Fiscal Year 2020–2021 Site Review Report

for

DentaQuest

March 2021

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 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 (the 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, Title 42 (42 CFR)—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) 2020–2021 was January 1, 2020, through December 31, 2020. This report documents results of the FY 2020–2021 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 FY 2020–2021 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2019–2020 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for both the grievance and appeal record reviews. Appendix C lists HSAG, **DentaQuest**, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan (CAP) process the PAHP plan will be required to complete for FY 2020–2021 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) External Quality Review (EQR) *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.[1-1]

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: July 15, 2020.

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

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
V. Member Information Requirements	20	19	12	7	0	1	63%
VI. Grievance and Appeal Systems	34	34	25	9	0	0	74%
VII. Provider Participation and Program Integrity	16	15	13	2	0	1	87%
IX. Subcontractual Relationships and Delegation	4	4	4	0	0	0	100%
Totals	**74**	**72**	**54**	**18**	**0**	**2**	**75%**

*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 grievance and appeal 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)
Grievances	60	50	47	3	10	94%
Appeals	60	58	49	9	2	84%
Totals	**120**	**108**	**96**	**12**	**12**	**89%**

*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 V—Member Information Requirements

Summary of Strengths and Findings as Evidence of Compliance

DentaQuest used a variety of mechanisms to assist members in understanding the benefits and services available. **DentaQuest** established a health literacy policy requiring the use of plain language, cultural and linguistic appropriateness, and a sixth-grade reading level to guide the development of member information materials. Following new member enrollment, **DentaQuest** sent each member a welcome letter, identification cards, a member handbook, a nondiscrimination notice, and an education document that contained instructions for using the member Web portal. According to policy, materials were mailed within seven days of new member enrollment.

Materials for members were available on the **DentaQuest** website. The member handbook was available for download and the portable document format (PDF) passed the accessibility test for machine readability. **DentaQuest**'s website offered adjustable text size and a Spanish language option. **DentaQuest**'s provider directory was available to members through the member website. The provider directory contained a search function, and the provider list was available for download.

DentaQuest's member handbook format was easily understood and contained essential benefit summary information. The handbook included the availability of written materials in prevalent non-English languages, along with information on how to access alternative formats, translation services, and auxiliary aids and services for members with special needs free of charge. **DentaQuest**'s *Member Communications Distribution* policy indicated enrollees are notified within 30 days of significant changes in benefits; automated calls to enrollees were initiated to convey information about the changes.

Summary of Findings Resulting in Opportunities for Improvement

While **DentaQuest** included information on translation services, alternative formats, and auxiliary services in the member handbook, HSAG recommends modifying the member handbook table of contents to more clearly convey the location of this information to members. HSAG also recommends adding information regarding the waiting period for CHP+ dental benefits to the member handbook.

HSAG conducted an accessibility check on a few **DentaQuest** webpages using the Web Accessibility Evaluation (WAVE) tool. Through the use of this tool, HSAG discovered several general accessibility and contrast errors on various webpages. **DentaQuest** stated a vendor is working to implement this process. HSAG recommends that **DentaQuest** implement a mechanism to ensure regular website accessibility testing and error correction following identification.

Definitions for managed care terminology were available in **DentaQuest**'s *CHP+ Office Reference Manual* (ORM). When comparing selected Department managed care definitions to the ORM definitions, HSAG found inconsistencies between the Department and ORM definitions. HSAG recommends that **DentaQuest** review the definitions listed in the ORM and revise as needed to improve

consistency with the contract definitions used by the Department. HSAG further recommends adding the definitions of "grievance," "appeal," and "adverse benefit determination" to the member handbook.

Summary of Required Actions

HSAG found that many sections of **DentaQuest**'s welcome letter and member handbook were in the correct font size; however, the toll-free and Teletype/Telecommunications Device for the Deaf (TTY/TDD) customer service numbers in the welcome letter and the member handbook require a tagline written in large font. The benefits section of the handbook was written in a smaller font than required. **DentaQuest** must correct the tagline and font sizes in the member handbook and welcome letter.

While **DentaQuest**'s *Member Communications Distribution* policy included information about electronic materials availability in paper form, an incorrect time frame was listed (seven business days) and should be corrected, and members must be informed of the paper document availability and time frame. **DentaQuest** must develop a mechanism to notify members that electronic information is available in paper form without charge upon request and is provided within five business days.

Although **DentaQuest** has a policy regarding the 15-day member notification of provider terminations, there was no evidence available to indicate a process for doing so was in place. **DentaQuest** must establish a mechanism to inform members of provider termination within 15 days of the termination notice.

While **DentaQuest** included a list of member rights in the member handbook, the list did not contain all of the required language. **DentaQuest** must ensure all of the required member rights are listed in the member handbook and ensure the member rights listed in the handbook and the member rights accessible through the Dental Program Rights and Responsibilities link on the website are consistent.

The member handbook did not include a statement regarding member liability for the cost of continued benefits during the appeal process (if the appeal decision is adverse to the member) and lacked complete information regarding the requirements and time frames for filing a grievance or appeal. The member handbook's section about appeals referenced claims appeals only. **DentaQuest** must add to the member handbook a statement that if benefits continue during the appeal or State fair hearing (SFH) process, the member may be required to pay the cost of services while the appeal or SFH is pending if the final decision is adverse to the member. In addition, **DentaQuest** must include complete information in the member handbook regarding the requirements and time frames for filing grievances and appeals. **DentaQuest** is also required to modify the member handbook language to clarify that the appeal process is not limited to denied claims.

Although **DentaQuest** included information in the member handbook about seeking emergency services, it did not include a statement that prior authorization is not required for emergency services or the fact that the member has the right to use any hospital or other setting for an emergency. **DentaQuest** must revise member handbook language to inform the member that prior authorization is not required for emergency services, and that the member has the right to seek services from any dental or emergency provider to obtain emergency care if needed.

DentaQuest's member handbook did not include information regarding how and where to access benefits available under the State plan but not covered under the CHP+ contract, a specific reference for the toll-free number for medical management or other units providing services directly to members, or information on how to report suspected fraud or abuse. **DentaQuest** must add information to the member handbook regarding how and where to access information about other healthcare services that are available under the State plan, but not covered under the CHP+ managed care contract, such as a link to the Department of Health Care Policy and Financing website section containing other types of benefit information. **DentaQuest** must also add information to the member handbook instructing members how to report suspected fraud or abuse and add the telephone number to contact medical management and any other departments that provide services for members.

Standard VI—Grievance and Appeal Systems

Summary of Strengths and Findings as Evidence of Compliance

DentaQuest outlined its organizational structure for managing grievances and appeals, and described a dedicated department located in Milwaukee, Wisconsin, that processes both grievances and appeals. **DentaQuest** assigned staff members to particular states to increase their understanding of state-specific timelines and requirements. **DentaQuest** also cross-trained staff members so they were able to process both grievances and appeals. **DentaQuest** processed all complaints as grievances unless a service denial was involved; denied services were processed as appeals.

DentaQuest updated policies, procedures, and member communications to address Colorado-specific timelines and to correct federal definitions through work on a CAP during calendar year (CY) 2020, based on Department and HSAG feedback and direction from the previous FY 2019–2020 compliance audit.

DentaQuest used a data system to document grievance and appeal information, which included notes, calls, due dates, and correspondence from members as well as **DentaQuest** staff members. Grievance audit results demonstrated that all grievance acknowledgment letters reviewed were sent within two working days, and that all resolution letters were easy to understand. Both the grievance and appeal resolution letters included the required content.

HSAG identified one record in which **DentaQuest** reviewed a standard appeal request to determine if an expedited appeal was necessary based on the member's report of pain. **DentaQuest** staff members reported that as part of their procedure, the report of pain triggered further evaluation to determine if an expedited appeal process was appropriate to meet the member's needs.

Summary of Findings Resulting in Opportunities for Improvement

While policies and procedures reflected the accurate Colorado timelines for grievances and appeal acknowledgement and resolutions, and **DentaQuest** staff members reported that training had occurred during the review period, there were isolated instances of appeal resolutions that were out of compliance

for timeliness after the reported date of complaint, grievance, and appeal (CGA) training. HSAG recommends ongoing periodic training on Colorado-specific timelines and/or enhanced auditing of Colorado records during the next FY.

While **DentaQuest** staff members accurately considered complaints to be the same as grievances, since some documents used the term "complaint" and others, "grievance," HSAG recommends defining both terms and selecting one to use throughout member documents to avoid confusion.

While member and provider documents addressed members' rights to file grievances and appeals, HSAG recommends that **DentaQuest** clarify in both member and provider materials that, with the member's written consent, a provider may file a grievance, a **DentaQuest**-level appeal, and may request an SFH on behalf of a member. HSAG also recommends adding additional detail in the member handbook to inform members that there is no deadline for filing grievances and that grievances and appeals may be filed verbally or in writing.

Some required language was included in the base content of the appeal policy that was not found in the corresponding section of the Colorado-specific exhibit of the policy. The Colorado-specific exhibit was depicted to "replace" the corresponding section of the base policy. HSAG recommends that **DentaQuest** clarify when the base content of the policies prevail and when the Colorado-specific section of the policies prevail.

While **DentaQuest**'s appeal policy did not specifically state that appeals will be resolved as expeditiously as the member's health condition requires (i.e., if needed prior to the required timeline), HSAG found through record review that **DentaQuest** had an effective process to meet this requirement. HSAG recommends that **DentaQuest** articulate this process in policy.

DentaQuest's appeals and grievances policies accurately described the process for **DentaQuest** to request an extension of resolution time frames and send written notice to the member. Both policies included language stating that the notice would inform the member of the right to "contact the state entity if they disagree with the extension invoked by **DentaQuest**." While members should be informed of their right to request a grievance with **DentaQuest** regarding the extension, HSAG recommends that **DentaQuest** remove language to contact the state entity from the policy and the appeal and grievance extension template letters (if applicable) as the State of Colorado has no such process.

Summary of Required Actions

During the grievance record reviews, HSAG found that three grievance resolution letters to members were sent more than 15 working days following the receipt of the grievance. **DentaQuest** must develop a mechanism to ensure that all grievance resolution letters are sent within 15 working days following the receipt of the grievance.

While **DentaQuest**'s policies and procedures and internal training documents accurately reflected the two-working-day time frame for acknowledging appeals in writing, there were two appeal records reviewed that did not contain evidence that an acknowledgement was sent in writing within the two-

working-day time frame. **DentaQuest** must develop a mechanism to ensure that all appeals are acknowledged in writing within two working days of the receipt of the appeal.

DentaQuest's policy accurately addressed the expedited resolution process and described content of the notice to members if **DentaQuest** denies expedition; however, the policy did not include the requirement that the notice to deny expedition will include the member's right to file a grievance if he or she disagrees with the decision to deny expedition. **DentaQuest** submitted a revised expedited review denial template letter that contained the required information within corrective action documents in 2020. **DentaQuest** must revise its *Member Appeals* policy to include the requirement that the notice to a member denying an expedited review of an appeal will inform the member that he or she has the right to file a grievance if he or she disagrees with the decision to deny expedition.

DentaQuest's policies and internal training documents included the correct time frames and requirements for appeal resolution; however, during the appeal record review, HSAG found that five appeal records did not contain evidence that a resolution letter was sent to the member within the required 10-working-day time frame. **DentaQuest** must develop a mechanism to ensure that all appeal resolution letters are sent within the required 10-working-day time frame.

DentaQuest's *Member Appeals* policy as well as member and provider informational materials incorrectly stated that members may request an SFH within 120 days from the notice of adverse of benefit determination (NABD). While **DentaQuest**'s revised appeal resolution letter template accurately stated the time frame from "this" notice, HSAG recommends that **DentaQuest** clarify that the time frame is from the notice of appeal resolution. **DentaQuest** must revise the policy/procedure, member handbook, and provider manual to clarify that the time frame is calculated from the notice of appeal resolution.

While **DentaQuest**'s policies, procedures, and member and provider informational materials addressed the members' rights to continue previously authorized services during an appeal and/or an SFH, the timelines and requirements were outdated and did not reflect the federal regulation changes effective May 2016. **DentaQuest** must ensure that policies, procedures, and member and provider materials make it clear that:

- Members have the right to continue services during an appeal, and again during the SFH *only* if the services were previously approved; part of a current course of treatment; and **DentaQuest** is proposing to terminate, reduce, or suspend the services prior to the end of the authorization period (via a 10-day advanced NABD).
- The member must request continuation of the services during the appeal within 10 days following the NABD (or before the intended effective date), but members have 60 calendar days to file the appeal.
- If a member has continued services during the appeal, he or she may request to continue services during the SFH if the request for the continuation and the SFH are both made within 10 calendar days following the **DentaQuest** *appeal resolution letter* date.

While **DentaQuest**'s policies, procedures, and member and provider informational materials addressed the duration of continued services during an SFH, the timelines were outdated and did not reflect the federal regulation changes effective May 2016. **DentaQuest** must ensure that policies, procedures, and member and provider materials make it clear that:

- If a member has continued services during the appeal, they will continue until one of the following occurs:
  - The member withdraws the appeal, or
  - The effective date of the termination, suspension, or reduction of the services occurs, and the member has not requested an SFH and has not requested continued services during the hearing process.
- If a member has continued services during the SFH, the services will continue until one of the following occurs:
  - The member withdraws the SFH, or
  - An SFH officer issues a hearing decision adverse to the member.

While **DentaQuest** had policies and procedures and a system designed to maintain documentation of grievances and appeals, HSAG found several instances during the review of appeal records that contained incorrect dates and inconsistent or confusing documentation. **DentaQuest** must ensure that grievance and appeal records are accurately maintained.

DentaQuest's ORM addressed grievances and appeals; however, the content was somewhat unclear as to whether members were consistently included as parties to the appeal and was missing some pertinent information about the time frames and requirements related to member grievances and appeals. **DentaQuest** must ensure that providers are notified at the time of contracting (through the ORM or other means) about the member grievance and appeal system and that the information is accurate, and must clarify or include the following:

- Providers, with written consent, may file a grievance, an appeal, and may request an SFH on behalf of the member.
- Peer-to-peer reconsiderations must occur prior to the member receiving an NABD, otherwise the appeal process must be conducted with members being parities to the appeal.
- Members or their representatives may appeal pre-service as well as claims denials.
- Appeals must be resolved within 10 business days following the receipt of the appeal (not from when documents are received) unless an extension is requested in writing that meets the content requirements.
- Grievances and appeals may be filed orally or in writing.
- SFHs must be requested within 120 days from the date of the notice of appeal resolution unless the member has received continued services during the appeal and is requesting continued services during the SFH, in which case the SFH and the services must be requested within 10 days following the notice of appeal resolution.
- Information about requesting expedited **DentaQuest**-level appeals.

Standard VII—Provider Participation and Program Integrity

Summary of Strengths and Findings as Evidence of Compliance

The Network Relations team for the West/Midwest region consisted of five staff members who handled reporting and provider issues. This team was the main point of contact for providers, in addition to some additional support provided through the contracting team, credentialing team, self-service support through the Web portal, and **DentaQuest**'s customer service team for more general questions. The software system, Intelex, was used to monitor contract execution and the Credentialing team used VerifPoint for initial credentialing and recredentialing, including initial and ongoing disclosure of ownership monitoring. Staff members reported that single case agreements were used very rarely, as rural and frontier dentists could often perform specialty work when needed. Additionally, more specialized service requests were rare for the CHP+ population. Network adequacy and other data were used to monitor any gaps in the provider network, and if demand for services or certain providers increased, staff members reported that provider outreach would be triggered.

Network managers described retention efforts such as trainings, regular updates via mass communications, newsletters, recurring meetings with higher profile offices, and availability for general questions. Throughout early CY 2020, retention efforts included in-person conferences, in-office meetings, and community events. After March 2020, support was provided through virtual platforms such as Microsoft Teams, Webex, email, and telephone.

Credentialing policies and procedures demonstrated CMS and National Committee for Quality Assurance (NCQA) requirements were followed, including checks for primary source verification, education, sanctions, exclusions, work history, board certification, drug enforcement agency, and controlled dangerous substances (CDS). **DentaQuest**'s policies and procedures related to human resources (HR) and credentialing were thorough in measures to ensure excluded entities or providers were not employed by **DentaQuest**. These policies described how **DentaQuest** performed initial and monthly exclusion checks (Office of the Inspector General, General Services Administration, the excluded parties list system, and others), including for temporary staff members and vendors. Documentation outlined how accounting and HR worked together alongside the compliance department to ensure all appropriate checks were conducted pre-hire, monthly, and ongoing as appropriate.

The general compliance training included instructions for how to promptly report any suspected fraud, waste, or abuse. In addition to the new employee onboarding training and annual refreshers, the board of directors also received a specialized training, which was described as updated annually and included unique topics based on the board's fiduciary duties. These board-level trainings included general counsel, outside law firms, and either new or recurring topics (with consideration to any new staff members in need of introductory topics). **DentaQuest**'s compliance team participated in various trainings and was expected to remain informed of ongoing changes in the industry. These training expectations were further supported by subscriptions to Compliance 360, which allowed staff members to monitor rules and regulations.

Compliance monitoring was described to occur routinely and consisted of operations meetings, contract monitoring, and feedback from multiple internal departments. Subject matter experts identified, discussed, and mitigated risks; this information passed through the compliance operational meeting, up to the compliance committee, and then to the board of directors, who reviewed and provided additional recommendations when appropriate. In addition to routine analysis of claims data, anomalous utilization, and billing patterns, employee feedback was also considered. Staff members described an annual and sometimes biannual random sampling survey of staff members, which was used to gain a sense of staff member's comfort reporting issues, satisfaction with response to any reported issues, and other topics surrounding trust in leadership. These data were reportedly used to inform and, if appropriate, adjust compliance tools and procedures.

Summary of Findings Resulting in Opportunities for Improvement

DentaQuest's ORM referenced general nondiscrimination for providers acting within their scope to advise or advocate on behalf of members. However, HSAG recommends that **DentaQuest** expand the language to include all the criteria within 42 CFR 438.102(a)(1):

- The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered.
- Any information the member needs in order to decide among all relevant treatment options.
- The risks, benefits, and consequences of treatment or non-treatment.
- The member's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions.

Regarding a provision for notification to the State about changes in a network provider's circumstances, while **DentaQuest** did include a general statement within the *Credentialing Guidelines* policy, HSAG recommends further clarifying "other appropriate institutions" to explicitly include "the State."

While **DentaQuest** did have a provider overpayment process outlined in claims policy, HSAG recommends further clarifying timelines to align with the 60-day reporting (by the provider to **DentaQuest**) and annual reporting (by **DentaQuest** to the State) requirements. HSAG also recommends including additional details about the overpayment reporting process in the provider contract, ORM, or other applicable documents.

Summary of Required Actions

DentaQuest did not submit documentation and was not able to describe a method to regularly verify, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. **DentaQuest** must develop and implement a method, such as sampling, to determine whether services represented by providers were in fact received by members.

DentaQuest did not provide details regarding written disclosure of prohibited affiliations, specifically details or procedures regarding how to report to the State. Similarly, although **DentaQuest** provided a sample template of how written disclosure of ownership and control is captured, and included a statement within the Credentialing Guidelines that providers must disclose, there were no details or procedures regarding how **DentaQuest** provided this information to the State. **DentaQuest** must update or create a procedure for how written disclosures of prohibited affiliations and written disclosure of ownership and control are reported to the State.

Standard IX—Subcontractual Relationships and Delegation

Summary of Strengths and Findings as Evidence of Compliance

DentaQuest submitted multiple contracts regarding printing services, but reported that the current delegate agreement was with Sepire, who mailed member identification cards, welcome packets, and handbooks. VerifPoint performed initial credentialing and recredentialing, and both VerifPoint and Provider Trust were delegated monitoring responsibilities related to ownership and disclosure (VerifPoint for initial and Provider Trust for ongoing monitoring). Grievances and appeals, utilization management, and other functions were all performed by **DentaQuest**.

The Vendor Management Program document was used internally as a procedural reference and distributed externally to vendors in order to inform delegates about the contracting process and expectations. In addition to this document, **DentaQuest** used the software Logic Manager as a contract repository and project management program.

Each delegate underwent a "scorecard" process in which performance, engagement, communication, and innovation were measured for a total score out of 10 possible points. While each sample delegate had scores of seven or above, staff members reported that if a score fell below the threshold of seven, additional conversations and possible actions may be pursued. **DentaQuest** did not have any open CAPs for its delegates; however, staff members were able to provide a sample template of possible corrective actions and follow-ups that would be followed, if necessary.

Summary of Findings Resulting in Opportunities for Improvement

While some oversight entities and responsibilities were described in detail (i.e., CMS, Health and Human Services, the Office of the Inspector General), others were referred to generally in the contract agreement template. HSAG recommends including more details related specifically to the Colorado CHP+ contract, where possible.

HSAG also recommends that **DentaQuest** strengthen the performance rating approach and further individualize the portion of the provider scorecard that assess performance. HSAG recommends that the performance metrics be defined in advance of the annual review and more closely reflect the specific delegated duties.

Summary of Required Actions

HSAG identified no required actions for this standard.

2. Overview and Background

Overview of FY 2020–2021 Compliance Monitoring Activities

For the FY 2020–2021 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard V—Member Information Requirements, Standard VI—Grievance and Appeal Systems, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontractual Relationships and Delegation. Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of the four standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used 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 site review activities; a review of records, documents, and materials requested during the site review; and interviews of key PAHP personnel to determine compliance with federal managed care regulations. Documents submitted for the desk review and site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, and member and provider informational materials.

HSAG also reviewed a sample of the PAHP's administrative records related to CHP+ grievances and CHP+ 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 grievances and appeals. Using a random sampling technique, HSAG selected the sample from all CHP+ grievance records that occurred between January 1, 2020, and December 31, 2020, and all CHP+ appeal records that occurred between January 1, 2020, and December 31, 2020. For the record review, the PAHP received a score of *Met (M)*, *Not Met (NM)*, or *Not Applicable (NA)* for each required element. Results of record reviews were considered in the review of applicable requirements in Standard VI—Grievance and Appeal Systems. HSAG separately calculated a record review score for each record review requirement and an overall record review score.

The site review processes were consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS EQR protocol. The four standards chosen for the FY 2020–2021 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, 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 PAHP regarding:

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

3. Follow-Up on Prior Year's Corrective Action Plan

FY 2019–2020 Corrective Action Methodology

As a follow-up to the FY 2019–2020 site review, each PAHP that received one or more *Partially Met* or *Not Met* scores was required to submit a CAP to the Department addressing those requirements found not to be fully compliant. If applicable, the PAHP was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by **DentaQuest** and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **DentaQuest** until it completed each of the required actions from the FY 2019–2020 compliance monitoring site review.

Summary of FY 2019–2020 Required Actions

For FY 2019–2020, HSAG reviewed Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, and Standard VI—Grievances and Appeals.

DentaQuest was required to complete 35 required actions, including:

Standard I—Coverage and Authorization of Services

- Developing a mechanism for interdepartmental communication regarding member grievances and appeals so they may be addressed in a way that meets members' needs and meets the terms of the CHP+ contract (i.e., services that are sufficient in amount, duration, and scope).
- Ensuring that reasons for denying services in part or in whole are accurately indicated to members and providers.
- Revising policies to align with required timelines for authorization determinations.
- Ensuring NABDs include 1) language that is easy to understand and 2) accurate timeline information.

Standard II—Access and Availability

- Ensuring providers are available in sufficient number, type, and specialty to furnish contracted services.
- Developing a mechanism to allow out-of-network providers to 1) furnish services if unavailable in network and 2) coordinate payment that is no greater than if the member received services in network.

- Developing a mechanism to ensure compliance with timely access standards and CAP steps if there is failure to comply.

Standard VI—Grievances and Appeals

- Developing and implementing training to 1) inform staff members of federal definitions related to grievances and appeals and 2) ensure all expressions of dissatisfaction are treated and logged as grievances in the system.
- Revising policies to include the provision for an authorized representative to file a grievance, appeal, or SFH and developing a mechanism to ensure this right is afforded to the member.
- Developing and implementing a mechanism to provide members reasonable assistance in filing a grievance or appeal.
- Updating policies, procedures, and developing tracking and training mechanisms for staff members to ensure understanding of grievance, appeal, and SFH time frames, procedures, requirements, and contents of member letters (13 required actions).
- Ensuring all comments, documents, and records are considered when deciding an appeal.
- Updating member communications to clarify that grievances are not required in writing.
- Updating internal policies and training staff members so they are informed that CHP+ only has one level of appeal.
- Developing a mechanism to track that acknowledgement letters for appeals are sent within two working days.
- Updating policies, procedures, and trainings to ensure oral appeals are treated as the earliest filing date and pursued.
- Ensuring members are afforded the right to provide additional evidence during the appeal process and informed of the right to receive records at no charge.
- Updating policies and procedures to clarify the provisions of the expedited appeal process (two required actions).
- Revising policy, procedures, and other documents to include the representative of a deceased member's estate is a party to the SFH.
- Revising provider documents to clearly differentiate between provider processes, Medicaid member processes, and CHP+ member processes for appeals.

Summary of Corrective Action/Document Review

DentaQuest submitted a proposed CAP in March 2020. HSAG and the Department reviewed and approved portions of the proposed plan and responded to **DentaQuest**. **DentaQuest** submitted initial documents as evidence of completion in September 2020 and two additional resubmissions in October and December 2020.

Summary of Continued Required Actions

All but two of the required actions were completed by the time of the virtual audit in January 2021. The two outstanding required actions will be carried through to the FY 2020–2021 CAP.

1. Revise policies, procedures, member and provider informational materials, and member communications templates to accurately inform members that the request for an SFH must be in writing and is due within 120 days from the **DentaQuest** internal notice of appeal resolution.
2. Revise provider documents to clearly differentiate between provider processes, Medicaid member processes, and CHP+ member processes for appeals.

Appendix A. Colorado Department of Health Care Policy and Financing FY 2020–2021 Compliance Monitoring Tool for DentaQuest

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor provides all required member information to members in a manner and format that may be easily understood and is readily accessible by enrollees. *Note: Readily accessible means electronic information which complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines.* *42 CFR 438.10(b)(1)*	See P&P MKT04-INS Health Literacy See P&P UM04-INS Notice of Action	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor has in place a mechanism to help members understand the requirements and benefits of the plan. *42 CFR 438.10(c)(7)*	See Member Handbook and Welcome letter	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. For consistency in the information provided to members, the Contractor uses the following as developed by the State: • Definitions for managed care terminology, including appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care.	See Member Handbook	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Model member handbooks and member notices. *42 CFR 438.10(c)(4)*		
4. The Contractor makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • All written materials for members must: – Use easily understood language and format. – Use a font size no smaller than 12 point. – Be available in alternative formats and through provision of auxiliary aids and service that takes into consideration the special needs of members with disabilities or limited English proficiency. – Include taglines in large print (18 point) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDY customer service number, and availability of materials in alternative formats. *42 CFR 438.10(d)(3) and (d)(6)*	Written materials that are critical to obtaining services include: provider directories, member handbooks, appeal and grievance notices, and denial and termination notices. See P&P MKT04-INS Health Literacy and Member Handbook p. 21	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: HSAG found that many sections of DentaQuest's welcome letter and member handbook were in the correct font size; however, the toll-free and TTY/TDY customer service numbers in the welcome letter and the handbook require a tagline written in large font. The benefits section of the handbook was written in a smaller font than required.		
Required Actions: DentaQuest must correct the tagline and font sizes in the member handbook and welcome letter.		

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. If the Contractor makes information available electronically—Information provided electronically must meet the following requirements: • The format is readily accessible (see definition of readily accessible above). • The information is placed in a website location that is prominent and readily accessible. • The information can be electronically retained and printed. • The information complies with content and language requirements. • The member is informed that the information is available in paper form without charge upon request and is provided within five (5) business days. *42 CFR 438.10(c)(6)*	Information is available electronically on our corporate website at www.dentaquest.com on this page specifically for CO CHIP: Colorado State Dental Plans | Medicare, Medicaid, CHIP Dental Insurance - DentaQuest As: "Members can reach out for paper by contacting Member services as noted on the web page: Colorado Child Health Plan Plus Member Services: 1-888-307-6561 Member E-Mail Form" See P&P MKT03-INS-COM Member	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: While DentaQuest's *Member Communications Distribution* policy included information about electronic materials availability in paper form, an incorrect time frame was listed (seven business days) and should be corrected, and members must be informed of the paper document availability and time frame.		
Required Actions: DentaQuest must develop a mechanism to notify members that electronic information is available in paper form without charge upon request and is provided within five business days.		

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor makes available to members in electronic or paper form information about its formulary: • Which medications are covered (both generic and name brand). • What tier each medication is on. • Formulary drug list must be available on the Contractor's website in a machine readable file and format. *42 CFR 438.10(i)*	N/A	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
7. The Contractor makes interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and written translation is available in prevalent languages, and how to access them. • This includes oral interpretation and use of auxiliary aids such as TTY/TDY and American Sign Language. *42 CFR 438.10(d)(4)*	See Policy CS09-INS-Customer Service-Member with LEP See Member Handbook p. 21	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor notifies members that auxiliary aids and services are available upon request and at no cost for members with disabilities, and how to access them. *42 CFR 438.10(d)(5)*	See Policy CS09-INS-Customer Service-Member with LEP See Member Handbook p. 21	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor provides each member with a member handbook in both electronic and paper format within a reasonable time after receiving notification of the member's enrollment. *42 CFR 438.10(g)(1)*	See P&P MKT03-INS-COM Member Communications Distribution	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor gives members written notice of any significant change (as defined by the State) in the information required at 438.10(g) at least 30 days before the intended effective date of the change. *42 CFR 438.10(g)(4)*	See P&P MKT03-INS-COM Member Communications Distribution	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. *42 CFR 438.10(f)(1)*	See NET08-INS Member Notification of Provider Termination	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Although DentaQuest had a policy regarding the 15-day member notification of provider terminations, there was no evidence available to indicate a process for doing so was in place.		
Required Actions: DentaQuest must establish a mechanism to inform members of provider termination within 15 days of the termination notice.		

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals, pharmacies, and behavioral health providers, and LTSS providers (as applicable): • The provider's name and group affiliation, street address(es), telephone number(s), website URL, specialty (as appropriate), whether the providers will accept new enrollees. • The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office, and whether the provider has completed cultural competency training. • Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment. *Note: Information included in a paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 30 calendar days after the Contractor receives updated provider information.* *42 CFR 438.10(h)(1-3)*	Colorado Medicaid FAD tool is available on the following links: • Search homepage (healthsparq.com) • Search results (healthsparq.com)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. Provider directories are made available on the Contractor's website in a machine readable file and format. *42 CFR 438.10(h)(4)*	If the CFR is requesting the display of the Website URL for Provider Records (cited statute 42 CFR 438.10(h)(4), we meet "Web site url, as appropriate. This attribute is displayed on the Corporate Website dentaquest.com here: Colorado State Dental Plans | Medicare, Medicaid, CHIP Dental Insurance - DentaQuest Find A Dentist> in the left navigation.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The member handbook provided to members following enrollment includes: • The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled. • Procedures for obtaining benefits, including authorization requirements and/or referrals for specialty care and for other benefits not furnished by the member's primary care provider. • The process of selecting and changing the member's primary care provider. • Any restrictions on the member's freedom of choice among network providers. • In the case of a counseling or referral service or CHP+ covered benefit that the Contractor does not cover due to	See Member Handbook	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
moral or religious objections, the Contractor informs the member that the service is not covered because of moral or religious objections and how and where the member can obtain the services. *42 CFR 438.10(g)(2)(iii, iv, vi, vii, x) and (g)(ii)(A-B)*		
15. The member handbook provided to members following enrollment includes the following member rights and protections as specified in 42 CFR 438.100. Members have the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for his or her dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding his or her health care, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. • Request and receive a copy of his or her medical records, and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for access, coverage, and coordination of medically necessary services.	See Member handbook	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Freely exercise his or her rights, and the exercising of those rights will not adversely affect the way the Contractor, its network providers, or the State Medicaid agency treats the member. *42 CFR 438.10(g)(2)(ix)*		
Findings: While DentaQuest included a list of member rights in the member handbook, the list did not contain all of the required language.		
Required Actions: DentaQuest must ensure all of the required member rights are listed in the member handbook and ensure the member rights accessible through the Dental Program Rights and Responsibilities link on the website are consistent.		
16. The member handbook provided to members following enrollment includes the following information regarding the grievance, appeal, and fair hearing procedures and time frames: • The right to file grievances and appeals. • The requirements and time frames for filing a grievance or appeal. • The right to a request a State fair hearing after the Contractor has made a determination on a member's appeal which is adverse to the member. • The availability of assistance in the filing process. • The fact that, when requested by the member: – Benefits that the Contractor seeks to reduce or terminate will continue if the member files an appeal or a request for State fair hearing is filed within the time frames specified for filing.	See Member handbook	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– If benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal or State fair hearing is pending if the final decision is adverse to the member. *42 CFR 438.10(g)(2)(xi)*		
Findings: The member handbook did not include a statement regarding member liability for the cost of continued benefits during the appeal process (if the appeal decision is adverse to the member) and lacked complete information regarding the requirements and time frames for filing a grievance or appeal. The member handbook's section about appeals referenced claims appeals only.		
Required Actions: DentaQuest must add to the member handbook a statement that if benefits continue during the appeal or SFH process, the member may be required to pay the cost of services while the appeal or SFH is pending if the final decision is adverse to the member. In addition, DentaQuest must include complete information in the member handbook regarding the requirements and time frames for filing grievances and appeals. DentaQuest is also required to modify the member handbook language to clarify that the appeal process is not limited to denied claims.		
17. The member handbook provided to members following enrollment includes the extent to which and how after-hours and emergency coverage are provided, including: • What constitutes an emergency medical condition and emergency services. • The fact that prior authorization is not required for emergency services. • The fact that the member has the right to use any hospital or other setting for emergency care. *42 CFR 438.10(g)(2)(v)*	See Member handbook	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: Although DentaQuest included information in the member handbook about seeking emergency services, it did not include a statement that prior authorization is not required for emergency services or the fact that the member has the right to use any hospital or other setting for an emergency.		
Required Actions: DentaQuest must revise member handbook language to inform the member that prior authorization is not required for emergency services, and that the member has the right to seek services from any dental or emergency provider to obtain emergency care if needed.		
18. The member handbook provided to members following enrollment includes: • Cost-sharing, if any is imposed under the State plan. • How and where to access any benefits that are available under the State plan but not covered under the CHP+ managed care contract. • How transportation is provided. • The toll-free telephone number for member services, medical management, and any other unit providing services directly to members. • Information on how to report suspected fraud or abuse. • How to access auxiliary aids and services, including information in alternative formats or languages. *42 CFR 438.10(g)(2)(ii, viii, xiii, xiv, xv)*	See Member handbook	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DentaQuest's member handbook did not include information regarding how and where to access benefits available under the State plan but not covered under the CHP+ contract, a specific reference for the toll-free number for medical management or other units providing services directly to members, or information on how to report suspected fraud or abuse.		

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: DentaQuest must add information to the member handbook about how and where to access information about other healthcare services that are available under the State plan, but not covered under the CHP+ managed care contract, such as a link to the Department of Health Care Policy and Financing website section containing other types of benefit information. DentaQuest must also add information to the member handbook instructing members how to report suspected fraud or abuse and the number to reach medical management or other departments that provide services for members.		
19. The Contractor provides member information by either: • Mailing a printed copy of the information to the member's mailing address. • Providing the information by email after obtaining the member's agreement to receive the information by email. • Posting the information on the Contractor's website and advising the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost. • Providing the information by any other method that can reasonably be expected to result in the member receiving that information. *42 CFR 438.10(g)(3)*	See P&P MKT03-INS-COM Member Communications Distribution	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
20. The Contractor must make available to members, upon request, any physician incentive plans in place. *42 CFR 438.10(f)(3)*	N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard V—Member Information Requirements							
Total	Met	=	12	X	1.00	=	12
	Partially Met	=	7	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	NA
Total Applicable		=	19	**Total Score**		=	12
				Total Score ÷ Total Applicable		=	63%

Standard VI—Grievance and Appeal Systems		
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 appeal 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)*	CGA09-INS-MCDCHIP	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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, 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). • For a resident of a rural area with only one managed care plan, the denial of a CHP+ member's request to exercise	CGA09-INS-MCDCHIP	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
his or her rights to obtain services outside of the network under the following circumstances: – The service or type of provider (in terms of training, expertise, and specialization) is not available within the network. – The provider is not part of the network, but is the main source of a service to the member—provided that: – The provider is given the opportunity to become a participating provider. – If the provider does not choose to join the network or does not meet the Contractor's qualification requirements, the member will be given the opportunity to choose a participating provider and then will be transitioned to a participating provider within 60 days. *42 CFR 438.400(b)* *42 CFR 438.52(b)(2)(ii)*		
3. The Contractor defines "appeal" as a review by the Contractor of an adverse benefit determination. *42 CFR 438.400(b)*	CGA09-INS-MCDCHIP	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor defines "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)*	CGA06-INS	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Contractor has provisions for who may file: • A member may file a grievance, 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, a Contractor-level appeal, and may request a State fair hearing on behalf of a member. *Note: Throughout this standard, when the term "member" is used it includes providers and authorized representatives (with the exception that providers cannot exercise the member's right to request continuation of benefits under 42 CFR 438.420).* *42 CFR 438.402(c)*	CGA09-INS-MCDCHIP	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. *42 CFR 438.406(a)(1)*	Policy Name: Member Appeals Policy ID: CGA09-INS-MCD-CHIP Policy Name: Customer Service Member with LEP Policy ID: CS09-INS and Handbook	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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)*	CGA09-INS-MCDCHIP	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
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 their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. *42 CFR 438.406(b)(2)*	CGA06-INS and CGA09-INS-MCDCHIP	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor accepts grievances orally or in writing. *42 CFR 438.402(c)(3)(i)*	CGA06-INS	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. Members may file a grievance at any time. *42 CFR 438.402(c)(2)(i)*	CGA06-INS	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor sends the member a written acknowledgement of each grievance within two (2) working days of receipt. *42 CFR 438.406(b)(1)*	CGA06-INS	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor must resolve each grievance and provide notice as expeditiously as the enrollee'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)*	CGA06-INS	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DentaQuest's policies and procedures accurately addressed grievance resolution time frames. However, during the grievance record reviews, HSAG found that three grievance resolution letters to members were sent more than 15 working days following the receipt of the grievance.		
Required Actions: DentaQuest must develop a mechanism to ensure that all grievance resolution letters are sent within 15 working days following the receipt of the grievance.		
13. The written notice of grievance resolution includes: • Results of the disposition/resolution process and the date it was completed.	CGA06-INS	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor may have only one level of appeal for members. *42 CFR 438.402(b)*	CGA09-INS-MCDCHIP	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
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)*	CGA09-INS-MCDCHIP	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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)* *42 CFR 438.406 (b)(3)*	CGA09-INS-MCDCHIP	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
17. The Contractor sends written acknowledgement of each appeal within two (2) working days of receipt, unless the member or designated representative requests an expedited resolution. *42 CFR 438.406(b)(1)*	CGA09-INS-MCDCHIP	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: While DentaQuest's policies and procedures and internal training documents accurately reflected the two-working-day time frame for acknowledging appeals in writing, there were two appeal records reviewed that did not contain evidence that an acknowledgement was sent in writing within the two-working-day time frame.		
Required Actions: DentaQuest must develop a mechanism to ensure that all appeals are acknowledged in writing within two working days of the receipt of the appeal.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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). • 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)(3-5)*	CGA09-INS-MCDCHIP	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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	CGA09-INS-MCDCHIP	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
charge and sufficiently in advance of the appeal resolution time frame. *42 CFR 438.406(b)(3-5)*		
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)*	CGA09-INS-MCDCHIP	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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)*	CGA09-INS-MCDCHIP	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: DentaQuest's policy accurately addressed the expedited resolution process and described content of the notice to members if DentaQuest denies expedition; however, the policy did not include the requirement that the notice to deny expedition will include the member's right to file a grievance if he or she disagrees with the decision to deny expedition. DentaQuest submitted a revised expedited review denial template letter that contained the required information within corrective action documents in 2020.		
Required Actions: DentaQuest must revise its *Member Appeals* policy to include the requirement that the notice to a member denying an expedited review of an appeal will inform the member that he or she has the right to file a grievance if he or she disagrees with the decision to deny expedition.		
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*	CGA09-INS-MCDCHIP	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DentaQuest's policies and internal training documents included the correct time frames and requirements for appeal resolution; however, during the appeal record review, HSAG found that five appeal records did not contain evidence that a resolution letter was sent to the member within the required 10-working-day time frame.		
Required Actions: DentaQuest must develop a mechanism to ensure that all appeal resolution letters are sent within the required 10-working-day time frame.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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)*	CGA09-INS-MCDCHIP	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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 need for additional information and how the delay is in the member's interest. *42 CFR 438.408(c)(1)*	CGA09-INS-MCDCHIP	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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.	CGA09-INS-MCDCHIP	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
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)*		
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. – The right to request that benefits/services continue* while the hearing is pending, and how to make the request. – That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's adverse benefit determination. **Continuation of benefits applies only to previously authorized services for which the Contractor provided 10-day advance notice to terminate, suspend, or reduce. In addition, to be eligible for continued benefits during a State fair hearing, the member must have received continued benefits during the Contractor appeal process.* *42 CFR 438.408(e)*	CGA09-INS-MCDCHIP	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
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)*	CGA09-INS-MCDCHIP	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DentaQuest's *Member Appeals* policy as well as member and provider informational materials incorrectly stated that members may request an SFH within 120 days from the NABD.		
Required Actions: While DentaQuest's revised appeal resolution letter template accurately stated the time frame from "this" notice, HSAG recommends that DentaQuest clarify that the time frame is from the notice of appeal resolution. DentaQuest must revise the policy/procedure, member handbook, and provider manual to clarify that the time frame is calculated from the notice of appeal 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)*	CGA09-INS-MCDCHIP	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
29. The Contractor provides for continuation of benefits/services (when requested by the member) while the Contractor-level appeal is pending if: • The member files in a timely manner* for continuation of benefits—defined as on or before the later of the following:	CGA09-INS-MCDCHIP	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Within 10 days of the Contractor mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The services were ordered by an authorized provider. • The original period covered by the original authorization has not expired. • The member requests an appeal within 60 days of the notice of adverse benefit determination. **This definition of timely filing only applies for this scenario—i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced. (Note: The provider may not request continuation of benefits on behalf of the member.)* The Contractor provides for continuation of benefits/services (when requested by the member) while the State fair hearing is pending if: • The member requests a State fair hearing with a request for continuation of benefits in a timely manner—defined as on or before the following: – Within 10 days of the Contractor mailing the notice of appeal resolution not in favor of the member. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
(and the member requested and received continued benefits during the Contractor appeal). • The services were ordered by an authorized provider. *42 CFR 438.420(a) and (b)*		
Findings: While DentaQuest's policies, procedures, and member and provider informational materials addressed the members' rights to continue previously authorized services during an appeal and/or an SFH, the timelines and requirements were outdated and did not reflect the federal regulation changes effective May 2016.		
Required Actions: DentaQuest must ensure that policies, procedures, and member and provider materials make it clear that: • Members have the right to continue services during an appeal, and again during the SFH *only* if the services were previously approved; part of a current course of treatment; and DentaQuest is proposing to terminate, reduce, or suspend the services prior to the end of the authorization period (via a 10-day advanced NABD). • The member must request continuation of the services during the appeal within 10 days following the NABD (or before the intended effective date), but members have 60 calendar days to file the appeal. • If a member has continued services during the appeal, he or she may request to continue services during the SFH if the request for the continuation and the SFH are both made within 10 calendar days following the DentaQuest *appeal resolution letter* date.		
30. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal is pending, the benefits must be continued until one of the following occurs: • The member withdraws the appeal. • The member does not request continued benefits during a State fair hearing within 10 calendar days after the Contractor sends the notice of an appeal resolution not in the member's favor. If, at the member's request, the Contractor continues or reinstates the benefits while the State fair hearing is pending,	CGA09-INS-MCDCHIP	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
the benefits must be continued until one of the following occurs: • The member withdraws the request for a State fair hearing. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR 438.420(c)*		
Findings: While DentaQuest's policies, procedures, and member and provider informational materials addressed the duration of continued services during an SFH, the timelines were outdated and did not reflect the federal regulation changes effective May 2016.		
Required Actions: DentaQuest must ensure that policies, procedures, and member and provider materials make it clear that: • If a member has continued services during the appeal, they will continue until one of the following occurs: o The member withdraws the appeal, or o The effective date of the termination, suspension, or reduction of the services occurs and the member has not requested an SFH and has not requested continued services during the hearing process. • If a member has continued services during the SFH, the services will continue until one of the following occurs: o The member withdraws the SFH, or o An SFH officer issues a hearing decision adverse to the member.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
31. Member responsibility for continued services: • If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's adverse benefit determination, the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. *42 CFR 438.420(d)*	CGA09-INS-MCDCHIP	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
32. Effectuation of reversed appeal resolutions: • If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than seventy-two (72) hours from the date it receives notice reversing the determination. • If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the Contractor must pay for those services. *42 CFR 438.424*	CGA09-INS-MCDCHIP	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
33. 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. • The Contractor quarterly submits to the Department a Grievance and Appeals report including this information. *42 CFR 438.416*	CGA06-INS and CGA09-INS-MCDCHIP	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: While DentaQuest had policies and procedures and a system designed to maintain documentation of grievances and appeals, HSAG found several instances during the review of appeal records that contained incorrect dates and inconsistent or confusing documentation.		
Required Actions: DentaQuest must ensure that grievance and appeal records are accurately maintained.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
34. 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. • The fact that, when requested by the member: – Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing.* – The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member. * *Time frames specified for filing:* *During an appeal: Request continued benefits within 10 days of the notice of adverse benefit determination.* *During a State fair hearing: Request continued benefits within 10 days of the notice of adverse appeal resolution.* *42 CFR 438.414* *42 CFR 438.10(g)(xi)*	Policy Name: Member Appeals • Policy ID: CGA09-INS-MCD-CHIP Please see DentaQuest Policy NET01-INS-Network Development Maintenance and Use-FINAL and Colorado Child Health Plan Plus (CHP+), commonly referred to as the Office Reference Manual (ORM).	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: DentaQuest's ORM addressed grievances and appeals; however, the content was somewhat unclear as to whether members were consistently included as parties to the appeal and was missing some pertinent information about the time frames and requirements related to member grievances and appeals.		
Required Actions: DentaQuest must ensure that providers are notified at the time of contracting (through the ORM or other means) about the member grievance and appeal system and that the information is accurate, and must clarify or include the following: • Providers, with written consent, may file a grievance, an appeal, and may request an SFH on behalf of the member. • Peer-to-peer reconsiderations must occur prior to the member receiving an NABD, otherwise the appeal process must be conducted with members being parities to the appeal. • Members or their representative may appeal pre-service as well as claims denials. • Appeals must be resolved within 10 business days following the receipt of the appeal (not from when documents are received) unless an extension is requested in writing that meets the content requirements. • Grievances and appeals may be filed orally or in writing. • SFHs must be requested within 120 days from the date of the notice of appeal resolution unless the member has received continued services during the appeal and is requesting continued services during the SFH, in which case the SFH and the services must be request within 10 days following the notice of appeal resolution. • Information about requesting expedited DentaQuest-level appeals.		

Results for Standard VI—Grievances and Appeals Systems							
Total	Met	=	25	X	1.00	=	25
	Partially Met	=	9	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	34	**Total Score**		=	25
				Total Score ÷ Total Applicable		=	74%

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements written policies and procedures for selection and retention of providers. *42 CFR 438.214(a)*	Please see DentaQuest Policy NET01-INS-Network Development Maintenance and Use-FINAL	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor follows a documented process for credentialing and recredentialing of network providers. *42 CFR 438.214(b) and (e)*	Please see PEC01 and PEC04	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor's provider selection policies and procedures include provisions that the Contractor does not: • Discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. • Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42 CFR 438.12(a)(1) and (2)* *42 CFR 438.214(c)*	Please see DentaQuest Policy NET01-INS-Network Development Maintenance and Use-FINAL	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This is not construed to: • Require the Contractor to contract with providers beyond the number necessary to meet the needs of its members. • Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. • Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members. *42 CFR 438.12(a-b)*	Please see sample denial letters and term letters	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Contractor has a signed contract or participation agreement with each provider. *42 CFR 438.206(b)(1)*	Please see example contract "190515 Comfort Dental Group Thornton 061673586 Holly Gerner.pdf"	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor does not employ or contract with providers or other individuals or entities excluded for participation in federal health care programs under either Section 1128 or 1128 A of the Social Security Act. *(This requirement also requires a policy.)* *42 CFR 438.214(d)* *42 CFR 438.610*	PEC01 and PEC04 HR02.18-ENT Background Checks and Reference Checks	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The Contractor may not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulation or Executive Order 12549. *42 CFR 438.610*	See policy COM12-ENT-OIG-GSA Exclusion Review	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: • The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered. • Any information the member needs in order to decide among all relevant treatment options.	Please see the Office Reference Manual (ORM) file (Colorado Child Health Plan Plus (CHP+)) sections on Member and provider rights.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The risks, benefits, and consequences of treatment or non-treatment. • The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. *42 CFR 438.102(a)(1)*		
9. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: • To the State upon contracting or when adopting the policy during the term of the contract. • To members before and during enrollment. • To members within 90 days after adopting the policy with respect to any particular service. *42 CFR 438.102(b)*	See COM15-ENT-Nondiscrimination Compliance Program	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
10. The Contractor has administrative and management arrangements or procedures, including a compliance program to detect and prevent fraud, waste, and abuse and includes: • Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal, State, and contract requirements. • The designation of a compliance officer who is responsible for developing and implementing policies,	See the following Compliance Program policies, procedures, and documentation: Compliance Program Description COM01-ENT-Policy Management and Control COM04-ENT-Code of Conduct Standards Code of Conduct and Ethics COM05-ENT-Chief Ethics & Compliance Officer Compliance Committee Charter	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
procedures and practices to ensure compliance with requirements of the contract and reports directly to the CEO and Board of Directors. • The establishment of a Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program. • Training and education of the compliance officer, management, and organization's staff members for the federal and State standards and requirements under the contract. • Effective lines of communication between the compliance officer and the Contractor's employees. • Enforcement of standards through well-publicized disciplinary guidelines. • Implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks. • Procedures for prompt response to compliance issues as they are raised, investigation of potential compliance problems identified in the course of self-evaluation and audits, corection of such problems quickly and thoroughly to reduce the potential for reoccurence, and ongoing compliance with the requirements under the contract. *42 CFR 438.608(a)(1)*	Description (Board Committees) COM06-ENT-Compliance Monitoring and Communication COM07-ENT-Training and Education COM-14-ENT-Enforcement and Discipline COM09-ENT-Duty to Report Noncompliance; Non-retaliation COM-13-ENT-Compliance Investigation COM16-ENT-Corrective Action Plans COM17-ENT-CAP Coordination FPR01-INS-DENT – Fraud Prevention and Recovery Program FPR04-DENT-SOP-Utilization Oversight Process	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor's administrative and management procedures to detect and prevent fraud, waste, and abuse include: • Written policies for all employees, contractors or agents that provide detailed information about the False Claims Act, including the right of employees to be protected as whistleblowers. • Provisions for prompt referral of any potential fraud, waste, or abuse to the Department and any potential fraud to the State Medicaid Fraud Control Unit. • Provisions for suspension of payments to a network provider for which the State determines there is credible allegation of fraud (in accordance with 455.12.) *42 CFR 438.608 (a)(6-8)*	Code of Conduct & Ethics COM-10-False Claims Act Information FPR01-INS-DENT – Fraud Prevention and Recovery Program FPR05-INS-MCD-Credible Allegation of Fraud Hold	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor's Compliance Program includes: • Provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying the overpayments due to potenial fraud. • Provision for prompt notification to the State about member circumstances that may affect the member's eligibility, including change in residence and member death. • Provision for notification to the State about changes in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including termination of the provider agreement with the Contractor.	Credentialing PEC01, PEC04 FPR01-INS-DENT – Fraud Prevention and Recovery Program CS05-INS-DENT-SOP-Customer Service – Call Handling - Eligibility Verification #3 PEC01 Procedure A 1. g ii	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Provision for a method to verify on a regular basis, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. *42 CFR 438.608 (a)(2-5)*	#4 This provision is not required by our client nor written into the contract. Therefore it is not an activity currently being performed by DentaQuest.	
Findings: DentaQuest did not submit documentation and was not able to describe a method to regularly verify, by sampling or other methods, whether services represented to have been delivered by network providers were received by members.		
Required Actions: DentaQuest must develop and implement a method, such as sampling, to determine whether serves represented by providers were in fact received by members.		
13. The Contractor ensures that all network providers are enrolled with the State as CHP+ providers consistent with the provider disclosure screening, and enrollment requirements of the State. • The Contractor may execute network provider agreements pending the outcome of the State's screening and enrollment process of up to one-hundred and twenty (120) days, but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one one-hundred and twenty (120)-day period without enrollment of the provider, and notify affected enrollees. *42 CFR 438.608 (b)*	Credentialing PEC01 and PEC04	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor has procedures to provide to the State: • Written disclosure of any prohibited affiliation (as defined in 438.610). • Written disclosure of ownership and control (as defined in 455.104) • Identification within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract. *42 CFR 438.608(c)*	• No disclosure of any prohibited affiliation • See Attachement A – for written disclosure of ownership and control • N/A - No capitation payments in the contract	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DentaQuest did not provide details regarding written disclosure of prohibited affiliations, specifically details or procedures regarding how to report to the State. Similarly, although DentaQuest provided a sample template of how written disclosure of ownership and control is captured, and included a statement within the Credentialing Guidelines that providers must disclose, there were no details or procedures regarding how DentaQuest provided this information to the State.		
Required Actions: DentaQuest must update or create a procedure for how written disclosures of prohibited affiliations and written disclosure of ownership and control are reported to the State.		
15. The Contractor has a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days of identifying the overpayment, and to notify the Contractor in writing of the reason for the overpayment. • The Contractor reports annually to the State on recoveries of overpayments. *42 CFR 438.608(d)(2) and (3)*	Please see "Sample EOB with Overpayment" PDF	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The Contractor provides that members are not held liable for: • The Contractor's debts in the event of the Contractor's insolvency. • Covered services provided to the member for which the State does not pay the Contractor. • Covered services provided to the member for which the State or the Contractor does not pay the health care provider that furnishes the services under a contractual, referral, or other arrangement. • Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly. *42 CFR 438.106*	Colorado Child Health Plan Plus (CHP+) – ORM Please see 200101 CO CHP+ MC, DentaQuest's provider contract – Hold Harmless provision 5 (b)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard VII—Provider Participation and Program Integrity							
Total	Met	=	13	X	1.00	=	13
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	NA
Total Applicable		=	15	**Total Score**		=	13
				Total Score ÷ Total Applicable		=	87%

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. Notwithstanding any relationship(s) with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. *42 CFR 438.230(b)(1)*	See Delegated Services Addendum : Article II Section 2.3 pgs 5-6	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. All contracts or written arrangements between the Contractor and any subcontractor specify— • The delegated activities or obligations and related reporting responsibilities. • That the subcontractor agrees to perform the delegated activities and reporting responsibilities. • Provision for revocation of the delegation of activities or obligations or specify other remedies in instances where the Contractor determines that the subcontractor has not performed satisfactorily. *Note: Subcontractor requirements do not apply to network provider agreements. In addition, wholly-owned subsidiaries of the health plan are not considered subcontractors.* *42 CFR 438.230(b)(2) and (c)(1)*	See Delegated Services Addendum : Article II Section 2.2 pgs 5-6 , Article III Section 3.3 pg 6 ; Article VIII Section 7.2 pg 11	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor's written agreement with any subcontractor includes: • The subcontractor's agreement to comply with all applicable Medicaid/CHP+ laws, regulations, including applicable sub regulatory guidance and contract provisions. *42 CFR 438.230(c)(2)*	See Delegated Services Addendum: Article II Section 2.1 , 2.3 pgs 5-6 ; Article III Section 3.4 pg 7	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The written agreement with the subcontractor includes: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State. – The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems related to CHP+ enrollees. – The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. – If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. *42 CFR 438.230(c)(3)*	See Delegated Services Addendum : Article IV Sections 4.1 ; 4.2; 4.3 , 4.5 Pgs 8-9	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard IX—Subcontractual Relationships and Delegation							
Total	Met	=	4	X	1.00	=	4
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	4	**Total Score**		=	4
				Total Score ÷ Total Applicable		=	100%

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Appeals Record Review Tool
for DentaQuest

Review Period:	January 1, 2020–December 31, 2020
Date of Review:	January 12–13, 2021
Reviewer:	Erica Arnold
Participating Health Plan Staff Member(s):	Jeanine Rank, Maureen Hartlaub, Logan Horn, and Noah Lehman

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	****	01/07/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	01/21/20	M ☒ N ☐	M ☒ N ☐	M ☐ N ☒
Comments: Resolution letter contains language that may be difficult to understand.											
2	****	02/18/20	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	02/18/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											
3	****	03/13/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	03/25/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											
4	****	03/26/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	08/18/20	M ☐ N ☒	M ☒ N ☐	M ☒ N ☐
Comments: Resolution letter not sent within 10 working days.											
5	****	06/03/20	M ☐ N ☒ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	08/18/20	M ☐ N ☒	M ☒ N ☐	M ☐ N ☒
Comments: Acknowledgement letter not sent within time frame. Resolution letter contains language that may be difficult to understand.											
6	****	07/01/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	07/17/20	M ☐ N ☒	M ☒ N ☐	M ☐ N ☒
Comments: Resolution letter sent on 11th working day. Letter contains clinical language that may be difficult to understand.											
7			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments: This case was not an appeal. Replaced by OS1.											
8	****	09/14/20	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	09/15/20	M ☒ N ☐	M ☒ N ☐	M ☐ N ☒
Comments: Resolution letter contains language that may be difficult to understand.											
9	****	10/12/20	M ☐ N ☒ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	10/26/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: No acknowledgement letter in documentation.											
10	****	10/27/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	11/10/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 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	****	02/28/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	03/13/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											
Do not score shaded columns below.											
Column Subtotal of Applicable Elements			**8**	**10**	**10**				**10**	**10**	**10**
Column Subtotal of Compliant (Met) Elements			**6**	**10**	**10**				**7**	**10**	**6**
Percent Compliant (Divide Met by Applicable)			**75%**	**100%**	**100%**				**70%**	**100%**	**60%**

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

Total Applicable Elements	**58**
Total Compliant (Met) Elements	**49**
Total Percent Compliant	**84%**

***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.

**** = Redacted Member ID

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Grievance Record Review Tool
for DentaQuest

Review Period:	January 1, 2020–December 31, 2020
Date of Review:	January 12–13, 2021
Reviewer:	Erica Arnold
Participating Health Plan Staff Member(s):	Jeanine Rank, Maureen Hartlaub, Logan Horn, and Noah Lehman

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	****	01/28/20	M ☒ N ☐ N/A ☐	02/14/20	13	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: Member billing issue.										
2	****	01/29/20	M ☒ N ☐ N/A ☐	02/19/20	14	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: Member billing issue.										
3	****	01/30/20	M ☒ N ☐ N/A ☐	02/27/20	19	M ☐ N ☒	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: Parent dissatisfied with treatment from dental office. Letter sent in 19 working days.										
4	****	06/03/20	M ☒ N ☐ N/A ☐	06/15/20	8	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: Billing issue.										
5	****	06/25/20	M ☒ N ☐ N/A ☐	12/14/20	121	M ☐ N ☒	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: Billing issue due to apparent coverage lapse. Resolution letter not sent within required timeline.										
6	****	07/24/20	M ☒ N ☐ N/A ☐	08/15/20	16	M ☐ N ☒	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: Member billed due to lapse in coverage. Letter sent in 16 working days.										
7	****	08/07/20	M ☒ N ☐ N/A ☐	08/28/20	15	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: Billing issue for service prior to coverage start date.										
8	****	09/22/20	M ☒ N ☐ N/A ☐	10/13/20	15	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: Billing issue.										
9	****	09/23/20	M ☒ N ☐ N/A ☐	09/29/20	4	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: Billing issue related to coverage lapse.										

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Grievance Record Review Tool
for DentaQuest

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
10	****	09/23/20	M ☒ N ☐ N/A ☐	10/14/20	15	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: Billing issue.										
Do not score shaded columns below.										
Column Subtotal of Applicable Elements			**10**			**10**	**10**	**0**	**10**	**10**
Column Subtotal of Compliant (Met) Elements			**10**			**7**	**10**	**0**	**10**	**10**
Percent Compliant (Divide Met by Applicable)			**100%**			**70%**	**100%**	**0%**	**100%**	**100%**

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

Total Applicable Elements	**50**
Total Compliant (Met) Elements	**47**
Total Percent Compliant	**94%**

* 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.

**** = Redacted Member ID

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2020–2021 site review of **DentaQuest**.

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

HSAG Review Team	Title
Barbara McConnell	Executive Director
Sarah Lambie	Project Manager III
Erica Miller-Arnold	Project Manager II
DentaQuest Participants	**Title**
Amanda Katz	Digital Marketing Specialist
Chad Jacquart	Audit Coordinator
Deseray A. Backman	Provider Enrollment and Credentialing Coordinator
Diane Natale	Manager, User Experience (UX)
Jeanine M. Rank	Operations Audit Coordinator II
Kamila Karnas	Financial Reporting Analyst
Lisa McTighe	Member Marketing Manager
Logan Horn	Associate Client Partner
Mark Waterbury	Manager, CMS Medical Compliance
Marleen Santiago	Manager, Human Resources
Marva Jefferson	Manager, Outreach & Engagement
Matthew Henning	Director Associate General Counsel
Maureen Hartlaub	Managing Client Partner
Noah R. Lehman	Managing Provider Partner
Sheila A. Schmidt	Manager, Customer Service
Ugonna Onyekwu	Senior Compliance Analyst
Wayne Brown	Director of Vendor Management
Department Observers	**Title**
Curt Curnow	Quality Improvement Section Manager
Michelle Kohler	Dental Contract Plan Manager
Russell Kennedy	Quality Program Manager

Appendix D. Corrective Action Plan Template for FY 2020–2021

If applicable, the PAHP 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 PAHP 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 PAHP 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 SAFE 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 2020–2021 Corrective Action Plan for DentaQuest

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
4. The Contractor makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • All written materials for members must: – Use easily understood language and format. – Use a font size no smaller than 12 point. – Be available in alternative formats and through provision of auxiliary aids and service that takes into consideration the special needs of members with disabilities or limited English proficiency. – Include taglines in large print (18 point) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDY customer service number, and availability of materials in alternative formats.	HSAG found that many sections of DentaQuest's welcome letter and member handbook were in the correct font size; however, the toll-free and TTY/TDY customer service numbers in the welcome letter and the handbook require a tagline written in large font. The benefits section of the handbook was written in a smaller font than required.	DentaQuest must correct the tagline and font sizes in the member handbook and welcome letter.

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
42 CFR 438.10(d)(3) and (d)(6)		
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 V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
5. If the Contractor makes information available electronically—Information provided electronically must meet the following requirements: • The format is readily accessible (see definition of readily accessible above). • The information is placed in a website location that is prominent and readily accessible. • The information can be electronically retained and printed. • The information complies with content and language requirements. • The member is informed that the information is available in paper form without charge upon request and is provided within five (5) business days. *42 CFR 438.10(c)(6)*	While DentaQuest's *Member Communications Distribution* policy included information about electronic materials availability in paper form, an incorrect time frame was listed (seven business days) and should be corrected, and members must be informed of the paper document availability and time frame.	DentaQuest must develop a mechanism to notify members that electronic information is available in paper form without charge upon request and is provided within five business days.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
Documents to be Submitted as Evidence of Completion:		

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
11. The Contractor makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. *42 CFR 438.10(f)(1)*	Although DentaQuest had a policy regarding the 15-day member notification of provider terminations, there was no evidence available to indicate a process for doing so was in place.	DentaQuest must establish a mechanism to inform members of provider termination within 15 days of the termination notice.
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 V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
15. The member handbook provided to members following enrollment includes the following member rights and protections as specified in 42 CFR 438.100. Members have the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for his or her dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding his or her health care, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. • Request and receive a copy of his or her medical records, and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for access, coverage, and coordination of medically necessary services.	While DentaQuest included a list of member rights in the member handbook, the list did not contain all of the required language.	DentaQuest must ensure all of the required member rights are listed in the member handbook and ensure the member rights accessible through the Dental Program Rights and Responsibilities link on the website are consistent.

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
• Freely exercise his or her rights, and the exercising of those rights will not adversely affect the way the Contractor, its network providers, or the State Medicaid agency treats the member. *42 CFR 438.10(g)(2)(ix)*		
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 V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
16. The member handbook provided to members following enrollment includes the following information regarding the grievance, appeal, and fair hearing procedures and time frames: • The right to file grievances and appeals. • The requirements and time frames for filing a grievance or appeal. • The right to a request a State fair hearing after the Contractor has made a determination on a member's appeal which is adverse to the member. • The availability of assistance in the filing process. • The fact that, when requested by the member: – Benefits that the Contractor seeks to reduce or terminate will continue if the member files an appeal or a request for State fair hearing is filed within the time frames specified for filing. – If benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal or State fair hearing is pending if the final	The member handbook did not include a statement regarding member liability for the cost of continued benefits during the appeal process (if the appeal decision is adverse to the member) and lacked complete information regarding the requirements and time frames for filing a grievance or appeal. The member handbook's section about appeals referenced claims appeals only.	DentaQuest must add to the member handbook a statement that if benefits continue during the appeal or SFH process, the member may be required to pay the cost of services while the appeal or SFH is pending if the final decision is adverse to the member. In addition, DentaQuest must include complete information in the member handbook regarding the requirements and time frames for filing grievances and appeals. DentaQuest is also required to modify the member handbook language to clarify that the appeal process is not limited to denied claims.

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
decision is adverse to the member. *42 CFR 438.10(g)(2)(xi)*		
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 V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
17. The member handbook provided to members following enrollment includes the extent to which and how after-hours and emergency coverage are provided, including: • What constitutes an emergency medical condition and emergency services. • The fact that prior authorization is not required for emergency services. • The fact that the member has the right to use any hospital or other setting for emergency care. *42 CFR 438.10(g)(2)(v)*	Although DentaQuest included information in the member handbook about seeking emergency services, it did not include a statement that prior authorization is not required for emergency services or the fact that the member has the right to use any hospital or other setting for an emergency.	DentaQuest must revise member handbook language to inform the member that prior authorization is not required for emergency services, and that the member has the right to seek services from any dental or emergency provider to obtain emergency care if needed.
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 V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
18. The member handbook provided to members following enrollment includes: • Cost-sharing, if any is imposed under the State plan. • How and where to access any benefits that are available under the State plan but not covered under the CHP+ managed care contract. • How transportation is provided. • The toll-free telephone number for member services, medical management, and any other unit providing services directly to members. • Information on how to report suspected fraud or abuse. • How to access auxiliary aids and services, including information in alternative formats or languages. *42 CFR 438.10(g)(2)(ii, viii, xiii, xiv, xv)*	DentaQuest's member handbook did not include information regarding how and where to access benefits available under the State plan but not covered under the CHP+ contract, a specific reference for the toll-free number for medical management or other units providing services directly to members, or information on how to report suspected fraud or abuse.	DentaQuest must add information to the member handbook about how and where to access information about other healthcare services that are available under the State plan, but not covered under the CHP+ managed care contract, such as a link to the Department of Health Care Policy and Financing website section containing other types of benefit information. DentaQuest must also add information to the member handbook instructing members how to report suspected fraud or abuse and the number to reach medical management or other departments that provide services for members.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
12. The Contractor must resolve each grievance and provide notice as expeditiously as the enrollee'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)*	DentaQuest's policies and procedures accurately addressed grievance resolution time frames. However, during the grievance record reviews, HSAG found that three grievance resolution letters to members were sent more than 15 working days following the receipt of the grievance.	DentaQuest must develop a mechanism to ensure that all grievance resolution letters are sent within 15 working days following the receipt of the grievance.
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—Grievance and Appeal Systems		
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 representative requests an expedited resolution. *42 CFR 438.406(b)(1)*	While DentaQuest's policies and procedures and internal training documents accurately reflected the two-working-day time frame for acknowledging appeals in writing, there were two appeal records reviewed that did not contain evidence that an acknowledgement was sent in writing within the two-working-day time frame.	DentaQuest must develop a mechanism to ensure that all appeals are acknowledged in writing within two working days of the receipt of the appeal.
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—Grievance and Appeal Systems		
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)*	DentaQuest's policy accurately addressed the expedited resolution process and described content of the notice to members if DentaQuest denies expedition; however, the policy did not include the requirement that the notice to deny expedition will include the member's right to file a grievance if he or she disagrees with the decision to deny expedition. DentaQuest submitted a revised expedited review denial template letter that contained the required information within corrective action documents in 2020.	DentaQuest must revise its *Member Appeals* policy to include the requirement that the notice to a member denying an expedited review of an appeal will inform the member that he or she has the right to file a grievance if he or she disagrees with the decision to deny expedition.
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—Grievance and Appeal Systems		
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*	DentaQuest's policies and internal training documents included the correct time frames and requirements for appeal resolution; however, during the appeal record review, HSAG found that five appeal records did not contain evidence that a resolution letter was sent to the member within the required 10-working-day time frame.	DentaQuest must develop a mechanism to ensure that all appeal resolution letters are sent within the required 10-working-day 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—Grievance and Appeal Systems		
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)*	DentaQuest's *Member Appeals* policy as well as member and provider informational materials incorrectly stated that members may request an SFH within 120 days from the NABD.	While DentaQuest's revised appeal resolution letter template accurately stated the time frame from "this" notice, HSAG recommends that DentaQuest clarify that the time frame is from the notice of appeal resolution. DentaQuest must revise the policy/procedure, member handbook, and provider manual to clarify that the time frame is calculated from the notice of appeal 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—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
29. The Contractor provides for continuation of benefits/services (when requested by the member) while the Contractor-level appeal is pending if: • The member files in a timely manner* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the Contractor mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The services were ordered by an authorized provider. • The original period covered by the original authorization has not expired. • The member requests an appeal within 60 days of the notice of adverse benefit determination. **This definition of timely filing only applies for this scenario—i.e., when the member requests continuation of benefits for previously authorized services proposed to be*	While DentaQuest's policies, procedures, and member and provider informational materials addressed the members' rights to continue previously authorized services during an appeal and/or an SFH, the timelines and requirements were outdated and did not reflect the federal regulation changes effective May 2016.	DentaQuest must ensure that policies, procedures, and member and provider materials make it clear that: • Members have the right to continue services during an appeal, and again during the SFH *only* if the services were previously approved; part of a current course of treatment; and DentaQuest is proposing to terminate, reduce, or suspend the services prior to the end of the authorization period (via a 10-day advanced NABD). • The member must request continuation of the services during the appeal within 10 days following the NABD (or before the intended effective date), but members have 60 calendar days to file the appeal. • If a member has continued services during the appeal, he or she may request to continue services during the SFH if the request for the continuation and the SFH are both made within 10 calendar days following the DentaQuest *appeal resolution letter* date.

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
terminated, suspended, or reduced. (Note: The provider may not request continuation of benefits on behalf of the member.) The Contractor provides for continuation of benefits/services (when requested by the member) while the State fair hearing is pending if: • The member requests a State fair hearing with a request for continuation of benefits in a timely manner—defined as on or before the following: – Within 10 days of the Contractor mailing the notice of appeal resolution not in favor of the member. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment (and the member requested and received continued benefits during the Contractor appeal). • The services were ordered by an authorized provider. *42 CFR 438.420(a) and (b)*		
Planned Interventions:		

Standard VI—Grievance and Appeal Systems		
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—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
30. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal is pending, the benefits must be continued until one of the following occurs: • The member withdraws the appeal. • The member does not request continued benefits during a State fair hearing within 10 calendar days after the Contractor sends the notice of an appeal resolution not in the member's favor. If, at the member's request, the Contractor continues or reinstates the benefits while the State fair hearing is pending, the benefits must be continued until one of the following occurs: • The member withdraws the request for a State fair hearing. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR 438.420(c)*	While DentaQuest's policies, procedures, and member and provider informational materials addressed the duration of continued services during an SFH, the timelines were outdated and did not reflect the federal regulation changes effective May 2016.	DentaQuest must ensure that policies, procedures, and member and provider materials make it clear that: • If a member has continued services during the appeal, they will continue until one of the following occurs: o The member withdraws the appeal, or o The effective date of the termination, suspension, or reduction of the services occurs and the member has not requested an SFH and has not requested continued services during the hearing process. • If a member has continued services during the SFH, the services will continue until one of the following occurs: o The member withdraws the SFH, or o An SFH officer issues a hearing decision adverse to the member.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		

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

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
33. 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. • The Contractor quarterly submits to the Department a Grievance and Appeals report including this information. *42 CFR 438.416*	While DentaQuest had policies and procedures and a system designed to maintain documentation of grievances and appeals, HSAG found several instances during the review of appeal records that contained incorrect dates and inconsistent or confusing documentation.	DentaQuest must ensure that grievance and appeal records are accurately maintained.
Planned Interventions:		

Standard VI—Grievance and Appeal Systems		
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—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
34. 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. • The fact that, when requested by the member: – Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing.* – The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member.	DentaQuest's ORM addressed grievances and appeals; however, the content was somewhat unclear as to whether members were consistently included as parties to the appeal and was missing some pertinent information about the time frames and requirements related to member grievances and appeals.	DentaQuest must ensure that providers are notified at the time of contracting (through the ORM or other means) about the member grievance and appeal system and that the information is accurate, and must clarify or include the following: • Providers, with written consent, may file a grievance, an appeal, and may request an SFH on behalf of the member. • Peer-to-peer reconsiderations must occur prior to the member receiving an NABD, otherwise the appeal process must be conducted with members being parities to the appeal. • Members or their representative may appeal pre-service as well as claims denials. • Appeals must be resolved within 10 business days following the receipt of the appeal (not from when documents are received) unless an extension is requested in writing that meets the content requirements. • Grievances and appeals may be filed orally or in writing. • SFHs must be requested within 120 days from the date of the notice of appeal resolution unless the member has received continued services during the appeal and is requesting continued services during the SFH, in which case the SFH and the services must be request within 10 days following the notice of appeal resolution.

Standard VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
* *Time frames specified for filing:* *During an appeal: Request continued benefits within 10 days of the notice of adverse benefit determination.* *During a State fair hearing: Request continued benefits within 10 days of the notice of adverse appeal resolution.* *42 CFR 438.414* *42 CFR 438.10(g)(xi)*		• Information about requesting expedited DentaQuest-level appeals.
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 VII—Provider Participation and Program Integrity		
Requirement	**Findings**	**Required Action**
12. The Contractor's Compliance Program includes: • Provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying the overpayments due to potenial fraud. • Provision for prompt notification to the State about member circumstances that may affect the member's eligibility, including change in residence and member death. • Provision for notification to the State about changes in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including termination of the provider agreement with the Contractor. • Provision for a method to verify on a regular basis, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. *42 CFR 438.608 (a)(2-5)*	DentaQuest did not submit documentation and was not able to describe a method to regularly verify, by sampling or other methods, whether services represented to have been delivered by network providers were received by members.	DentaQuest must develop and implement a method, such as sampling, to determine whether serves represented by providers were in fact received by members.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		

Standard VII—Provider Participation and Program Integrity		
Requirement	**Findings**	**Required Action**
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VII—Provider Participation and Program Integrity		
Requirement	**Findings**	**Required Action**
14. The Contractor has procedures to provide to the State: • Written disclosure of any prohibited affiliation (as defined in 438.610). • Written disclosure of ownership and control (as defined in 455.104) • Identification within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract. *42 CFR 438.608(c)*	DentaQuest did not provide details regarding written disclosure of prohibited affiliations, specifically details or procedures regarding how to report to the State. Similarly, although DentaQuest provided a sample template of how written disclosure of ownership and control is captured, and included a statement within the Credentialing Guidelines that providers must disclose, there were no details or procedures regarding how DentaQuest provided this information to the State.	DentaQuest must update or create a procedure for how written disclosures of prohibited affiliations and written disclosure of ownership and control are reported to the State.
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:		

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 the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.

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 Department 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, 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 health plans.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided health plans with proposed site review dates, group technical assistance, and training, as needed. • HSAG confirmed a primary PAHP contact person for the site review and assigned HSAG reviewers to participate in the site review. • Sixty days prior to the scheduled date of the site review, HSAG notified the PAHP in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and site review agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards and site review activities. Thirty days prior to the review, the PAHP provided documentation for the desk review, as requested. • Documents submitted for the desk review and site review consisted of the completed desk review form, the compliance monitoring tool with the PAHP's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. • The PAHP also submitted a list of all member grievance and all member appeal records that occurred between January 1, 2020, and December 31, 2020 (to the extent available at the time of the site review). The PAHP submitted the lists to HSAG 10 days following receipt of the desk review request. HSAG used a random sampling technique to select records for desk review and the site review. HSAG notified the

For this step,	HSAG completed the following activities:
	PAHP five days following receipt of the lists of records regarding the sample records selected. • The HSAG review team reviewed all documentation submitted prior to the site review and prepared a request for further documentation and an interview guide to use during the site review.
Activity 3:	**Conduct PAHP Site Review**
	• During the site review, HSAG met with groups of the PAHP's key staff members to obtain a complete picture of the PAHP's compliance with federal healthcare regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the PAHP's performance. • HSAG requested, collected, and reviewed additional documents as needed. • At the close of site review, HSAG provided PAHP staff and Department personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2020–2021 Department-approved Site Review Report Template to compile the findings and incorporate information from the pre-site review and site review activities. • HSAG analyzed the findings and calculated final scores based on Department-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the Department**
	• HSAG populated the Department-approved report template. • HSAG submitted the draft Site Review Report to the PAHP and the Department for review and comment. • HSAG incorporated the PAHP and Department comments, as applicable, and finalized the report. • HSAG included a pre-populated CAP template in the final report for all elements determined to be out of compliance with managed care regulations. • HSAG distributed the final report to the PAHP and the Department.