are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the services are furnished. *42 CFR 438.210(a)(3)(i)* Contract: Amendment 1—Exhibit G	Although policies and procedures articulated processes to monitor the provision of services to ensure the services are sufficient to respond to the needs of members, during the on-site review, it was evident that organizational practices were not in place to effectively implement these policies and procedures. HSAG found that many grievances, denials, and appeals were related to an insufficient network of providers and DentaQuest staff members stated that Denver-based staff members were not informed of the type or number of grievances or appeals.	Communication between the grievance and appeal staff members and the provider network staff members is imperative so the provider network staff members have an understanding of the extent of network issues, allowing them the ability to work with providers and members to solve the members' issues related to the insufficiency of the network. DentaQuest must develop a mechanism for interdepartmental communication so member grievances and appeals can be addressed in a way that meets the members' needs and meets the terms of the CHP+ contract.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
6. The Contractor and its subcontractors have in place mechanisms to ensure consistent application of review criteria for authorization decisions. *42 CFR 438.210(b)(2)(i)* Contract: Amendment 1—Exhibit G	During the review of denial records, HSAG found that, for one record, DentaQuest indicated the denial of service was due to the service being not medically necessary (as described in the letter to the member: the member was not in enough pain), when in fact, it is not a service authorized by DentaQuest to provide to members (the use of nitrous oxide in dental procedures) and the reason for the denial should have been listed as "not a covered benefit."	DentaQuest must ensure that the reasons for denying services in part or in whole are indicated accurately and consistently to members and providers.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
10. The Contractor adheres to the following time frames for making standard and expedited authorization decisions: • For standard authorization decisions—as expeditiously as the member's condition requires and not to exceed 10 calendar days following the receipt of the request for service. • If the provider indicates, or the Contractor determines, that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization determination and provides notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service. *42 CFR 438.210(d)(1–2)* Contract: Exhibit B—4.3.7.2.1.2 & 4.3.7.2.1.3	During the on-site record review, although HSAG found that all denial decisions reviewed were made within the required time frames, DentaQuest's Authorization Review policy stated that, "unless specified differently by the Plan or regulation" standard decisions are made within 14 calendar days. The policy had no Colorado-specific addendum to specify Colorado-specific time frames. Colorado's required time frame for standard pre-service authorization decisions is 10 calendar days following the receipt of the request for service.	DentaQuest must revise its Authorization Review policy and any other applicable policies and documents to depict Colorado-specific time frames for determinations related to a standard request for service.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
12. The notice of adverse benefit determination must be written in language easy to understand, available in prevalent non-English languages in the region, and available in alternative formats for persons with special needs. *42 CFR 438.404(a)* *42 CFR 438.10(c)* Contract: Exhibit B—None Reference: 10 CCR 2505-10 8.209	In the denial letters sent the members (NABD), HSAG found that DentaQuest listed a general CCR citation as criteria used in making the decision to deny the request for services, which was not specific to the denial in the member letter. Within the letter, DentaQuest did not explain the citation or the criteria in easy-to-understand language.	DentaQuest must either remove the CCR citation or provide additional language that is easy for the member to understand.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
13. The notice of adverse benefit determination must explain the following: • The adverse benefit determination the Contractor has made or intends to make. • The reasons for the adverse benefit determination, including the right of the member to be provided upon request (and free of charge), reasonable access to and copies of all documents, and records relevant to the adverse benefit determination (includes medical necessity criteria and strategies, evidentiary standards, or processes used in setting coverage limits). • The member's (or member's designated representative's) right to request one level of appeal with the Contractor and the procedures for doing so. • The member's right to request a State review after receiving an appeal resolution notice from the Contractor that the adverse benefit determination is upheld. • The procedures for exercising the right to request a State review.	HSAG reviewed DentaQuest's denial letter (NABD) and found that template language describing the appeal and State fair hearing processes included inaccurate time frames. Specifically, the time frame DentaQuest would acknowledge an appeal request was stated as five days instead of two days, the time frame for DentaQuest to make an appeal decision was stated as 20 days instead of 15 days, and it was not clear that the time frame for a member to submit a request for a State fair hearing started at the appeal decision letter date and not the NABD date.	DentaQuest must review the template language in its NABD to ensure that the information and timelines provided to members are accurate.

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
• The circumstances under which an appeal process can be expedited and how to make this request. *42 CFR 438.404(b)* Contract: Exhibit B—None Reference: 10 CCR 2505-10 8.209		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard II—Access and Availability		
Requirement	**Findings**	**Required Action**
1. The Contractor maintains and monitors a network of providers sufficient to provide access to all covered services to all members, including those with limited English proficiency or physical or mental disabilities. *42 CFR 438.206(b)(1)* Contract: Amendment 1—Exhibit G	At the time of the compliance review, DentaQuest described credentialing issues that were preventing the credentialing of a sufficient quantity of providers to meet the needs of the members. DentaQuest described efforts to forego credentialing efforts temporarily for providers that were previously aligned with Delta Dental's CHP+ line of business in order to expedite their privileges to provide dental care with DentaQuest. DentaQuest also described efforts to prioritize credentialing providers that were in the greatest demand, such as periodontists and oral surgeons in rural and frontier regions. Despite these efforts, grievances and appeals reviewed on-site indicated that members were not getting needed services despite indication that they were experiencing dental pain. Further, Colorado-based DentaQuest staff members stated that they were not apprised of grievances or appeals that had been filed, which indicated a lack of cohesion between the departments or oversight and monitoring of the provision of care to ensure Colorado CHP+ members were receiving covered services."	DentaQuest must ensure that providers are available in sufficient number, type, and specialty to furnish contracted services.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		

Standard II—Access and Availability		
Requirement	**Findings**	**Required Action**
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard II—Access and Availability		
Requirement	**Findings**	**Required Action**
5. If the provider network is unable to provide necessary covered services to a particular member in network, the Contractor must adequately and in a timely manner cover the services out of network for as long as the Contractor is unable to provide them. *42 CFR 438.206(b)(4)* Contract: Amendment 1—Exhibit G	Although DentaQuest's policies and procedures allowed for use of out-of-network providers, several grievances, denials, and appeals were due to out-of-network providers requesting the service. During the on-site interviews, DentaQuest staff members acknowledged difficulty with credentialing providers from the previous Delta Dental network in a timely manner. Many cases reviewed on-site were members that had been previously seen by Delta Dental providers under the CHP+ program. In addition, there was no evidence provided of direction given to the utilization management staff members to allow out-of-network providers to furnish services until such time that the DentaQuest provider network is sufficient.	DentaQuest must develop a mechanism to allow out-of-network providers to furnish services under the CHP+ contract with the Department for as long as it is unable to provide the services.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard II—Access and Availability		
Requirement	**Findings**	**Required Action**
6. The Contractor requires out-of-network providers to coordinate with the Contractor for payment and ensures that the cost to the member is no greater than it would be if the services were furnished within the network. *42 CFR 438.206(b)(5)* Contract: Amendment 1—Exhibit G	DentaQuest provided no evidence of having a mechanism to make arrangements with out-of-network providers for claims submissions and payment or to ensure that members are not charged more than if the services are provided by the network.	DentaQuest must develop a mechanism to coordinate with the out-of-network providers for payment and to ensure that the cost to the member is no greater than it would be if the services were furnished within the network. For example, a single case agreement contract template could be developed to inform out-of-network providers of claims and payment procedures as well as the prohibition of balance billing members.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard II—Access and Availability		
Requirement	**Findings**	**Required Action**
10. The Contractor ensures timely access by: • Establishing mechanisms to ensure compliance with access (e.g., appointment) standards by network providers. • Monitoring network providers regularly to determine compliance. • Taking corrective action if there is failure to comply. *42 CFR 438.206(c)(1)(iv)–(vi)* Contract: Amendment 1—Exhibit G	DentaQuest had a process in place for monitoring compliance with timely access standards for other states; however, DentaQuest had not yet begun monitoring its Colorado CHP+ market to ensure providers were compliant with timely access standards.	DentaQuest must ensure timely access by: establishing mechanisms to ensure compliance with access (e.g., appointment) standards by network providers, monitoring network providers regularly to determine compliance, and taking corrective action if there is failure to comply.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
3. The Contractor defines an "appeal" as a review by the Contractor of an adverse benefit determination. *42 CFR 438.400(b)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	Although the definitions section of the *Member Appeals* policy depicted the correct definition of "appeal," the rest of the policy interchanged the terms "appeal," "reconsideration," and "grievance." During the on-site interview, Complaints and Grievance Department staff members were unable to clearly articulate an understanding of the difference between a grievance, a member appeal, and a provider reconsideration (based on technical issues, i.e., coding or timeliness of claims).	DentaQuest must develop and implement a grievance and appeal staff training module that accurately reflects federal definitions related to the Grievance and Appeal System.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
4. The Contractor defines a "grievance" as an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. A grievance includes a member's right to dispute an extension of time proposed by the Contractor to make an authorization decision. *42 CFR 438.400(b)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	Although the definitions section of the *Member Complaints/Grievances* policy depicted the correct definitions of "complaints" and "grievances," the policy also referred to appeals as "grievances" and, during the on-site interview, Complaints and Grievance Department staff members were unable to clearly articulate an understanding of the difference between a grievance and an appeal. In addition, the policy indicated that, if the matter was resolved within the initial call, it would be considered an inquiry rather than a grievance.	DentaQuest must develop and implement a grievance and appeal staff training module that accurately reflects federal definitions related to the Grievance and Appeal System. DentaQuest must also ensure that, if there is an expression of dissatisfaction, the interaction must be treated and logged as a grievance to ensure accurate information for quality improvement purposes.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
5. The Contractor has provisions for who may file: • A member may file a grievance or a Contractor-level appeal and may request a State fair hearing. • With the member's written consent, a provider or authorized representative may file a grievance or a Contractor-level appeal and may request a State fair hearing on behalf of a member. *42 CFR 438.402(c)* Contract: Exhibit B—4.3.8.3.2, 4.4.1.2 Reference: 10 CCR 2505-10 8.209	The authority to file appeals and request State fair hearings was adequately addressed in the *Member Appeals* policy. The authority to file grievances was adequately addressed in the *Member Complaints/Grievances* policy. The requirement of member written consent to file on behalf of the member was addressed within the *Member Appeals* policy, but not adequately addressed within the *Member Complaints/Grievances* policy. During the on-site review, DentaQuest staff members stated that DentaQuest does not require the member's written consent for providers or other authorized representatives to file on the member's behalf.	DentaQuest must revise the *Member Complaints/Grievances* policy to address the requirement that providers and authorized representatives may file an appeal or grievance and may request a State fair hearing on behalf of the member with the member's written consent. DentaQuest must also develop and implement an effective mechanism to ensure that members are afforded the right to provide consent for authorized representatives to file an appeal on their behalf.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
6. In handling grievances and appeals, the Contractor must give members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, as well as providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability. *42 CFR 438.406(a)(1)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	Neither the *Member Appeals* policy nor the *Member Complaints/Grievances* policy addressed member assistance in filing grievances or appeals. The grievance acknowledgement template letter offered TTY assistance. The Non Discrimination notice attached to the appeal and grievance acknowledgement letter templates offered language assistance, sign language, and written information in other formats, then refers to the website to get the phone number to ask for these services. It is important to note, however, that only three of the seven grievances reviewed, and zero of the 10 appeal records reviewed contained evidence that an acknowledgement letter was sent. The Notice of Action (NABD) letters reviewed contained the Non Discrimination notice.	DentaQuest must revise applicable policies and procedures and develop and implement effective mechanisms to provide members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, as well as providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
7. The Contractor ensures that the individuals who make decisions on grievances and appeals are individuals who: • Were not involved in any previous level of review or decision-making nor a subordinate of any such individual. • Have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if deciding any of the following: – An appeal of a denial that is based on lack of medical necessity. – A grievance regarding the denial of expedited resolution of an appeal. – A grievance or appeal that involves clinical issues. *42 CFR 438.406(b)(2)* Contract: Exhibit B—4.3.8.3.3, 4.4.1.2Reference: 10 CCR 2505-10 8.209	Both the *Member Appeals* policy and *Member Complaints/Grievances* policy stated the requirement that the individuals who make decisions on grievances and appeals are individuals who have the appropriate clinical expertise and were not involved in a previous level of review. In the appeals record review, however, there were cases in which the original denial was a clinical review, but the appeal was denied inappropriately for untimely filing rather than providing a clinical review to decide the appeal.	DentaQuest must develop and implement effective training for Complaints and Grievance Department staff members to ensure that staff members understand the federal managed care regulations and Colorado's State-specific time frames so members receive accurate information and may execute their rights to receive services.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
8. The Contractor ensures that the individuals who make decisions on grievances and appeals: • Take into account all comments, documents, records, and other information submitted by the member or the member's representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. *42 CFR 438.406(b)(2)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	Both the *Member Appeals* policy and *Member Complaints/Grievances* policy included language that DentaQuest will ensure all comments, records, and documents will be considered when deciding the appeal. During the on-site interview, staff members described a process whereby any information is placed in a folder for the decision maker to access. However, in several appeal records reviewed, there was evidence that the parent provided information to the Complaints and Grievance specialist that was not acknowledged or considered during the administrative processing of the appeal.	DentaQuest must develop and implement a process to ensure that all comments, documents, records, and other information submitted by the member or the member's representative is considered when deciding the appeal without regard to whether such information was submitted or considered in the initial ABD.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
9. The Contractor accepts grievances orally or in writing. *42 CFR 438.402(c)(3)(i)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	While the *Member Complaints/Grievances* policy included the provision that DentaQuest accepts grievances orally or in writing, the member handbook was misleading by stating that, if the customer relations department is unable to address the problem, the member can write a detailed letter and can expect prompt action if the information is submitted in writing.	DentaQuest must revise member communications to ensure that members understand that grievances are not required to be in writing to expect response.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
11. The Contractor sends the member written acknowledgement of each grievance within two (2) working days of receipt. *42 CFR 438.406(b)(1)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	The *Member Complaints/Grievances* policy stated that grievance acknowledgement would be sent within the "specified regulatory time frame." During the on-site interviews, staff members reported that internal desktop procedures state that acknowledgements are sent within five days. The on-site record review revealed that acknowledgement letters were sent in only three of seven cases reviewed.	DentaQuest must develop and implement effective training for Complaints and Grievance Department staff members to ensure that staff members understand the federal managed care regulations and Colorado's State-specific time frames for sending written acknowledgement of grievances. DentaQuest must also develop and implement an effective tracking mechanism to ensure compliance with the time frames for sending written grievance acknowledgement.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
12. The Contractor must resolve each grievance and provide notice as expeditiously as the member's health condition requires, and within 15 working days of when the member files the grievance. • Notice to the member must be in a format and language that may be easily understood by the member. *42 CFR 438.408(a) and (b)(1) and (d)(1)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	The *Member Complaints/Grievances* policy stated that grievance resolution would be sent within 30 calendar days from the receipt of the grievance. During the on-site interviews, staff members reported following internal desktop procedures. The on-site record review revealed that four of seven grievance resolutions were sent within the required time frame.	DentaQuest must develop and implement effective training for Complaints and Grievance Department staff members to ensure that staff members understand the federal managed care regulations and Colorado's State-specific time frames for sending grievance resolution notices. DentaQuest must also develop and implement an effective tracking mechanism to ensure compliance with the time frames for sending grievance resolution notices.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
13. The written notice of grievance resolution includes: • Results of the disposition/resolution process and the date it was completed. Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	The *Member Complaints/Grievances* policy adequately described requirements for the content of grievance resolution notices; however, it also described other content more appropriate for an appeal resolution letter. During the on-site record review, HSAG found that the notices did not consistently include information that was responsive to the members' needs.	DentaQuest must revise its policies and procedures to accurately describe the content of the grievance resolution notices. DentaQuest must also develop and implement effective training for Complaints and Grievance Department staff members to ensure understanding of grievance resolution content requirements. HSAG recommends that Complaints and Grievance Department staff members be required to attend basic customer service training.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
14. The Contractor may have only one level of appeal for members. *42 CFR 438.402(b)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	Although the *Member Appeals* policy included requirement language about one level of appeal, the policy and the member handbook also indicated that a second-level appeal could be requested.	DentaQuest must revise its policies and procedures to accurately describe the internal appeals process. DentaQuest must also develop and implement effective training for Complaints and Grievance Department staff members to ensure understanding of the regulations at 42 CFR 438.400–424 and 10 CCR 2505-10 8.209.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
15. A member may file an appeal with the Contractor within 60 calendar days from the date on the adverse benefit determination notice. *42 CFR 438.402 (c)(2)(ii)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	While the *Member Appeals* policy stated that members have 60 days to file an appeal, the on-site record review revealed that staff members did not consistently operationalize this standard. In two appeal cases, the communication to the member stated that DentaQuest would not process the appeal due to untimely filing. In one letter, the filing time frame was stated as 10 days. In another letter, the filing time frame was accurately depicted as 60 days; however, the member had filed the appeal in 44 days and the appeal was denied for untimely filing. In both cases, the member had filed the appeal within the required time frame.	DentaQuest must develop and implement effective training for Complaints and Grievance Department staff members to ensure understanding of the regulations at 42 CFR 438.400–424 and 10 CCR 2505-10 8.209.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
16. The member may file an appeal either orally or in writing and must follow the oral request with a written, signed appeal (unless the request is for expedited resolution). *42 CFR 438.402(c)(3)(ii)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	Although the *Member Appeals* policy included the required provision that members must follow an oral appeal with a written appeal, the Notice of Action letters reviewed on-site we unclear and stated, "we may ask you to also send it in writing." During the on-site interview, DentaQuest's Complaints and Grievance Department staff members were unable to clearly articulate the requirement, or what is being done in practice by DentaQuest.	DentaQuest must develop and implement effective training for Complaints and Grievance Department staff members to ensure understanding of the regulations at 42 CFR 438.400–424 and 10 CCR 2505-10 8.209. In addition, communication to members regarding the requirement to follow an oral appeal with a written signed appeal must be clear and not require a second communication to inform the member that a written signed appeal is required.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
17. The Contractor sends written acknowledgement of each appeal within two (2) working days of receipt, unless the member or designated client representative requests an expedited resolution. *42 CFR 438.406(b)(1)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	The *Member Appeals* policy stated that appeal acknowledgement letters will be sent by DentaQuest within five business days of the receipt of the appeal. In addition, HSAG found no appeal acknowledgement letters in the 10 appeal records reviewed on-site.	DentaQuest must develop and implement a mechanism to track and ensure that acknowledgement letters are sent within the two-working day required time frame.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
18. The Contractor's appeal process must provide: • That oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date) and must be confirmed in writing unless the member or provider requests expedited resolution. • That if the member orally requests an expedited appeal, the Contractor shall not require a written, signed appeal following the oral request. • That included, as parties to the appeal, are: – The member and his or her representative, or – The legal representative of a deceased member's estate. *42 CFR 438.406(b)(3) and (6)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	The *Member Appeals* policy did not address the provision that oral inquiries seeking to appeal an ABD are treated as appeals (to establish the earliest possible filing date), or that parties to the appeal include the representative of a deceased member's estate. During the on-site interview, staff members were unable to clearly articulate which date the Complaints and Grievance specialist uses to calculate compliance with the time frame for resolution of the appeal.	DentaQuest must revise policies and procedures to include the provisions that oral inquiries seeking to appeal an ABD are treated as appeals (to establish the earliest possible filing date), and that parties to the appeal include the representative of a deceased member's estate. DentaQuest must also develop and implement effective staff training to ensure that staff members responsible for processing appeals understand the federal managed care requirements at 42 CFR 438.400–424 and 10 CCR 2505-10 8.209.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
19. The Contractor's appeal process must provide: • The member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. (The Contractor must inform the member of the limited time available for this sufficiently in advance of the resolution time frame in the case of expedited resolution.) • The member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional documents considered, relied upon, or generated by the Contractor in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the appeal resolution time frame. *42 CFR 438.406(b)(4-5)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	The *Member Appeals* policy addressed the provision to allow the member the right to review documents and records and present evidence or testimony; however, there was no provision in the policy that addressed informing the member of the limited time available to do so in the case of an expedited review. During the on-site review, there was no clear process articulated to provide evidence of operationalizing this provision. The policy stated that the case file is sent with the acknowledgement letter; however, DentaQuest staff members confirmed on-site that this did not occur. The appeal acknowledgement template included language to inform the member of the right to provide additional information and to review records; however, in practice, HSAG found that no appeal acknowledgement letters were sent in any of the 10 cases reviewed for the record review.	DentaQuest must develop a mechanism to ensure that members are afforded the right to provide additional evidence or testimony and to receive documents and records upon request at no charge.
Planned Interventions:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
20. The Contractor maintains an expedited review process for appeals when the Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life; physical or mental health; or ability to attain, maintain, or regain maximum function. The Contractor's expedited review process includes that: • The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. *42 CFR 438.410(a–b)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	The *Member Appeals* policy described an expedited appeal process; however, it did not include the provision to ensure that punitive action cannot be taken against providers who request an expedited resolution or support a member's appeal.	DentaQuest must revise its policies and procedures to accurately describe all required provisions of expedited review of appeals as required at 42 CFR 438.410 and 10 CCR 2505-10 8.209.4.R.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
21. If the Contractor denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the time frame for standard resolution. • Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and within two (2) calendar days provide the member written notice of the reason for the decision and inform the member of the right to file a grievance if he or she disagrees with that decision. *42 CFR 438.410(c)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	The *Member Appeals* policy did not address denial of expedition. None of the appeals reviewed on-site were processed as expedited.	DentaQuest must revise its policies and procedures to accurately describe all required provisions of expedited review of appeals as required at 42 CFR 438.410 and 10 CCR 2505-10 8.209.4.S.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
22. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR 438.408(b)(2)* *42 CFR 438.408(d)(2)* *42 CFR 438.10* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	The *Member Appeals* policy depicted the appeal resolution time frame as 20 calendar days. Six of the 10 appeal records reviewed on-site were resolved with notice sent within the required time frame.	DentaQuest must develop and implement an effective training to ensure staff members who process appeals understand the federal managed care regulations and State-required timelines at 10 CCR 2505-10 8.209. Policies and procedures and associated template member communications must be revised to reflect the required time frame. DentaQuest must also develop and implement an effective mechanism to track content of member communications for accuracy.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
23. For expedited appeal, the Contractor must resolve the appeal and provide written notice of disposition to affected parties within 72 hours after the Contractor receives the appeal. • For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. *42 CFR 438.408(b)(3) and (d)(2)(ii)* Contract: Exhibit B—4.3.8.3.4, 4.4.1.2	The *Member Appeals* policy stated that a verbal notice would be provided to members within 72 hours of a request for expedited review of an appeal and that a written notice would be sent within 24 hours following the verbal notice.	DentaQuest must develop a mechanism to ensure that written notice of the resolution of an expedited appeal is sent within 72 hours and that reasonable efforts to provide oral notice of the resolution also occurs within the 72-hour time frame.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
24. The Contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if: • The member requests the extension; or • The Contractor shows (to the satisfaction of the Department, upon request) that there is a need for additional information and how the delay is in the member's interest. *42 CFR 438.408(c)(1)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	Although the *Member Appeals* policy included extension language, the provision in the policy was inadequate, and staff members, during the on-site review, were unable to articulate whether this policy provision was operationalized. For grievance extensions, HSAG found no policy provisions and during the on-site interview, Complaints and Grievance Department staff members reported that they believed no extension was allowed for grievances.	DentaQuest must revise its policies and procedures to include all required provisions related to extending the time frames for resolution of grievances and appeals. DentaQuest must also develop and implement an effective training to ensure staff members who process appeals understand the federal managed care regulations and State-required timelines at 10 CCR 2505-10 8.209.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
25. If the Contractor extends the time frames, it must—for any extension not requested by the member: • Make reasonable efforts to give the member prompt oral notice of the delay. • Within two (2) calendar days, give the member written notice of the reason for the delay and inform the member of the right to file a grievance if he or she disagrees with that decision. • Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. *42 CFR 438.408(c)(2)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	The *Member Appeals* policy did not include the provision that, if requested by DentaQuest, DentaQuest would give the member written notice within two business days of the reason for the delay and inform the member of the right to file a grievance if he or she disagrees with that decision. During the on-site record review, HSAG found one appeal case and two grievance cases in which the staff member processing the cases requested internally that an extension be allowed; however, no response from the supervisor was found in the documentation and no extension notice was provided the member.	DentaQuest must develop and implement an effective mechanism to ensure, if the PAHP requires additional information and time to effectively process the appeal, a notice that includes the required content is provided to the member.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
26. The written notice of appeal resolution must include: • The results of the resolution process and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing, and how to do so. *42 CFR 438.408(e)* Contract: Exhibit B—4.3.8.3.5	Although the appeal resolution letters reviewed on-site had language to address the required elements, the information (time frames and description of processes) was inaccurate and did not provide the members with the information needed.	DentaQuest must develop and implement an effective mechanism to track appeal resolutions sent to ensure that members are provided accurate information in appeal resolution letters.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
27. The member may request a State fair hearing after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of resolution. • If the Contractor does not adhere to the notice and timing requirements regarding a member's appeal, the member is deemed to have exhausted the appeal process and may request a State fair hearing. *42 CFR 438.408(f)(1–2)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	Although the policy language regarding the time frame for requesting a State fair hearing was accurate, in practice, members are not provided accurate information; therefore, this policy provision was not adequately operationalized. The Notice of Action (NABD) letter stated that the State fair hearing request is due 120 days following "this letter", i.e. the ABD. The member handbook stated that the State fair hearing is due 60 days following the ABD. In addition, the provision for deemed exhaustion is not addressed in the policy and the policy stated that a State fair hearing may be requested "by telephone, fax, or on-line."	DentaQuest must revise policies, procedures, member and provider informational materials, and member communications templates to accurately inform members that the request for a State fair hearing must be in writing and is due within 120 days from the DentaQuest internal appeal notice of resolution.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
28. The parties to the State fair hearing include the Contractor as well as the member and his or her representative or the representative of a deceased member's estate. *42 CFR 438.408(f)(3)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	The *Member Appeals* policy did not include the provision that parties to the State fair hearing include the representative of a deceased member's estate.	DentaQuest must revise its policy and procedure to include the provision that parties to the State fair hearing include the representative of a deceased member's estate.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
30. The Contractor provides the information about the grievance, appeal, and State fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. *42 CFR 438.414* *42 CFR 438.10(g)(xi)* Contract: Exhibit B—4.4.1.2 Reference: 10 CCR 2505-10 8.209	DentaQuest's Provider ORM included no information about the DentaQuest internal appeal process for CHP+ members. In addition, the ORM stated that reconsiderations must be requested within 10 calendar days from the Notice of Action; however, given the interchange within DentaQuest policies of the terms "appeal" and "reconsideration," it was unclear whether this refers to reconsideration of provider payment disputes or member appeals.	DentaQuest must revise the ORM to clearly differentiate between provider processes, Medicaid member processes, and CHP+ member processes for appeals.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		

Standard VI—Grievances and Appeals		
Requirement	**Findings**	**Required Action**
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Appendix E. Compliance Monitoring Review Protocol Activities

The following table describes the activities performed throughout the compliance monitoring process. The activities listed below are consistent with CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the site review to assess compliance with federal managed care regulations and contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, on-site agendas; and set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all site reviewers to ensure consistency in scoring across plans.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided group technical assistance and training, as needed. • Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the dental plan in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the three standards and on-site activities. Thirty days prior to the review, the dental plan provided documentation for the desk review, as requested. • Documents submitted for the desk review and on-site review consisted of the completed desk review form, the compliance monitoring tool with the dental plan's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The dental plan also submitted a list of all denials of authorization of services (denials), grievances, and appeals records that occurred between July 1, 2019, and December 31, 2019 (to the extent available at the time of the site visit). HSAG used a random sampling technique to select records for review during the site visit. • The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.

For this step,	HSAG completed the following activities:
Activity 3:	**Conduct Site Visit**
	• During the on-site portion of the review, HSAG met with the dental plan's key staff members to obtain a complete picture of the dental plan's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the dental plan's performance. • HSAG reviewed a sample of administrative records to evaluate implementation of managed care regulations related to denials, grievances, and appeals. • While on-site, HSAG collected and reviewed additional documents as needed. • At the close of the on-site portion of the site review, HSAG met with dental plan staff and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2019–2020 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities. • HSAG analyzed the findings. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the Department**
	• HSAG populated the report template. • HSAG submitted the draft site review report to the dental plan and the Department for review and comment. • HSAG incorporated the dental plan's and Department's comments, as applicable, and finalized the report. • HSAG distributed the final report to the dental plan and the Department.