CHP+

Child Health Plan *Plus*

Fiscal Year 2022–2023 Compliance Review Report

for

DentaQuest

February 2023

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

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

Introduction

The prepaid ambulatory health plan (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. The updated Medicaid and CHIP managed care regulations published May 6, 2016, which became applicable to CHIP effective July 1, 2018. Additional revisions were released in November 2020, with an effective date of December 2020. The CFR requires that states conduct a periodic evaluation of their managed care entities (MCEs), including PAHPs to determine compliance with federal healthcare regulations and managed care contract requirements. The Department of Health Care Policy & Financing (the Department) administers and oversees the CHP+ program (Colorado's implementation of CHIP). The Department has elected to complete this requirement for the 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) 2022–2023 was January 1, 2022, through December 31, 2022. This report documents results of the FY 2022–2023 compliance 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 2022–2023 compliance monitoring review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2021–2022 compliance review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the denials of authorization of services (denials), grievances, and appeals record reviews. Appendix C lists HSAG, PAHP, and Department personnel who participated in some way in the compliance review process. Appendix D describes the corrective action plan (CAP) process the PAHP will be required to complete for FY 2022–2023 and the required template for doing so. Appendix E contains a detailed description of HSAG's compliance 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: Sep 27, 2021.

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)
I. Coverage and Authorization of Services	17	17	12	2	3	0	71%
II. Adequate Capacity and Availability of Services	12	12	9	3	0	0	75%
VI. Grievance and Appeal Systems	31	31	18	11	2	0	58%
XII. Enrollment and Disenrollment	2	2	2	0	0	0	100%
Totals	**62**	**62**	**41**	**16**	**5**	**0**	**66%**

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

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

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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Denials	65	65	54	11	0	83%
Grievances	51	51	45	6	0	88%
Appeals	55	55	47	8	0	85%
Totals	**171**	**171**	**146**	**25**	**0**	**85%**

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

Standard I—Coverage and Authorization of Services

Evidence of Compliance and Strengths

DentaQuest's policies and procedures describe processes to ensure that member information, including notices of adverse benefit determination, are written to ensure members are easily able to understand the content of the notices and, when requested, are available in alternative formats. A review of denial case files supported that **DentaQuest** denial notices are almost always written in easily understood language, usually at or around the sixth-grade reading level.

During interviews, **DentaQuest** stated that it does not deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the enrollee or reduce, suspend, or terminate previously authorized services. **DentaQuest** policies and procedures also indicate that once a service is approved by **DentaQuest**, it does not deny, reduce, or suspend a previously authorized service. In some instances, **DentaQuest** extends authorizations when services are not completed within the approved time frames. Staff members described that when over- or under-utilization is identified during post-service review, **DentaQuest** works with providers regarding appropriate service utilization.

Staff members described a broad range of dental consultants used to review authorization requests and denials and confirmed that dental consultants are dental professionals with unrestricted licenses with a wide variety of dental specialties. Furthermore, **DentaQuest** has implemented annual inter-rater reliability processes that include staff testing to ensure consistent use of criteria. The inter-reliability testing process provides education and training on review criteria, as needed, to ensure consistent application of criteria. Inter-rater reliability reports submitted by **DentaQuest** showed results consistently above 96 percent.

Policies and procedures state that **DentaQuest** compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member.

Opportunities for Improvement and Recommendations

DentaQuest has an opportunity to update policies, procedures, member information, and provider information to include all federal and State requirements, such as:

- Member rights related the notice of adverse benefit determination process and members' rights to submit grievances, appeals, and requests for a State fair hearing.
- The correct time frames for standard, expedited, and extended authorization decisions.
- Using the most current terminology in the Medicaid Managed Care Rule and in its contract with the Department, **DentaQuest** should discontinue the use of "notice of action" and replace it with "notice of adverse benefit determination." Submitted documents frequently referred to "external appeals" rather than the "State fair hearing" process.

Required Actions

The *Authorization Review* policy and *Exhibit P* did not include the correct time frames for Colorado CHP+ standard or expedited authorization determination. **DentaQuest** must update its policies and procedures to align with the federal and State contract requirements, including adhering to standard and expedited authorization decisions, and as expeditiously as the member's condition requires and not to exceed 10 calendar days following the receipt of the requested service. **DentaQuest** must also address expedited authorization determinations and ensure that members are provided notice no later than 72 hours after receipt of the request. **DentaQuest** indicated that it was able to track the date and time authorization requests were received and should use this information to implement monitoring and oversight processes.

Policies and procedures related to notice of adverse benefit determination requirements did not include all required details. **DentaQuest** must update policies, procedures, and member-facing documents to:

- Describe member rights related to the State fair hearing process.
- Ensure notices of adverse benefit determination include all applicable member rights such as access to copies of all documents (not only review criteria) and correct information regarding appeal acknowledgements and resolutions, expedited requests, and extensions.
- Include the specific circumstances in which **DentaQuest** must give notice on or before the intended effective date of an adverse benefit determination.

Standard II—Adequate Capacity and Availability of Services

Evidence of Compliance and Strengths

According to a December 2022 *CO CHIP Network Analysis* report produced by **DentaQuest**, providers met time and distance standards in the following instances, coming close to its goal of 100 percent compliance with time and distance standards:

- General dentists in urban, rural, and frontier settings around 99.5 to 99.9 percent
- Pediatric dentists in urban counties 99.5 percent
- Oral surgeons in urban counties 95 percent
- Orthodontists in urban counties 99.9 percent and 96 percent in rural areas

Additionally, the HSAG FY 2021–2022 network adequacy validation (NAV) reports stated, "general dentist network performs fairly well with only six counties not meeting the standard. However, of those six counties not meeting the standard, five counties are less than 1 percentage point away from meeting the standard."

The *Office Reference Manual* (ORM) described emergency and urgent care timely appointment standards, and the *Dental Participating Practice Agreement* stated the expectation for providers to follow these standards.

Staff members described the quarterly process of producing and submitting network adequacy reports and submitted written policies and procedures regarding quarterly reporting and ad-hoc reporting to the Department in the event of a significant change in the provider network.

DentaQuest and mentions "accessibility of dental services to persons with sensory disabilities" in the *Dental Participating Practice Agreement*, and the August 2022 *Colorado Summit* newsletter included tips for accessibility and accommodations for members with Ehlers-Danlos syndrome to "ensure these patients have a good experience." **DentaQuest** submitted a *Product Accessibility* template to describe how the website is made accessible and evaluated for accessibility.

Opportunities for Improvement and Recommendations

Staff members described that in some instances, specialty services may be performed at a general dentistry office to meet time and distance standards; however, this was not currently reflected within the geoaccess reporting. HSAG encourages **DentaQuest** to work with the Department and the HSAG NAV team to explore how to reflect any additional instances where **DentaQuest** may meet time and distance standards.

DentaQuest reported that regional network managers attempt to outreach additional providers to join the provider network; however, there were no single case agreements completed during the review period. In these cases, staff members shared that members may travel longer distances to see an in-network provider. HSAG noted that members needing to travel longer distances to see in-network providers is contradictory to the requirement to provide out-of-network services in a timely manner and, furthermore, is not aligned with **DentaQuest**'s written policy *NET07-INS Access to Services for Members* and the associated standard operating procedure *NET07-INS Member Placement Process.* HSAG encourages **DentaQuest** to increase efforts to proactively fill gaps in the provider network where members do not have access within time and distance standards.

HSAG recommends adding information that the member has a right to a second opinion at no cost to the member in the member handbook.

Lastly, HSAG recommends expanding internal policies and procedures such as *NET05-INS Provider Network Adequacy*, or similar, to include the timeline details that notification to the Department will be sent "within 10 business days" and the definition of a significant change which is "5 percent in a 30 day calendar period."

Required Actions

Although many policies and procedures stated that monitoring and oversight were performed, specifically the *NET05-INS Provider Network Adequacy* policy states that results of monitoring efforts

are "documented and presented to the Quality Oversight Committee for review," and the ORM states that **DentaQuest** "administers a Quality Improvement Program that includes quarterly quality indicator tracking (i.e., appointment waiting time, access to care, etc.)." However, staff members were not able to describe or produce evidence of such oversight or monitoring through any regular internal reporting, meetings, committees, or results of quarterly provider surveys to indicate that the network is being monitored. Results of NAV reports between quarter three and quarter four of FY 2021–2022 showed a significant drop in access percentages; however, **DentaQuest** did not include this information in its own narrative or discuss this as a significant change. **DentaQuest** must enhance its internal policies, procedures, and monitoring of its network to identify gaps and to assess, act on, and address any ongoing trends related to access to care for all contracted provider types.

The September 2022 *CO CHIP Network Analysis* did not include accurate time and distance standards for general and pediatric dentists in urban, rural, and frontier counties. Additionally, many rural and frontier counties in the September and December 2022 *CO CHIP Network Analysis* reports did not have access within time and distance standards. NAV reports from FY 2021–2022 also described low adherence to requirements for oral surgeons and pediatric dentists. **DentaQuest** must:

- Ensure that ongoing network adequacy reporting adheres to current time and distance standards.
- Increase its efforts to recruit and add orthodontists, oral surgeons, and pediatric dentists in rural and frontier counties to its provider network. Evidence of an improved provider network may include analysis of quarterly NAV reports that show an improvement in access percentages and a reduction in "compliance mismatch" rows.

In instances where a general dentist may be able to perform services (e.g., oral surgeon), **DentaQuest** should consult with the Department about how this can be reflected in data and reports.

Related to cultural competency, policies and procedures described staff and provider training expectations and how staff members are expected to offer assistance to members who do not speak English as a primary language. The August 2022 *Colorado Summit* newsletter reminded providers of National Standards on Culturally and Linguistically Appropriate Services (CLAS), and staff members reported that provider cultural capabilities are collected through a quarterly credentialing survey. The *DentaQuest Enterprise Cultural Competency Plan* stated that **DentaQuest** will "periodically review current and emergent demographic trends, and identify and acquire knowledge about health beliefs and practices of emergent or new populations in service delivery areas." However, when asked for specific details regarding efforts focused on the Colorado CHP+ population, staff members were not able to describe or submit additional evidence of efforts. **DentaQuest** must enhance its cultural competency program or other related efforts to:

- Identify members whose cultural norms and practices may affect their access to dental care.
- Establish and maintain policies specific to Colorado CHP+ dental outreach for specific cultural and ethnic members for prevention, oral health education, and treatment for oral diseases prevalent in those groups.

Standard VI—Grievance and Appeal Systems

Evidence of Compliance and Strengths

DentaQuest used a new system, Salesforce, to track grievance and appeal cases. Staff members reported that the system has the capability to track the date and time of receipt, each action taken, and the resolution of the grievance and appeal case. Grievance and appeal supervisors described running daily reports to track the status of cases and to monitor timeliness of acknowledgement and resolution notices. During interviews, **DentaQuest** stated that customer service staff members have access to the Salesforce system to enter grievance and appeal cases.

DentaQuest policies and procedures describe processes to ensure that member acknowledgement and resolution notices are written in easily understood language. Case file reviews identified that grievance and appeal communications with members were written in easily understood language and were usually written at or around the sixth-grade reading level.

Opportunities for Improvement and Recommendations

While the CHP+ PAHP contract in place during the review period included the member's right to continue benefits during the appeal and State fair hearing process, it is the Department's intent to remove this language in alignment with federal regulations, which no longer require continuation of benefits for CHP+. HSAG recommends that upon contract updates, **DentaQuest** remove any references to continuation of benefits during appeal and State fair hearings in the member handbook, ORM, and any other materials so that **DentaQuest** does not misinform members about paying for ongoing services that is not required federally.

To ensure the member has a reasonable opportunity to present evidence and testimony and make legal and factual arguments, **DentaQuest** needs to not only ensure acknowledgement letters are mailed in a timely manner but also that members have the option to submit additional information in writing or in person. The *Member Appeal Form* only encourages the member to "attach" supporting documentation. HSAG recommends updating this to ensure that the member is informed sufficiently in advance of the resolution time frame and has reasonable opportunities to present evidence.

Required Actions

During interviews, staff members stated that member calls that express grievances or complaints, when resolved by the customer service representative or are resolved during the first call to customer services, may not be included in grievance and appeals tracked in the Salesforce system. This may indicate that the quarterly reports submitted to the State do not include all grievances received through customer service calls. Although **DentaQuest** indicated that complaints received by customer services and in grievance and appeals were tracked and trended, **DentaQuest** was unable to describe how customer service inquiries that included complaints were counted in the overall grievance system, the review, or

monitoring processes, nor whether actions were taken when trends were identified. **DentaQuest** must develop and implement processes to ensure that all grievances received by customer services, including those categorized as an inquiry, are included in the grievance and appeal system, and tracked, trended, and included in its quarterly reporting to the Department.

While many of the policies submitted included most of the required language, there were occasional inconsistencies with timeline and member rights details. **DentaQuest** must update its policies, procedures, provider documents, and member-facing documents to:

- Explain that providers or member representatives may file a State fair hearing request on behalf of the member with the member's written consent.
- Describe through the CHP+ member handbook and provider manual how **DentaQuest** gives members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or an appeal.
- Clearly state that the member may file an appeal either orally or in writing. **DentaQuest** must treat oral appeals in the same manner as appeals received in writing and remove language in policies, procedures, and all member communications (e.g., notices, acknowledgement, resolutions, and associated forms and attachments) that require oral requests for an appeal be followed with a written request.
- Train staff members and ensure inter-connectivity and communications between **DentaQuest** departments so that all grievances received by customer services, including those categorized as an inquiry that include a complaint and those that are resolved during the calls, are included in the grievance system and tracked, trended, and included in its quarterly reporting to the Department as required.

DentaQuest grievance record reviews demonstrated 88 percent compliance and appeals record reviews demonstrated 85 percent compliance. **DentaQuest** must implement procedures and ongoing monitoring to ensure that grievance and appeal acknowledgement and resolution notices are sent in a timely manner and include accurate information within member communications.

Standard XII—Enrollment and Disenrollment

Evidence of Compliance and Strengths

DentaQuest's *Member Enrollment* policy and procedure described organizational processes to receive and manage CHP+ membership enrollments from the State 834 enrollment file. The *Enrollment and Eligibility Subsystem* workflow provided an overview of the described policy and procedure to detail the steps involved in receiving the 834 enrollment files via a secure file transfer protocol (SFTP) site and how **DentaQuest** processed, validated, reviewed, and approved the enrollment files before the files are uploaded to the appropriate systems. During the interview, **DentaQuest** confirmed that eligible CHP+ members are accepted in the order in which they apply and without restriction. **DentaQuest** staff members described that manual processes for enrollment processing involved correcting inaccurate data

as needed. Furthermore, staff members explained how a one-day eligibility request may come in for a member to obtain needed services from **DentaQuest**. Staff members reported that **DentaQuest** responds to the manual requests within 24 to 48 hours.

DentaQuest's *Non-Discrimination Compliance Program* policy provided a framework to ensure non-discrimination practices related to the access of the member's healthcare benefits and services. **DentaQuest** made members aware of its non-discrimination practices and statements through the member handbook and member-facing website. Additionally, **DentaQuest** staff members reported that they were unaware of receiving any grievances related to enrollment practices.

Opportunities for Improvement and Recommendations

HSAG recommends, as a best practice, that **DentaQuest** add the CHP+ manual enrollment process to the existing *Member Enrollment* policy and procedure to ensure staff members are aware of the appropriate steps for manual entry.

Required Actions

HSAG identified no required actions for this standard.

2. Overview and Background

Overview of FY 2022–2023 Compliance Monitoring Activities

For the FY 2022–2023 compliance 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 I—Coverage and Authorization of Services, Standard II—Adequate Capacity and Availability of Services, Standard VI—Grievance and Appeal Systems, and Standard XII—Enrollment and Disenrollment. Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of the four standards.

Compliance Monitoring Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the PAHP's contract requirements and regulations specified by the federal Medicaid/CHP+ managed care regulations published May 6, 2016. Additional revisions were released in November 2020, with an effective date of December 2020. HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable.* The Department determined that the review period was January 1, 2022, through December 31, 2022. HSAG conducted a desk review of materials submitted prior to the compliance review activities; a review of records, documents, and materials requested during the compliance review; and interviews of key PAHP personnel to determine compliance with federal managed care regulations and contract requirements. Documents submitted for the desk review and compliance review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, and member, provider informational materials, and administrative records related to authorization of services (denials), grievances, and appeals.

HSAG also reviewed a sample of the PAHP's administrative records related to denials, grievances, and appeals to evaluate implementation of federal and State 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 the denials, grievances, and appeals. Using a random sampling technique, HSAG selected the samples from all CHP+ denial, grievance, and appeal records that occurred between January 1, 2022, and December 31, 2022. 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 I—Coverage and Authorization of Services and 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 compliance 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 compliance review activities consistent with those outlined in the CMS EQR protocol. The four standards chosen for the FY 2022–2023 compliance reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights, Protections, and Confidentiality, Standard V—Member Information Requirements, Standard VII—Provider Selection and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontractual Relationships and Delegation, and Standard X—Quality Assessment and Performance Improvement (QAPI).

Objective of the Compliance Review

The objective of the compliance 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 dental 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 2021–2022 Corrective Action Methodology

As a follow-up to the FY 2021–2022 compliance 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 the PAHP 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 2021–2022 compliance monitoring review.

Summary of FY 2021–2022 Required Actions

For FY 2021–2022, HSAG reviewed Standard III—Coordination and Continuity of Care, Standard IV—Member Rights, Protections, and Confidentiality, Standard VIII—Credentialing and Recredentialing, and Standard X—QAPI.

Related to Standard III—Coordination and Continuity of Care, **DentaQuest** met four of the 10 applicable elements and was required to complete the following actions:

- Develop and implement procedures to deliver care to and coordinate services for all members.
- Develop and implement procedures to coordinate services between settings of care and with any other managed care plan.
- Provide best efforts to conduct an initial screening for each new member (i.e., an assessment when the member presents for services with a provider)
- Implement a method to ensure that providers maintain member health records in accordance with professional standards.
- Define special healthcare needs for the CHP+ dental population and implement a mechanism to assess CHP+ members with special health care needs for appropriate dental services and associated support needs.
- Develop and implement a process to require providers to produce a treatment or service plan, including revision of such plan when the member's circumstances or needs change significantly or at the request of the member.

Related to Standard X—QAPI, **DentaQuest** met eight of the 16 elements and was required to complete the following actions:

- Develop a comprehensive QAPI program to provide oversight for CHP+ services.
- Include performance improvement project information in the QAPI program.
- Incorporate other CHP+ performance measure reporting into the QAPI program.
- Develop a mechanism to detect over- and under-utilization of services specific to the CHP+ line of business.
- Develop a mechanism to assess the quality and appropriateness of care furnished to members with special health care needs.
- Include a process for evaluating the impact and effectiveness of the QAPI program that is specific to the CHP+ line of business, on at least an annual basis.
- Ensure that decisions for utilization management, member education, coverage of services, and other areas to which the clinical practice guidelines apply are consistent.
- Monitor CHP+ members' satisfaction, which includes complaints, appeals, and grievance information.

DentaQuest did not have any required actions for Standard IV—Member Rights, Protections, and Confidentiality or Standard VIII—Credentialing and Recredentialing.

Summary of Corrective Action/Document Review

DentaQuest submitted a proposed CAP in April 2022. HSAG and the Department reviewed the CAP and requested that the CAP to be resubmitted to include proposed interventions, training, monitoring, and expected documents for final submission. **DentaQuest** resubmitted the CAP in June 2022 and received approval from the Department to continue to the implementation phase. **DentaQuest** submitted evidence in September 2022 and 11 items were requested to be resubmitted again on January 3, 2023.

Summary of Continued Required Actions

DentaQuest completed the required actions for all but 11 items, resulting in ongoing work regarding care coordination and the QAPI program. These items will be carried over into the FY 2022–2023 CAP.

Appendix A. Colorado Department of Health Care Policy & Financing
FY 2022–2023 Compliance Monitoring Tool
for DentaQuest

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
1. The Contractor ensures that the services are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the services are furnished. *42 CFR 438.210(a)(3)(i)* Contract Amendment 5: Exhibit B-1—4.1.8.1	**Suggested Documents:** Oral Health Action Plan Coverage and authorization policies and procedures (Throughout this standard, HSAG will use results from denial record reviews to score the related requirements.) **Submitted Documents:** UM01-INS-Establishment and Adoption of Utilization Review Criteria and Clinical Guidelines pg. 2 - Procedure A.8	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. *42 CFR 438.210(a)(3)(ii)* Contract Amendment 5: Exhibit B-1—None	**Suggested Documents:** Coverage and authorization policies and procedures **Submitted Documents:** UM01-INS-Establishment and Adoption of Utilization Review Criteria and Clinical Guidelines pg. 2 - Procedure A.9	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor may place appropriate limits on services— • On the basis of criteria applied under the State plan (such as medical necessity). • For the purpose of utilization control, provided that: – The services furnished can reasonably achieve their purpose. • The Contractor shall establish review criteria that reflect best practices and are responsive to utilization trends. • The Contractor shall establish criteria for each prior authorized service using Department coverage policies as well as nationally	**Suggested Documents:** Coverage and authorization policies and procedures **Submitted Documents:** UM01-INS-Establishment and Adoption of Utilization Review Criteria and Clinical Guidelines pgs. 1-2 - Procedure A & B	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
recognized, evidenced-based criteria to make Prior Authorization Request (PAR) determinations. *42 CFR 438.210(a)(4)* Contract Amendment 5: Exhibit B-1—4.1.8.1.3.8; 4.3.1.2.8-1		
4. The Contractor definition of "medically necessary": • Is no more restrictive than that used in Colorado's Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in Colorado statutes and regulations, the Health First Colorado plan, and other Colorado policies and procedures; and • Addresses the extent to which the CHP+ is responsible for covering services that address: – The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability. – The ability for a member to achieve age-appropriate growth and development. – The ability for a member to attain, maintain, or regain function capacity. *42 CFR 438.210(a)(5)* Contract Amendment 5: Exhibit B-1—1.1.48	**Suggested Documents:** Coverage and authorization policies and procedures Relevant member materials **Submitted Documents:** UM01-INS-Establishment and Adoption of Utilization Review Criteria and Clinical Guidelines pg. 2 - Procedure A UM Program Description pg. 6 – first paragraph A-E Colorado CHP+ ORM	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
5. The Contractor and its subcontractors have in place and follow written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42 CFR 438.210(b)(1)* Contract Amendment 5: Exhibit B-1—4.3.12.1	**Suggested Documents:** Utilization review/utilization management (UR/UM) policies and procedures Provider agreement or manual/Office Reference Manual (ORM) **Submitted Documents:** Colorado CHP+ ORM UM Program Description pgs. 6-8 – Prior Authorization Review and Prepayment Review UM08-INS-Authorization Review – entire policy UM17-INS-GOV-Continuation of Care – entire policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The Contractor and its subcontractors have mechanisms in place to ensure consistent application of review criteria for authorization decisions. *42 CFR 438.210(b)(2)(i)* Contract Amendment 5: Exhibit B-1—4.1.8.1.7	**Suggested Documents:** UR/UM policies and procedures **Submitted Documents:** UM Program Description pg. 10 – Inter-Rater Reliability Program UM01-INS-Establishment and Adoption of Utilization Review Criteria and Clinical Guidelines pg. 1 – Purpose & Policy sections; pg. 3 – Ongoing and Annual Assessment	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
7. The Contractor and its subcontractors have in place mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider for dental services, when appropriate. *42 CFR 438.210(b)(2)(ii)* Contract Amendment 5: Exhibit B-1—4.1.8.1.7	**Suggested Documents:** UR/UM policies and procedures Inter-rater reliability procedures **Submitted Documents:** UM Program Description pg. 6 – Prior Authorization Review last paragraph; pg. 10 – Inter-Rater Reliability Program UM01-INS-Establishment and Adoption of Utilization Review Criteria and Clinical Guidelines pg. 1 – Purpose & Policy sections; pg. 3 – Ongoing and Annual Assessment UM IRR Results 2022	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by an individual who has appropriate expertise in treating the member's dental health needs. *42 CFR 438.210(b)(3)* Contract Amendment 5: Exhibit B-1—4.3.7.1.2	**Suggested Documents:** Denial policies and procedures **Submitted Documents:** UM08-INS-Authorization Review pg. 3 – Procedure A.1 UM Program Description pg. 2 – Title of Position and Qualifications	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor notifies the requesting provider and gives the member written notice of any decision by the Contractor to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. *Note: Notice to the provider may be oral or in writing.*	**Suggested Documents:** Denial policies and procedures **Submitted Documents:** UM04-INS-Notice of Action Letters pgs. 1-2 Procedure A & B	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
42 CFR 438.210(c) Contract Amendment 5: Exhibit B-1—4.8.14.6 10 CCR 2505-10 8.209.4.A.1		
10. The Contractor adheres to the following time frames for making standard and expedited authorization decisions: • For standard authorization decisions—as expeditiously as the member's condition requires and not to exceed 10 calendar days following the receipt of the request for service. • If the provider indicates, or the Contractor determines, that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization determination and provides notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service. *42 CFR 438.210(d)(1–2)* Contract Amendment 5: Exhibit B-1—4.6.1 10 CCR 2505-10 8.209.4.A.3.c	**Suggested Documents:** Authorization policies and procedures **Submitted Documents:** UM08-INS-Authorization Review pg. 3 – Prior Authorization Review A.2 and Exhibit P – Colorado CHP	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DentaQuest's *UM08-INS-Authorization Review* policy and procedure includes authorization time frames as follows: Unless specified differently by the plan or regulation, determinations are completed within the following time frames from the receipt of the request: • Standard: 14 calendar days. • Emergent/urgent: 72 hours.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
DentaQuest's *Exhibit P – Colorado CHP* states that this section replaces section A.2. in the general policy. Time frames for prior authorizations are determined within the following time frames from the receipt of the request for service: • Standard: Within four business days of receiving all information for the request, in any given month, and under no circumstances may the review exceed 10 business days. • Expedited: Within two business days.		
Required Actions: DentaQuest must update its policies and procedures to align with the federal regulations and the Department's contract requirements including: • For standard authorization decisions—as expeditiously as the member's condition requires and not to exceed 10 calendar days following the receipt of the request for service. • If the provider indicates, or the Contractor determines, that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization determination and provides notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service. DentaQuest indicated that it was able to track the date and time authorization requests were received and should use this information to implement monitoring and oversight processes. DentaQuest should ensure that reasonable time is spent assessing clinical documentation and outreaching providers during the 10 calendar days to ensure that the case review is sufficient before closing the case.		
11. The Contractor may extend the time frame for making standard or expedited authorization decisions by up to 14 additional calendar days if: • The member or the provider requests an extension, or • The Contractor justifies (to the Department, upon request) a need for additional information and how the extension is in the member's interest. *42 CFR 438.210(d)(1)(i–ii) and (d)(2)(ii)* Contract Amendment 5: Exhibit B-1—4.7.6.1; 4.7.8.1	**Suggested Documents:** Authorization policies and procedures Member communication samples/templates **Submitted Documents:** UM08-INS-Authorization Review pg. 3 – Prior Authorization Review A.4 CO CHP Preservice Extension Notice	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
12. The notice of adverse benefit determination must be written in language easy to understand, available in state-established prevalent non-English languages in the region, and available in alternative formats for persons with special needs. *42 CFR 438.404(a)* Contract Amendment 5: Exhibit B-1—4.7.1-4 10 CCR 2505-10 8.209.4.A.1	**Suggested Documents:** Denial policies and procedures **Submitted Documents:** UM Program Description pg. 8 – Authorization Determination Notification UM04-INS-Notice of Action Letters pgs. 2-3 – Denial Notification B.1-2	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Nine out of 10 sample files included member communications at or around the sixth-grade reading level. However, denial sample file #2 included the denied service codes and clinical explanation of the service, but did not include a plain language explanation regarding which services were denied (e.g., lower left quadrant, surgical flap). Many denial notices cited "CCR" but did not explain or define the abbreviation to members.		
Required Actions: DentaQuest must ensure that any clinical terminology or abbreviations include an easy-to-understand explanation.		
13. The notice of adverse benefit determination must explain the following: • The adverse benefit determination the Contractor has made or intends to make. • The reasons for the adverse benefit determination, including the right of the member to be provided upon request (and free of charge), reasonable access to and copies of all documents, and records relevant to the adverse benefit determination (includes medical necessity criteria and strategies, evidentiary standards, or processes used in setting coverage limits). • The member's (or member's designated representative's) right to request one level of appeal with the Contractor and the procedures for doing so.	**Suggested Documents:** Denial policies and procedures Forms **Submitted Documents:** UM04-INS-Notice of Action Letters pgs. 2-3 – Denial Notification B.1-2	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
• The member's right to request a State fair hearing after receiving an appeal resolution notice from the Contractor that the adverse benefit determination is upheld. • The procedures for exercising the right to request a State fair hearing. • The circumstances under which an appeal process can be expedited and how to make this request. *42 CFR 438.404(b)* Contract Amendment 5: Exhibit B-1—4.7.1.5-10; 4.7.1.12 10 CCR 2505-10 8.209.4.A.2		
Findings: DentaQuest's *UM04-INS-Notice of Action Letters* policy states that the notice of action (NOA) or integrated denial letter (IDN) includes: • State fair hearing request information, if applicable. • A reference to the external appeal process available for all final adverse [benefit] determinations. The policy did not reference the requirement that the notice include the circumstances under which an appeal process can be expedited and how to make this request. The policy did not fully include the requirement that the State fair hearing can be requested by the member after receiving an appeal resolution notice that the adverse benefit determination is upheld, or the member is informed of the process to exercise their right to a State fair hearing. A review of 10 sample case files identified that DentaQuest had not implemented these requirements in any of its member notices. All 10 sample denial cases included incorrect information regarding appeal acknowledgements and resolutions and incomplete information regarding expedited requests and extension procedures. None of the 10 sample denial cases stated that the member could request reasonable access to and copies of all documents (only stated that the review criteria were available).		
Required Actions: DentaQuest must update its policies, procedures, and notice of adverse benefit determination (NABD) templates to explain all required details. It is recommended that DentaQuest review policies and procedures and make updates to ensure consistent use of NABD rather than NOA to align with the Medicaid Managed Care Rule terminology.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
14. The Contractor mails the notice of adverse benefit determination within the following time frames: • For termination, suspension, or reduction of previously authorized CHP+-covered services, as defined in 42 CFR 431.211, 431.213, and 431.214 (see below). • For denial of payment, at the time of any denial affecting the claim. • For standard service authorization decisions that deny or limit services, no later than 10 calendar days after receipt of request for service. • For expedited service authorization decisions, no later than 72 hours after receipt of request for service. • For extended service authorization decisions, no later than the date the extension expires. • For service authorization decisions not reached within the required time frames, on the date the time frames expire. *42 CFR 438.404(c)* *42 CFR 438.210(d)* Contract Amendment 5: Exhibit B-1—4.6.1 10 CCR 2505-10 8.209.4.A.3	**Suggested Documents:** Denial policies and procedures Authorization policies and procedures Tracking reports or evidence of time frame monitoring **Submitted Documents:** UM08-INS-Authorization Review pg. 3 – Prior Authorization Review A.2-4 and Exhibit P – Colorado CHP	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
Findings: All sample denials reviewed were mailed within timeliness standards. However, DentaQuest's *UM08-INS-Authorization Review* policy states that the time frames for completing determinations include: • Standard: 14 calendar days; which should be 10 calendar days.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
DentaQuest's *Exhibit P – Colorado CHP* states time frames for prior authorizations are determined within the following time frames from the receipt of the request for service: • Expedited: Within two business days; which should be 72 hours.		
Required Actions: DentaQuest must update its policies and procedures to include the process and time frame for mailing the standard, urgent/emergent, and extended notices to the member; mailing a notice at the time of any denial affecting the claim; for extended service authorization decisions, the requirement to mail the notice no later than the date the extension expires; and, for service authorization decisions not reached within the required time frames, on the date the time frames expire. DentaQuest must also update its policies to consistently state that that for standard service authorization decisions that deny or limit services, a notice of adverse benefit determination will be mailed to the member no later than 10 calendar days after receipt of the request for service.		
15. For reduction, suspension, or termination of a previously authorized CHP+-covered service, the Contractor gives notice at least 10 days before the intended effective date of the proposed adverse benefit determination except: • The Contractor gives notice on or before the intended effective date of the proposed adverse benefit determination if: – The Contractor has factual information confirming the death of a member. – The Contractor receives a clear written statement signed by the member that the member no longer wishes services or gives information that requires termination or reduction of services and indicates that the member understands that this must be the result of supplying that information. – The member has been admitted to an institution where the member is ineligible under the plan for further services and the Department notifies the Contractor of this change. – The member's whereabouts are unknown, and the post office returns Contractor mail directed to the member indicating no forwarding address.	**Suggested Documents:** Policies and procedures **Submitted Documents:** N/A DentaQuest does not reduce, suspend, or terminate previously authorized services UM-08-INS-Authorization Review pg. 6 – Retrospective Review or Prepayment Review B.5-6	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
– The Contractor establishes that the member has been accepted for CHP+ services by another local jurisdiction, state, territory, or commonwealth and the Department notifies the Contractor of this change. – A change in the level of dental services is prescribed by the member's dentist. • If probable member fraud has been verified, the Contractor gives notice five calendar days before the intended effective date of the proposed adverse benefit determination. *42 CFR 438.404(c)* *42 CFR 431.211* *42 CFR 431.213* *42 CFR 431.214* Contract Amendment 5: Exhibit B-1—4.7.3.1-2; 4.7.4.1-4 10 CCR 2505-10 8.209.4.A.3(a)		
Findings: DentaQuest's *UM-08-INS-Authorization Review* policy states that authorizations approved by DentaQuest cannot be retrospectively denied except for fraud or abuse, or misinformation and/or incomplete information from the provider, subject to the eligibility and coverage provisions of the contract, and therefore the requirement is not applicable. DentaQuest's policies and procedures do not state that it gives notice on or before the intended effective date of the proposed adverse benefit determination in the specific circumstances listed in this requirement.		
Required Actions: : DentaQuest must update its policies and procedures to include the requirement that DentaQuest gives notice on or before the intended effective date of the proposed adverse benefit determination in the specific circumstances listed in this requirement.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
16. If the Contractor extends the time frame for standard authorization decisions, it must give the member written notice of the reason for the extension and inform the member of the right to file a grievance if the member disagrees with that decision. *42 CFR 438.404(c)(4)* Contract Amendment 5: Exhibit B-1—4.7.6.2 10 CCR 2505-10 8.209.4.A.3.c.i	**Suggested Documents:** Authorization policies and procedures Sample letter template **Submitted Documents:** UM08-INS-Authorization Review pg. 3 – Prior Authorization Review A.4 CO CHP Preservice Extension Notice	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
17. The Contractor provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42 CFR 438.210(e)* Contract Amendment 5: Exhibit B-1—4.3.12.1.7	**Suggested Documents:** Policies and procedures Staff messaging **Submitted Documents:** UM Program Description pg. 5 – last paragraph HR02.07-ENT-UM Staff De-Incentives – entire policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	12	X	1.00	=	12
	Partially Met	=	2	X	.00	=	0
	Not Met	=	3	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	17	**Total Score**		=	12
				Total Score ÷ Total Applicable		=	71%

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
1. The Contractor maintains and monitors a statewide network of oral healthcare providers sufficient to provide access to all covered services to all members, including those with limited English proficiency or physical or mental disabilities. The provider network includes the following types of providers: general dentists, orthodontists, periodontists, prosthodontists, endodontists, pediatric dentists, oral surgeons, and dental hygienists. *42 CFR 438.206(b)(1)* Contract Amendment 5: Exhibit B-1—4.1.2.1; 4.1.2.3.2	**Suggested Documents:** Network adequacy reports Network adequacy committee minutes (or equivalent) Evidence of monitoring: tracking tools, spreadsheets, etc. **Submitted Documents:** NET05-INS. (Entire Document) 210901 CP CHP+ MC contract (pg.2 section d) CHP+ ORM (Different Sections) NET07-INS (Pg. 1 Purpose and Policy, Pg.2 sections B. and D.) Network Adequacy Report (Entire Document) 2022 HCSC-WAS Product Accessibility (Entire Document) Online Provider Directory Policies and SOP (Entire Document)	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Although many policies and procedures stated that monitoring and oversight were performed, specifically the *NET05-INS Provider Network Adequacy* policy states that results of monitoring efforts are "*documented and presented to the Quality Oversight Committee for review,*" and the ORM states that DentaQuest "*administers a Quality Improvement Program that includes quarterly quality indicator tracking (i.e., appointment waiting time, access to care, etc.).*" However, staff members were not able to describe or produce evidence of such oversight or monitoring through any regular internal reporting, meetings, committees, or results of quarterly provider surveys to indicate that the network is being monitored.		
Required Actions: DentaQuest must enhance its internal policies, procedures, and monitoring of its network to identify gaps and to assess, act on, and address any ongoing trends related to access to care for all contracted provider types. Examples of evidence may include additional oversight reporting or committee review.		

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
2. The Contractor shall have written policies guaranteeing each member's right to a second opinion from a network provider or arranges for the member to obtain one outside the network (if there is no qualified provider within the network), at no cost to the member. *42 CFR 438.206(b)(3)* Contract Amendment 5: Exhibit B-1—4.4.8.4	**Suggested Documents:** Policies and procedures Member messaging **Submitted Documents:** CHP+ ORM (Different Sections) UM Program Description pg. 9 – Second Opinions	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. If the provider network is unable to provide necessary covered services to a particular member in network, the Contractor must cover the services (timely and without compromising the member's quality of care or health) out of network for as long as the Contractor is unable to provide them. *42 CFR 438.206(b)(4)* Contract Amendment 5: Exhibit B-1—4.1.2.8.1	**Suggested Documents:** Policies and procedures Relevant member materials Committee minutes or network structure **Submitted Documents:** NET07-INS (Pg. 1 Purpose and Policy, Pg. 2 Sections A., C.) NET07-INS-SOP (Entire Document) UM15-INS-Access to Services-Out of Network	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor requires out-of-network providers to coordinate with the Contractor for payment and ensures that the cost to the member is no greater that it would be if the services were furnished within the network. *42 CFR 438.206(b)(5)* Contract Amendment 5: Exhibit B-1—4.1.2.8.2	**Suggested Documents:** Out-of-network policies and procedures Single case agreement template Communications to out-of-network providers via explanation of payments (EOP) or other means **Submitted Documents:** NET07-INS (Pg. 3 Section C)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
	NET07-INS-SOP (Entire Document) UM15-INS-Access to Services-Out of Network pg. 1 Procedure D	
5. The Contractor must meet, and require its providers to meet, the State standards for timely access to care and services, taking into account the urgency of the need for services. The Contractor ensures that services are available as follows: • Emergency dental services— – Immediately, during normal dental office business hours. – A taped telephone message shall instruct members to go directly to an emergency room if the member needs emergency care after normal business hours. • Urgent care is available within 48 hours from the initial identification of need. • Emergent care is available within 24 hours from the initial identification of need. *42 CFR 438.206(c)(1)(i)* Contract Amendment 5: Exhibit B-1—4.1.2.11.5; 4.3.1.5	**Suggested Documents:** Network adequacy reporting Policies and procedures Provider agreement or manual/ORM **Submitted Documents:** NET01-INS (Pg. 3 Number 6) NET05-INS (Pg. 2 Section B.) CHP+ORM (Different Sections)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The Contractor ensures that its dental network complies with time and distance standards as follows: • General and pediatric dentists – Urban—30 miles and/or 30 minutes – Rural—45 miles and/or 45 minutes – Frontier—60 miles and/or 60 minutes	**Suggested Documents:** Policies and procedures Network adequacy reports Provider agreement or manual/ORM **Submitted Documents:** NET05-INS (Pg. 1 Purpose, Policy and Procedure; Section A., Pg. 2 Section C, D., and E.)	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
• Orthodontists and Oral Surgeons – Urban—60 miles and/or 60 minutes – Rural—75 miles and/or 75 minutes – Frontier—90 miles and/or 90 minutes *42 CFR 438.206(a)* Contract Amendment 5: Exhibit B-1—4.1.2.3.1	Network Adequacy Report (Entire Document)	

Findings:
The September 2022 *CO CHIP Network Analysis* report did not include accurate time and distance standards for general and pediatric dentists in urban, rural, and frontier counties (i.e., 60, 75, 90 miles and minutes instead of 30, 45, 60 miles and minutes).

The results in the report showed that the majority of time and distance standards were not met. The September 2022 *CO CHIP Network Analysis* report submitted by DentaQuest indicated:

- In rural counties:
  - 60.8 percent of members without access to oral surgeons
  - 7.5 percent of members without access to orthodontists
  - 6.3 percent of members without access to a pediatric dentist
- In frontier counties:
  - 71 percent of members without access to oral surgeons
  - 23 percent of members without access to orthodontists
  - 10 percent of members without access to pediatric dentists

The December 2022 *CO CHIP Network Analysis* report submitted by DentaQuest indicated:

- In rural counties:
  - 32 percent of members without access to pediatric dentists
  - 57.7 percent of members without access to oral surgeons

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
• In frontier counties: – 34.2 percent of members without access to pediatric dentists – 66.2 percent of members without access to oral surgeons – 17.8 percent of member without access to orthodontists Additionally, the HSAG FY 2021–2022 NAV results stated that DentaQuest did not meet the minimum time and distance network requirements for more than half of its contracted counties for oral surgeons and pediatric dentists.		
Required Actions: DentaQuest must update internal reports and associated procedures to include the correct time and distance standards for general and pediatric dentists in urban, rural, and frontier counties. Monitoring efforts should include ongoing demonstration of the correct time and distance standards through future quarterly reports. While HSAG acknowledges a shortage of providers in rural and frontier counties, DentaQuest must increase its efforts to recruit and add orthodontists and oral surgeons in rural and frontier counties to the provider network. Evidence of an improved provider network may be demonstrated in quarterly NAV reports that show an improvement in access percentages and a reduction in "compliance mismatch" rows. In instances where a general dentist may be able to perform services (e.g., oral surgeon), DentaQuest should consult with the Department about how this can be reflected in data and reports.		
7. The Contractor and its providers offer hours of operation that are no less than the hours of operation offered to commercial members or are comparable to Medicaid fee-for-service (FFS) members, if the provider serves only CHP+ members. *42 CFR 438.206(c)(1)(ii)* Contract Amendment 5: Exhibit B-1—4.1.2.16	**Suggested Documents:** Policies and procedures Provider agreement or manual/ORM **Submitted Documents:** UM10-INS-Acces to UM Department pg. 1 – Procedure A & C 210901 CO CHP+ MC contract (pg.2 section d) CS03-INS-DENT-Customer Service Incoming Phone Lines (pg.1, section B.1) Addendum to Policy CS03	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
8. The Contractor makes services included in the contract available 24 hours a day, seven days a week, when medically necessary. *42 CFR 438.206(c)(1)(iii)* Contract Amendment 5: Exhibit B-1—None	**Suggested Documents:** Policies and procedures Provider agreement or manual **Submitted Documents:** UM10-INS-Acces to UM Department pg. 1 – Procedure A & C CS03-INS-DENT-Customer Service Incoming Phone Lines (pg.1, section B.2) CHP+ ORM (Different Sections) NET05-INS (Pg. 2 Section D.)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor ensures timely access by: • Establishing mechanisms to ensure compliance with access (e.g., appointment) standards by network providers. • Monitoring network providers regularly to determine compliance. • Taking corrective action if there is failure to comply. *42 CFR 438.206(c)(1)(iv)–(vi)* Contract Amendment 5: Exhibit B-1—4.1.2.11.6	**Suggested Documents:** Network adequacy reports Timely access survey Corrective action plans **Submitted Documents:** CHP+ ORM (Different Sections) NET05-INS (Pg. 1- Policy, Pg. 2 Section B, D and E) NET01-INS (Pg.3 Number 6)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
10. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. This includes: • Developing and providing cultural competency training programs, as needed, to network providers and Contractor staff regarding: – Healthcare attitudes, values, customs, and beliefs that affect access to and benefit from healthcare services. – Oral health risks associated with the member population's racial, ethnic, and socioeconomic conditions. • Identifying members whose cultural norms and practices may affect their access to healthcare. • Establishing and maintaining policies to reach out to specific cultural and ethnic members for prevention, oral health education, and treatment for oral diseases prevalent in those groups. *42 CFR 438.206(c)(2)* Contract Amendment 5: Exhibit B-1—4.1.2.5; 4.1.12	**Suggested Documents:** Access and cultural consideration policies and procedures Cultural competency plan and associated trainings Quality initiatives or studies **Submitted Documents:** CHP+ ORM (Different Sections) Provider Newsletter (Pg. 1-2 – Cultural Competency Program) NET01-INS (Pg. 2 number 5, Pg.4 Number 9) NET07-INS (Pg.1 Purpose and Policy, Pg.2 Section B., Pg.4 Section D)	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Related to cultural competency, policies and procedures described staff and provider training expectations and how staff members are expected to offer assistance to members who do not speak English as a primary language. The August 2022 *Colorado Summit* newsletter reminded providers of National Standards on Culturally and Linguistically Appropriate Services (CLAS), and staff members reported that provider cultural capabilities are collected through a quarterly credentialing survey. The *DentaQuest Enterprise Cultural Competency Plan* stated that DentaQuest will "periodically review current and emergent demographic trends, and identify and acquire knowledge about health beliefs and practices of emergent or new populations in service delivery areas." However, when asked for specific details regarding efforts focused on the Colorado CHP+ population, staff members were not able to describe or submit additional evidence of efforts.		

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
Required Actions: DentaQuest must enhance its cultural competency program or other related efforts to: • Identify members whose cultural norms and practices may affect their access to dental care. • Establish and maintain policies specific to Colorado CHP+ dental outreach for specific cultural and ethnic members for prevention, oral health education, and treatment for oral diseases prevalent in those groups.		
11. The Contractor must ensure that network providers have the ability to provide physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities. *42 CFR 438.206(c)(3)* Contract Amendment 5: Exhibit B-1—4.1.2.11.2; 4.1.6.17	**Suggested Documents:** Policies and procedures Provider agreement or manual/ORM Reports of accommodations provided **Submitted Documents:** NET07-INS (Pg.2 Section B., Pg.4 Section D) 210901 CO CHP+ MC contract (pg.2 section d)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor submits to the State (in a format specified by the State) documentation to demonstrate that the Contractor offers an appropriate range of preventive, primary care, and specialty services that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. • Quarterly documentation related to network adequacy. • Within 10 business days, in writing, all changes in provider networks related to quality of care, competence, or professional conduct. • Within 10 business days, in writing, any changes greater than or equal to 5 percent in the Contractor's provider network in a 30-calendar-day period. *42 CFR 438.207(b)* Contract Amendment 5: Exhibit B-1—4.1.2.12–14	**Suggested Documents:** Network adequacy reports **Submitted Documents:** Network Adequacy Report (Entire Document) NET05-INS (Pg.2 Section C.) No Network changes occurred during the audit period that exceeded the 5% threshold. PEC05-INS-Provider Disciplinary Action CAP and Appeal Policy-FINAL	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard II—Adequate Capacity and Availability of Services							
Total	Met	=	9	X	1.00	=	9
	Partially Met	=	3	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	12	**Total Score**		=	9
			Total Score ÷ Total Applicable			=	75%

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
1. The Contractor has an established internal grievance and appeal system in place for members, or providers acting on their behalf, or designated member representatives. 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)* Contract Amendment 5: Exhibit B-1—4.6.1 10 CCR 2505-10 8.209.1	**Suggested Documents:** Grievance and appeal policies and procedures Reports Grievances and Appeals Department Overview (Throughout this standard, HSAG will use results from grievance and appeal record reviews to score the related requirements.) **Submitted Documents:** Grievance and appeal policies and procedures **CGA06-INS Member complaints/grievances** **Page 3; B. a,** **CGA09-INS-MCDCHIP Member appeals** **Page 3; B. 1.** Reports ***Record Reviews Universe Provided 10/10/2022***	☒ 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.	**Suggested Documents:** Policies and procedures that address denials/adverse benefit determination **Submitted Documents:** Policies and procedures that address denials/adverse benefit determination **CGA09-INS-MCDCHIP Member appeals** **Page 1; Definitions. Adverse Benefit Determination**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
• 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). *Note: A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a ''clean claim'' at 42 CFR §447.45(b) is not an adverse benefit determination.* *42 CFR 438.400(b)* Contract Amendment 5: Exhibit B-1—None 10 CCR 2505-10 8.209.2.A		
3. The Contractor defines "appeal" as a review by the Contractor of an adverse benefit determination. *42 CFR 438.400(b)* Contract Amendment 5: Exhibit B-1—4.8.1 10 CCR 2505-10 8.209.2.B	**Suggested Documents:** Policies and procedures Staff training materials, agendas, presentation materials, minutes, etc. **Suggested Documents:** Grievance policies and procedures CGA09-INS-MCDCHIP Member appeals Page 2; Definitions. Appeal	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Dental 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)* Contract Amendment 5: Exhibit B-1—4.6.5.1 10 CCR 2505-10 8.209.2. D, 8.209.4. A.3.c.i	**Suggested Documents:** Grievance policies and procedures Staff training materials, agendas, presentation materials, minutes, etc. Provider newsletter, if applicable Critical member informing materials such as the member handbook and member-specific letter templates **Submitted Documents:** Grievance policies and procedures CGA06-INS Member complaints/grievances Page 1; Definitions. Grievance: CO CHP Grievance Resolution CO CHP Grievance Acknowledgement CO CHP Grievance Withdrawal Confirmation	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DentaQuest described processes where customer service representatives received calls from members which were categorized as inquiries. DentaQuest indicated that although the call may have been initiated as a complaint or grievance, it was categorized as an inquiry. DentaQuest did not provide a process that ensured complaints or grievances received by customer services were included in the grievance and appeal system. The description identified that when the customer service representative categorized the call as an inquiry, it remained in the customer service system. During the interview session, DentaQuest was unable to confirm that grievances received anywhere in the organization were included in its grievance and appeal system, were tracked and trended, or included in is quarterly reporting to the Department. Furthermore, the UM Program Description includes the term "formal complaint."		
Required Actions: DentaQuest must develop and implement processes to ensure that all grievances received by customer services, including those categorized as an inquiry, are included in the grievance and appeal system, and tracked, trended, and included in its quarterly reporting to the Department. Additionally, DentaQuest must update the UM Program Description to remove the word "formal" in reference to complaints.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
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 acting on behalf of the member.* *42 CFR 438.402(c)* Contract Amendment 5: Exhibit B-1—4.4.9.1; 4.6; 4.7 ; 4.8.5	**Suggested Documents:** Grievance policies and procedures **Submitted Documents:** Grievance policies and procedures CGA09-INS-MCDCHIP Member appeals Page 15; D. 1. 2.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DentaQuest's *CGA06-INS Member Complaints/Grievances* policy states that members have the right to submit a grievance to DentaQuest at any time. It also states that the member must provide written consent for the representative, which may include the provider, to act on their behalf during the grievance, including the filing of the grievance. DentaQuest's *CGA09-INS-MCDCHIP Member Appeals* policy states that members have the right to submit an appeal to DentaQuest. It also states that members have the right to assign a representative. The representative can be any individual of the member's choosing including spouse, family member, attorney, provider, power of attorney, guardian, etc. This may also include the legal representative of a deceased member's estate. It also states that the member must provide written consent for the representative to act on their behalf during the appeal, including requesting the appeal. For a request for a State fair hearing, the *Appeals* policy indicates that members, providers, or member representatives have 120 calendar days from the date of the notice of the appeal resolution from DentaQuest to file a request for a State fair hearing. The policy does not state that the member's written consent is needed to file a State fair hearing request on behalf of the member. The policy does state that the member's written consent is needed for someone else to be the member's representative at a State fair hearing.		
Required Actions: DentaQuest must update its policies and procedures to state that providers or member representatives may file a State fair hearing request on behalf of the member with the member's written consent.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Dental 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 TeleTYpe/Telecommunications Device for the Deaf (TTY/TDD) and interpreter capabilities. *42 CFR 438.406(a)* Contract Amendment 5: Exhibit B-1—4.6.3 10 CCR 2505-10 8.209.4.C	**Suggested Documents:** Grievance and appeals policies and procedures - NA Staff training materials, agendas, presentation materials, minutes, etc. Critical member informing materials such as the member handbook and member-specific letter templates Reports on interpretation or language line use **Submitted Documents:** CS09-INS-Customer Service-Member Access with LEP Member Handbook	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DentaQuest submitted the *CS09-INS-Customer Service-Member Access with LEP* policy, which describes the processes to ensure that there is a mechanism for customer services to be accessible to all members. The policy provides the procedure for members with limited English proficiency and the availability of interpretation services through a contracted vendor. The policy also describes assistance for speech or hearing-impaired individuals by contacting DentaQuest's customer service at 800-466-7566 via an Ultratec machine and use of the National Relay Service 711. The policy describes fulfillment of member material requests in alternative formats. DentaQuest also submitted the July 2022 Member Handbook. The handbook includes information on how to access customer service through a toll-free number at 1-888-307-6561, TTY 711, and for the deaf and hearing impaired, it describes how DentaQuest offers free aids and services to people with disabilities such as qualified sign language interpreters and written information in other formats such as large print, audio, and accessible electronic formats. The handbook also describes availability of free language services to people whose primary language is not English using qualified interpreters and information in other languages. Documentation submitted did not describe the process for members to receive reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal.		
Required Actions: DentaQuest must update its policies, procedures, and the CHP+ member handbook to describe how DentaQuest gives members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
7. The Contractor ensures that the individuals who make decisions on grievances and appeals are individuals who: • Were not involved in any previous level of review or decision-making nor a subordinate of any such individual. • Have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if deciding any of the following: – An appeal of a denial that is based on lack of medical necessity. – A grievance regarding the denial of expedited resolution of an appeal. – A grievance or appeal that involves clinical issues. *42 CFR 438.406(b)(2)* Contract Amendment 5: Exhibit B-1—4.6.5.4; 4.8.4 10 CCR 2505-10 8.209.5.C, 8.209.4.E	**Suggested Documents:** UR policies and procedures Grievance and appeals policies and procedures **Submitted Documents:** Grievance and appeals policies and procedures CGA06-INS Member complaints/grievances Page 3; 5. a,b,c CGA09-INS-MCDCHIP Member appeals Page 5; 6. a.b,c	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DentaQuest's *CGA06-INS Member Complaints/Grievances* policy states that all grievances that are clinical in nature, including quality of care and expedited review denials, are reviewed and determined by a dental consultant. DentaQuest clarified during the virtual review that dental consultants had expertise in the field of dental medicine that was appropriate for the services at issue and hold an active, unrestricted license or certification to practice medicine. The policy also states that the dental director for grievances was not involved in the decision process for a service authorization request. DentaQuest's *CGA09-INS-MCDCHIP Member Appeals* policy states that all appeals that are clinical in nature are reviewed and determined by a dental consultant. The dental consultant for appeal determinations is not involved in the decision process for a service authorization request. The dental consultant for appeal determinations is not a subordinate to the dental consultant involved in the previous decision. A dental consultant is a licensed dentist with expertise in the field of dental medicine that is appropriate for the services at issue that is of same or similar specialty and holds an active, unrestricted license or certification to practice medicine or a health profession in a state or territory of the United States. A review of a sample of case files found that appeal sample file #8 did not provide evidence of the credentials of the reviewer nor that the decision-maker was not involved in the previous level of review and samples #3 and #5 were also difficult to determine whether this requirement was upheld.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
Required Actions: DentaQuest must enhance its process to document in appeal case files that the reviewer has the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease as well as the credentials of the reviewer and that the reviewer was not involved in any previous level of review or decision-making nor a subordinate of any such individual.		
8. The Contractor ensures that the individuals who make decisions on grievances and appeals: • Take into account all comments, documents, records, and other information submitted by the member or the member's representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. *42 CFR 438.406(b)(2)* Contract Amendment 5: Exhibit B-1—4.7.2 10 CCR 2505-10 8.209.5.C, 8.209.4.E	**Suggested Documents:** UR policies and procedures Grievance and appeals policies and procedures **Submitted Documents:** Grievance and appeals policies and procedures CGA06-INS Member complaints/grievances Page 3; 3. a.b,c,d CGA09-INS-MCDCHIP Member appeals Page 4; 3. a,b,c,d	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor accepts grievances orally or in writing. *42 CFR 438.402(c)(3)(i)* Contract Amendment 5: Exhibit B-1—4.6.5.3 10 CCR 2505-10 8.209.5.D	**Suggested Documents:** Grievance policies and procedures **Submitted Documents:** Grievance policies and procedures CGA06-INS Member complaints/grievances Page 2; A. 3,4	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
10. Members may file a grievance at any time. *42 CFR 438.402(c)(2)(i)* Contract Amendment 5: Exhibit B-1—4.6.5.3 10 CCR 2505-10 8.209.5.A	**Suggested Documents:** Grievance policies and procedures Critical member informing materials such as the member handbook **Submitted Documents:** Grievance policies and procedures CGA06-INS Member complaints/grievances Page 2; A. 1 Colorado CHP+ ORM (Different Sections) Member Handbook (Different Sections)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor sends the member a written acknowledgement of each grievance within two working days of receipt. *42 CFR 438.406(b)(1)* Contract Amendment 5: Exhibit B-1—4.6.5.3 10 CCR 2505-10 8.209.5.B	**Suggested Documents:** Grievance policies and procedures **Submitted Documents:** Grievance policies and procedures CGA06-INS Member complaints/grievances Page 6; 2.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DentaQuest's *CGA06-INS Member Complaints/Grievances* policy stated that DentaQuest sends the member a written acknowledgement of each grievance within two working days of receipt. A review of a sample case files found that in three out of 10 cases, the acknowledgement notice was not sent within two working days of receipt.		
Required Action: DentaQuest must implement its policy to send the member a written acknowledgement of each grievance within two working days of receipt. DentaQuest must implement an ongoing process to monitor that the timelines are met.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
12. The Contractor must resolve each grievance and provide written notice of the resolution as expeditiously as the member's health condition requires, and within 15 working days of when the member files the grievance. • Notice to the member must be in a format and language that may be easily understood by the member. *42 CFR 438.408(a); (b)(1); and (d)(1)* Contract Amendment 5: Exhibit B-1—4.6.5.5; 4.6.5.8 10 CCR 2505-10 8.209.5.D	**Suggested Documents:** Grievance policies and procedures Tracking reports or evidence of time frame monitoring **Submitted Documents:** Grievance policies and procedures CGA06-INS Member complaints/grievances Page 6; C.2. Page 4; C. 4. A	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: A review of a sample case files found that in three of 10 cases, the resolution notice was not sent within 15 working days of when the member filed the grievance. All acknowledgement letters incorrectly stated resolutions would be completed within 30 days.		
Required Action: DentaQuest must implement its policy and resolve each grievance and provide written notice of the resolution as expeditiously as the member's health condition requires, and within 15 working days of when the member files the grievance. DentaQuest must update its acknowledgement letters to include the correct time frames.		
13. The written notice of grievance resolution includes: • Results of the disposition/resolution process and the date it was completed. *42 CFR 438.408(a)* Contract Amendment 5: Exhibit B-1—4.6.5.8 10 CCR 2505-10 8.209.5.G	**Suggested Documents:** Grievance policies and procedures **Submitted Documents:** Grievance policies and procedures CGA06-INS Member complaints/grievances Page 4; C. 4. c. i,ii, iii,iv,v,vi,vii,viii,ix	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
14. The Contractor may have only one level of appeal for members. *42 CFR 438.402(b)* Contract Amendment 5: Exhibit B-1—4.4.9.1.10	**Suggested Documents:** Appeal policies and procedures **Submitted Documents:** Appeal policies and procedures CGA09-INS-MCD-CHIP-Member Appeals-CHIP-FINAL Page 2; 1.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
15. A member may file an appeal with the Contractor within 60 calendar days from the date on the adverse benefit determination notice. *42 CFR 438.402(c)(2)(ii)* Contract Amendment 5: Exhibit B-1—4.8.5.1 10 CCR 2505-10 8.209.4.B	**Suggested Documents:** Grievance and appeal policies and procedures **Submitted Documents:** Grievance and appeal policies and procedures CGA09-INS-MCD-CHIP-Member Appeals-CHIP-FINAL Page 2; A.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. The member may file an appeal either orally or in writing, and the Contractor must treat oral appeals in the same manner as appeals received in writing. The Contractor may not require that oral requests for an appeal be followed with a written request. *42 CFR 438.402(c)(3)(ii)* *42 CFR 438.406 (b)(3)* Contract Amendment 5: Exhibit B-1—4.8.5.2; 4.8.6 10 CCR 2505-10 8.209.4.F	**Suggested Documents:** Grievance and appeal policies and procedures Critical member informing materials such as the member handbook and template notice of adverse benefit determination letter (NABD) **Submitted Documents:** Grievance and appeal policies and procedures	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
	CGA09-INS-MCD-CHIP-Member Appeals-CHIP-FINAL Page 2; A. CO CHP Denial NOA letter Member Handbook (Different Sections)	

Findings: DentaQuest's *CGA09-INS-MCDCHIP Member Appeals* policy states that members have the right to submit an appeal to DentaQuest within 60 calendar days from the date of the notice of action. The appeal can be verbal or written. Written appeals policies and procedures are available, upon request, to any patient, provider, or facility rendering service and through oral interpretive services. The DentaQuest *CHP+ Office Reference Manual* states that members have the right to appeal any adverse determination made on a claim or pre-authorization, whether in whole or in part. An appeal request must be submitted within 60 days of the date of the original explanation of benefits (EOB).

The CHP+ member handbook, page 9, states that DentaQuest recommends that the member's appeal request be submitted in writing and must be within 60 days of the date of the original explanation of benefits. It does not state that the appeal may be submitted orally.

The notice of adverse benefit determination letter template informs the member that to appeal, the member, the member's authorized representative, or the member's dentist can contact DentaQuest at its mailing address or customer service phone number. It also states that if DentaQuest receives the request verbally, DentaQuest may ask the member to send it in writing. It states that if the member requests an expedited appeal, the member does not need to notify DentaQuest in writing. The member appeal request form attached to the notice of adverse benefit determination specifies that the member should complete the form and return it to the appeals department.

Appeal sample file #3 stated, "Because your request was received verbally, we need you to also submit it in writing." And appeal sample file #8 includes staff member notes stating, "cannot accept verbal appeals."

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
Required Actions: DentaQuest must update and implement its policies, procedures, member handbook, and notice of adverse benefit determination templates to state that the member may file an appeal either orally or in writing, and DentaQuest must treat oral appeals in the same manner as appeals received in writing. DentaQuest may not require that oral requests for an appeal be followed with a written request.		
17. The Contractor sends written acknowledgement of each appeal within two working days of receipt, unless the member or designated representative requests an expedited resolution. *42 CFR 438.406(b)(1)* Contract Amendment 5: Exhibit B-1—4.6.1; 4.8.3 10 CCR 2505-10 8.209.4.D	**Suggested Documents:** Appeal policies and procedures Appeal log, tracking reports, or evidence of time frame monitoring **Submitted Documents:** Appeal policies and procedures CGA09-INS-MCD-CHIP-Member Appeals-CHIP-FINAL Page 11; 2. **Appeal log** Record Reviews Universe Provided 10/10/2022	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DentaQuest's *CGA09-INS-MCD CHIP Member Appeals* policy states that upon receipt of the member appeal, an acknowledgement letter will be forwarded to the member, provider, or authorized representative within two business days from receipt. The policy does not address the time frame for sending the expedited appeal acknowledgement notice but does state that if the expedited appeal is denied, it will follow the notice timelines for a standard appeal. A review of a sample case files found that in six of 10 cases, DentaQuest did not send a written acknowledgement of each appeal within two working days of receipt. Within the sample case files reviewed for denials, the notices described the appeal acknowledgement process "within five business days of receiving your appeal, we will send you a letter acknowledging that we received it." DentaQuest's *CGA09-INS-MCD CHIP Member Appeals* policy, in some cases, delegated the notice of expedited appeals to providers or provider representatives (section 5.e.i). The policy also indicate that DentaQuest may leave voicemail notices to members on voicemail systems (5.e.iii.). The Department confirmed that these processes are not approved.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
Required Action: DentaQuest must implement its policy and send a written acknowledgement of each appeal within two working days of receipt, unless the member or designated representative requests an expedited resolution. DentaQuest must update member-facing communications to be consistent with the two working day timeline. DentaQuest must update its policies and procedures to remove language regarding delegating expedited appeal notices to providers and also processes to leave voicemail messages for members related to grievances or appeals on member voicemail systems.		
18. The Contractor's appeal process must provide that included, as parties to the appeal, are: • The member and the member's representative, or • The legal representative of a deceased member's estate. *42 CFR 438.406(b)(3) and (6)* Contract Amendment 5: Exhibit B-1—4.8.6 -8.7; 4.8.12 10 CCR 2505-10 8.209.4.I	**Suggested Documents:** Appeal policies and procedures **Submitted Documents:** Appeal policies and procedures CGA09-INS-MCD-CHIP-Member Appeals-CHIP-FINAL Page 2; A.1.b	☒ 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 case file to the member and their representative, including medical records, other documents and records, and any new or additional documents considered, relied upon, or generated by the Contractor in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the appeal resolution time frame. *42 CFR 438.406(b)(4-5)*	**Suggested Documents:** Appeal policies and procedures **Submitted Documents:** Appeal policies and procedures CGA09-INS-MCD-CHIP-Member Appeals-CHIP-FINAL Page 6; 7. Page 3; 2. c	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
Contract Amendment 5: Exhibit B-1—4.8.9–8.11 10 CCR 2505-10 8.209. 4.G, 8.209.4.H		
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 punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. *42 CFR 438.410(a–b)* Contract Amendment 5: Exhibit B-1—4.8.13; 4.8.15.2 10 CCR 2505-10 8.209.4.Q-R	**Suggested Documents:** Appeal policies and procedures **Submitted Documents:** Appeal policies and procedures CGA09-INS-MCD-CHIP-Member Appeals-CHIP-FINAL Page 4; 5. b,c	☒ 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 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 the member disagrees with that decision. *42 CFR 438.410(c)* Contract Amendment 5: Exhibit B-1—4.8.15.2.2 10 CCR 2505-10 8.209.4.S	**Suggested Documents:** Appeal policies and procedures **Submitted Documents:** Appeal policies and procedures CGA09-INS-MCD-CHIP-Member Appeals-CHIP-FINAL Page 12; 5. c,d,e	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
Findings: The notices of adverse benefit determination in the sample denial files did not indicate that DentaQuest will make a reasonable effort to give the member prompt oral notice of a denial to expedite an appeal or inform the member that they have the right to file a grievance if they disagree with the decision not to expedite the appeal.		
Required Actions: DentaQuest must update related policies, procedures, and member communications to include the member's right to a prompt oral notice and the right to file a grievance if DentaQuest denies a request to expedite the appeal resolution. Evidence of completing this required action should include procedural and documentation enhancements and staff member training.		
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)(i)* *42 CFR 438.10* Contract Amendment 5: Exhibit B-1—4.8.15.1 10 CCR 2505-10 8.209.4.J.1	**Suggested Documents:** Appeal policies and procedures **Submitted Documents:** Appeal policies and procedures CGA09-INS-MCD-CHIP-Member Appeals-CHIP-FINAL Page 13; 2. Page 14; 5. c. i	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The notices of adverse benefit determination in the sample denial files stated, "DentaQuest will make a decision and notify you within 20 business days from the date we received your appeal." One of the sample appeal files did not include accurate dates on member letters and compliance with the appeal resolution could not be determined.		
Required Actions: DentaQuest must update related policies, procedures, and member communications to include the correct time frame for appeal resolutions. Furthermore, DentaQuest must enhance its quality checks to ensure letters include correct dates.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
23. For an expedited appeal, the Contractor must resolve the appeal and provide written notice of disposition to affected parties within 72 hours after the Contractor receives the appeal. • For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. *42 CFR 438.408(b)(3) and (d)(2)(ii)* Contract Amendment 5: Exhibit B-1—4.8.15.2.3 10 CCR 2505-10 8.209.4.J.2, 8.209.4.L	**Suggested Documents:** Appeal policies and procedures **Submitted Documents:** Appeal policies and procedures CGA09-INS-MCD-CHIP-Member Appeals-CHIP-FINAL Page 13; C. 1 a,b,c,d,e,f	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
Findings: DentaQuest's *CGA09-INS-MCD-CHIP Member Appeals* policy states that the expedited appeal resolution notice will be sent within 72 hours of the appeal request. Verbal notification of determination will be provided within 72 hours of receipt of the expedited appeal request. DentaQuest will make reasonable efforts to give verbal notice of expedited appeals to the member or member's authorized representative, provider or provider's representative**, or provider or provider's representative where the provider has agreed to be responsible for promptly notifying the member or authorized representative of the determination.** Reasonable effort is defined as two or more attempts by phone. DentaQuest will wait until someone answers the phone, the call goes to voicemail, or 10 rings have occurred. **If the call goes to voicemail, a message will be left.** A review of a sample of case files found no evidence that DentaQuest made a reasonable effort to provide oral notice of the expedited resolution to the member.		
Required Actions: DentaQuest must update policies and procedures to ensure privacy rules are followed and do not include a process to delegate member notice requirements to providers or provider representatives. DentaQuest must update is policies, procedures, and processes to ensure that notices of an expedited resolution are not left on member voicemails. DentaQuest must also implement a process and document its reasonable effort to provide oral notice of the resolution of the expedited appeal to the member.		
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.	**Suggested Documents:** Appeal policies and procedures Extension notice templates **Submitted Documents:** Appeal policies and procedures CGA06-INS Member complaints/grievances	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
42 CFR 438.408(c)(1) Contract Amendment 5: Exhibit B-1—4.6.5.6; 4.8.15.2.4 10 CCR 2505-10 8.209.4.K, 8.209.5.E	Page 6; C. 5. CGA09-INS-MCDCHIP Member appeals Page 13; 4. a,b CO CHP Appeal Extension Notice	
25. If the Contractor extends the time frames for a grievance or appeal, 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 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 the member disagrees with that decision. • Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires (14 days following the expiration of the original grievance or appeal resolution time frame). *42 CFR 438.408(c)(2)* Contract Amendment 5: Exhibit B-1—4.6.5.7; 4.8.15.2.5 10 CCR 2505-10 8.209.4.L, 8.209.4.K, 8.209.4.A. 3.C(ii), 8.209.5.E	**Suggested Documents:** Grievance and appeal policies and procedures **Submitted Documents:** Grievance and appeal policies and procedures CGA06-INS Member complaints/grievances Page 7; b) i,ii,iii,iv,v,vi CGA09-INS-MCDCHIP Member appeals Page 14; d. i,ii,iii,iv,v,vi Sample member letters/templates – folder	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DentaQuest's *CGA06-INS Member Complaints/Grievances* policy and the *CGA09-INS-MCDCHIP Member Appeals* policy do not include the requirement of making reasonable efforts to give the member prompt oral notice of the delay; or how DentaQuest resolves the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires (14 days following the expiration of the original grievance or appeal resolution time frame). Three of 10 sample grievance cases reviewed included an extension, and two of these three cases still did not meet resolution time frames. The case files showed that DentaQuest did not, within two 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 the member disagrees with that decision. Additionally, in the denial sample case files reviewed, the NOA did not include that DentaQuest will make reasonable efforts to give the member prompt oral notice of the delay.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
Required Actions: DentaQuest must update its policies, procedures, monitoring practices, and member communications to ensure its process to make a reasonable effort to give the member prompt oral notice of the delay or need for an extension and to provide written notice within two calendar days. The policy must also be updated to describe the process used to resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires (14 days following the expiration of the original grievance or appeal resolution time frame).		
26. The written notice of appeal resolution must include: • The results and data of the resolution process, and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing, and how to do so. *42 CFR 438.408(e)* Contract Amendment 5: Exhibit B-1—4.8.15.3; 4.8.15.4–15.4.3. 10 CCR 2505-10 8.209.4.M	**Suggested Documents:** Appeal policies and procedures **Submitted Documents:** Appeal policies and procedures CGA09-INS-MCDCHIP Member appeals Page 7. 6. c) iv,v,vi,vii,viii,ix	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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 appeal resolution. • If the Contractor does not adhere to the notice and timing requirements regarding a member's appeal, the member is deemed to have exhausted the appeal process and may request a State fair hearing. *42 CFR 438.408(f)(1–2)* Contract Amendment 5: Exhibit B-1—4.6.1, 4.8.16.1–16.2 10 CCR 2505-10 8.209.4.N and O	**Suggested Documents:** Policies and procedures Sample letter/template **Submitted Documents:** Policies and procedures CGA09-INS-MCDCHIP Member appeals Page 9; 14. CO CHP Appeal Resolution - Upheld	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
28. The parties to the State fair hearing include the Contractor as well as the member and their representative or the representative of a deceased member's estate. *42 CFR 438.408(f)(3)* Contract Amendment 5: Exhibit B-1—4.8.16.3	**Suggested Documents:** Policies and procedures Sample letter/template **Submitted Documents:** Policies and procedures CGA09-INS-MCDCHIP Member appeals Page 15; 2. CO CHP Appeal Resolution - Upheld	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
29. 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 72 hours from the date it receives notice reversing the determination. *42 CFR 438.424(a)* Contract Amendment 5: Exhibit B-1—4.8.14.4 10 CCR 2505-10 8.209.4.W	**Suggested Documents:** Appeal policies and procedures **Submitted Documents:** Appeal policies and procedures CGA09-INS-MCDCHIP Member appeals Page 16; 12.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
30. 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* Contract Amendment 5: Exhibit B-1—4.6.1; 4.9 10 CCR 2505-10 8.209.3.C	**Suggested Documents:** Grievance and appeal policies and procedures Grievance and appeal tracking reports **Submitted Documents:** Grievance and appeal policies and procedures CGA06-INS Member complaints/grievances Page 3; a. i,ii,iii,iv,v,vi CGA09-INS-MCDCHIP Member appeals Page 3; f) B.1. a,b,c,d,e	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
31. 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.	**Suggested Documents:** Grievance and appeal policies and procedures – NA Provider agreement Provider manual/ORM Subcontractor contract	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
• The right to a State fair hearing after the Contractor has made a decision on an appeal that is adverse to the member. • The availability of assistance in the filing processes. *42 CFR 438.414* Contract Amendment 5: Exhibit B-1—4.4.9.1; 4.6.4.1 10 CCR 2505-10 8.209.3.B	**Submitted Documents:** Colorado CHP+ ORM (Different Sections) 210901 CO CHP+ MC contract (pg.2 section f. and pg. 3 #3)	
Findings: The ORM did not include grievance time frames on page 36 or that DentaQuest will assist the member in filing a grievance.		
Required Actions: DentaQuest must update the ORM to include grievance time frames and inform the member of the availability of assistance in the grievance process. Lastly, HSAG recommends updating "appeal notice" to "appeal resolution notice" in the paragraph above "How to submit an ALJ appeal."		

Results for Standard VI—Grievance and Appeal Systems							
Total	Met	=	18	X	1.00	=	18
	Partially Met	=	11	X	.00	=	0
	Not Met	=	2	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	31	**Total Score**		=	18
				Total Score ÷ Total Applicable		=	58%

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Dental Plan**	**Score**
1. The Contractor agrees to accept individuals eligible for enrollment into its PAHP in the order in which they apply without restriction (unless authorized by CMS) up to the limits set under that contract (if applicable). *42 CFR 438.3(d)(1)* Contract Amendment 5: Exhibit B-1—4.1.6.24	**Suggested Documents:** Enrollment policies and procedures Workflow documents Internal protocols Process flowcharts and system diagrams—regarding enrollment and eligibility **Submitted Documents:** DentaQuest receives member enrollment from The State of Colorado (HCPF). We are not delegated for any member enrollment or disenrollment functions.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor does not discriminate against individuals eligible to enroll or use any policy or practice that has the effect of discriminating against individuals based upon health status or need for dental services, race, color, national origin, sex, sexual orientation, gender identity, or disability. *42 CFR 438.3(d)(3-4)* Contract Amendment 5: Exhibit B-1—4.1.6.25	**Suggested Documents:** Enrollment policies and procedures Internal protocols **Submitted Documents:** DentaQuest receives member enrollment from The State of Colorado (HCPF). We are not delegated for any member enrollment or disenrollment functions.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard XII—Enrollment and Disenrollment							
Total	Met	=	2	X	1.00	=	2
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	2	**Total Score**		=	2
				Total Score ÷ Total Applicable		=	100%

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2022–2023 External Quality Review
Denials Record Review
for DentaQuest

Review Period:	January 1, 2022–December 31, 2022
Date of Review:	November 3, 2022
Reviewer:	Kim M. Elliott, PhD, CPHQ, CHCA
Participating MCE Staff Member(s):	Michaelle Schrank

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Member ID #	****	****	****	****	****	****	****	****	****	****					
Date of Initial Request [XX/XX/XXXX]	1/18/2022	2/3/2022	2/18/2022	4/19/2022	6/1/2022	6/22/2022	7/29/2022	9/8/2022	1/4/2022	3/2/2022					
Type of Denial: Termination (T), New Request (NR), Claim (CL)	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR					
Type of Request: Standard (S), Expedited (E), Retrospective (R), SUD Inpatient/Residential (SUD), or SUD Inpatient/Residential Special Connections (SUD SC)	S	S	S	S	E	S	S	S	S	S					
Date of Decision for Adverse Benefit Determination [XX/XX/XXXX]	1/19/2022	2/3/2022	2/22/2022	4/20/2022	6/2/2022	6/22/2022	7/29/2022	9/8/2022	1/4/2022	3/2/2022					
Date Notice of Adverse Benefit Determination (NABD) Sent [XX/XX/XXXX]	1/19/2022	2/3/2022	2/22/2022	4/20/2022	6/2/2022	6/22/2022	7/31/2022	9/9/2022	1/4/2022	3/2/2022					
Notice Sent to Provider and Member? [I.9]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Number of Hours or Days for Decision (H/D)	1 D	0 D	4 D	1 D	9 H	0 D	0 D	0 D	0 D	0 D					
Number of Hours or Days for Notice (H/D)	1 D	0 D	4 D	1 D	1 D	0 D	2 D	1 D	0 D	0 D					
Adverse Benefit Determination Decision Made Within Required Time Frame? [I.10] Standard: 10 calendar days Expedited: 72 hours SUD: 72 hours (calendar) or 24 hours (calendar) for special connections	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Notice Sent Within Required Time Frame? [I.14] Standard: 10 calendar days Expedited: 72 hours SUD: 72 hours (calendar) or 24 hours (calendar) for special connections Termination: 10 calendar days before the date of action	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Was Authorization Decision Timeline Extended? Yes or No	No	No	No	No	No	No	No	No	No	No					
If Extended, Extension Notification Sent to Member? [I.16]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA					
If Extended, Extension Notification Includes Required Content? [I.16]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA					
NABD Includes Required Content [I.13]	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met					
Authorization Decision Made by Qualified Clinician? [I.8]	Met	NA	Met	NA	Met	NA	Met	NA	Met	NA					
If Denied for Lack of Information, Was the Requesting Provider Contacted for Additional Information or Consulted (if applicable)? [I.7]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA					
Was the Decision Based on Established Authorization Criteria (i.e., not arbitrary)? [I.2]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Was Correspondence With the Member Easy to Understand? [I.12]	Met	Not Met	Met	Met	Met	Met	Met	Met	Met	Met					

Scoring	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Applicable Elements	7	6	7	6	7	6	7	6	7	6					
Compliant (Met) Elements	6	4	6	5	6	5	6	5	6	5					
Percent Compliant	86%	67%	86%	83%	86%	83%	86%	83%	86%	83%					
Overall Total Applicable Elements	**65**														
Overall Total Compliant Elements	**54**														
Overall Total Percent Compliant	**83%**														

Comments:
Files 1-10: All sample file NABD letters included the incorrect time frame for appeal acknowledgement and resolution; did not state that DentaQuest would make an attempt to orally notify the member about expedited appeals; and did not inform the member of their right to submit a grievance if they disagree with an extension. The NABD only stated the review criteria and did not inform the member that they have the right to copies of all documents. The NABD and Member Appeal Request Form did not clarify that appeals may be submitted orally; each contained references to submitting only in writing. Recommend spelling out the CCR citation in all files.
File 2: Two of the denied services included a code, but no plain langugae explanation (e.g., lower left quadrant, surgical flap).
File 4: Indicated urgent in the request but processed as a standard request.
File 5: Expedited request. Hours were not documented to make the decision; however, based on dates, it is less than 24 hours from receipt to decision.

Yes and No = not scored—for informational purposes only
**** = Redacted Member ID

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2022–2023 External Quality Review
Grievances Record Review
for DentaQuest

Review Period:	January 1, 2022–December 31, 2022
Date of Review:	November 3, 2022
Reviewer:	Kim M. Elliott, PhD, CPHQ, CHCA
Participating MCE Staff Member(s):	Jeanine Rank

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Member ID #	****	****	****	****	****	****	****	****	****	****					
Date Grievance Received [XX/XX/XXXX]	1/10/2022	2/1/2022	2/1/2022	2/11/2022	3/2/2022	3/8/2022	3/8/2022	4/28/2022	5/24/2022	6/8/2022					
Date of Acknowledgement Letter [XX/XX/XXXX]	1/11/2022	2/4/2022	2/3/2022	2/14/2022	3/4/2022	3/10/2022	3/10/2022	5/4/2022	5/25/2022	6/13/2022					
Days From Grievance Received to Acknowledgement	1	3	2	1	2	2	2	4	1	3					
Acknowledgement Letter Sent in 2 Working Days [VI.11]	Met	Not Met	Met	Met	Met	Met	Met	Not Met	Met	Not Met					
Date of Written Notice [XX/XX/XXXX]	1/27/2022	2/22/2022	2/22/2022	3/21/2022	4/4/2022	4/7/2022	4/22/2022	5/19/2022	5/25/2022	6/29/2022					
# of Days to Notice	12	14	14	32	22	24	39	15	1	14					
Resolved and Notice Sent in Time Frame* [VI.12,24] Standard: 15 working days Extension: 15 working days + 14 calendar days	Met	Met	Met	Not Met	Not Met	Met	Not Met	Met	Met	Met					
Decision-Maker Not Involved in Grievance [VI.7]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Appropriate Level of Expertise (If Clinical) [VI.7]	NA	NA	NA	NA	NA	NA	Met	NA	NA	NA					
Resolution Letter Includes Required Content [VI.13]**	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Resolution Letter Easy to Understand [VI.12]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Scoring	**File 1**	**File 2**	**File 3**	**File 4**	**File 5**	**File 6**	**File 7**	**File 8**	**File 9**	**File 10**	**File OS1**	**File OS2**	**File OS3**	**File OS4**	**File OS5**
Applicable Elements	5	5	5	5	5	5	6	5	5	5					
Compliant (Met) Elements	5	4	5	4	4	5	5	4	5	4					
Percent Compliant	100%	80%	100%	80%	80%	100%	83%	80%	100%	80%					
Overall Total Applicable Elements	**51**														
Overall Total Compliant Elements	**45**														
Overall Total Percent Compliant	**88%**														

Comments:
Files 1-10: Acknowledgement letter stated 30 days instead of 15 working days to resolve the issue. Incomplete tag lines (auxillary aids missing). Recommend increased clarity regarding the credentials of clinical reviewers, when needed.
File 2: Acknowledgement letter sent on day three and not on day two.
File 4: Documentation of internal approval for an extension was March 7 (15th day of standard resolution time frame). However, no documentation of an extension notice notifying the member of the extension. The extension request did not indicate that the extension was in the member's best interest. Documentation indicates that the provider was not credentialed. Resolution was untimely.
File 5: Appeal acknowledgement used instead of grievance acknowledgment. Took 22 days to resolve.
File 6: This case was extended. Internal email approval at 15 working days after the acknowledgement letter was sent. Extension notice to member was not included in the file. 15 working days and 9 calendar days, 24 total days.
File 7: Internal email approval of extension; however, the internal request occured after the 15 working day deadline (due 3/29 but requested 4/4). Note that the member was called regarding the extension and left a voice message. Note stated, "unable to send ext letter - no ext letter was created for CO CHP." 15 working days and 24 calendar days, 39 total days to resolution, which was untimely.
File 8: Acknowlegement letter mailed on day four.
File 9: Combined acknowledgement and resolution notice.
File 10: Acknowledgement mailed on day three.

* Grievance timeline for resolution and notice sent is 15 working days (unless extended, then up to 14 calendar days).

**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 B. Colorado Department of Health Care Policy & Financing
FY 2022–2023 External Quality Review
Appeals Record Review
for DentaQuest

Review Period:	January 1, 2022–December 31, 2022
Date of Review:	November 3, 2022
Reviewer:	Kim M. Elliott, PhD, CPHQ, CHCA
Participating MCE Staff Member(s):	Jeanine Rank

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Member ID #	****	****	****	****	****	****	****	****	****	****					
Date Appeal Received [XX/XX/XXXX]	2/3/2022	2/7/2022	2/11/2022	3/21/2022	3/29/2022	3/31/2022	4/29/2022	4/29/2022	5/2/2022	5/6/2022					
Date of Acknowledgement [XX/XX/XXXX]	NA	2/9/2022	2/15/2022	None	None	None	5/4/2022	None	5/3/2022	12/7/2021					
Days From Appeal Received to Acknowledgement	NA	2	2				3		1	-107					
Acknowledgement Sent Within 2 Working Days? [VI.17]	Met	Met	Met	Not Met	Not Met	Not Met	Not Met	Not Met	Met	Not Met					
Decision-Maker Not Previous Level [VI.7]	Met	Met	NA	Met	Met	Met	Met	Met	Met	Met					
Decision-Maker—Clinical Expertise [VI.7]	NA	Met	NA	NA	NA	Met	Met	Not Met	Met	Met					
Expedited Appeal: Yes or No	No	Yes	Yes	No	No	No	No	No	No	No					
Time Frame Extended: Yes or No	No	No	No	No	No	No	No	No	No	No					
Date Resolution Notice Sent [XX/XX/XXXX]	2/4/2022	2/10/2022	2/15/2022	4/5/2022	4/5/2022	4/6/2022	5/12/2022	5/4/2022	5/4/2022	1/20/2022					
Hours or Days From Appeal Filed to Resolution Notice Sent	1 D	3 D	2 D	10 D	4 D	3 D	9 D	3 D	2 D	-76 D					
Notice Sent Within Time Frame*? [VI.22-25] Standard Resolution: 10 working days Expedited Resolution: 72 hours Time Frame Extended: +14 calendar days	Met	Met	Met	Met	Met	Met	Met	Met	Met	Not Met					
Resolution Letter Includes Required Content [VI.26]**	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Resolution Letter Easy to Understand [VI.22]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					

Scoring	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Applicable Elements	5	6	4	5	5	6	6	6	6	6					
Compliant (Met) Elements	5	6	4	4	4	5	5	4	6	4					
Percent Compliant	100%	100%	100%	80%	80%	83%	83%	67%	100%	67%					
Overall Total Applicable Elements	**55**														
Overall Total Compliant Elements	**47**														
Overall Total Percent Compliant	**85%**														

Comments:
All files: Recommend updating tagline to specify auxillary aids. NOA states five business days versus two business days to receive an appeal acknowledgement letter. NABD states 20 business days to resolve rather than 10 business days. Authorization determination also has incorrect dates.
File 1: Untimely filing so appeal was not accepted.
File 2: Member requested an expedited appeal (verbal). No confirmation to the member that DentaQuest categorized the case as an expedited appeal. Internal email approving the case as an expedited appeal. DentaQuest's appeal acknowledgement to member states that for DentaQuest to use the member's information for the appeal decision, DentaQuest must receive it by 2/10/2022. The acknowledgement letter was sent on 2/9/2022 and resolution was on 2/10/2022.
File 3: Appeal acknowledgement states "because your request was received verbally, we need you to also submit it in writing." Notes say "sent expedited request" but also "no need to call." No documentation regarding an attempt to notify the member orally. Not a covered benefit.
File 4: No acknowledgement letter. Denial for untimely filing.
File 5: No acknowledgement letter. Not a covered service.
File 6: No acknowledgement letter included in the file.
File 7: Acknowledgement notice not timely. Three working days.
File 8: Acknowledgement notice not sent to member. Notes state "cannot accept verbal appeals." Clinical case, unable to determine reviewer credentials. No notes regarding the 5/4/2022 decision or evidence of provider outreach to obtain x-rays or request for extension to continue provider outreach.
File 10: Appeal received 5/6/2022. Appeal acknowledgement letter dated 12/7/2021, which is before the appeal was received; resolution notice dated 1/20/2022, which is before the appeal was received. Staff members confirmed typos in letter templates. Unable to determine timeliness.

***Appeal resolution letter time frame** does not exceed 10 working days from the day the MCE receives the appeal (unless expedited—72 hours; 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 (does not apply to CHP+).

**** = Redacted Member ID

Appendix C. Compliance Review Participants

Table C-1 lists the participants in the FY 2022–2023 compliance review of **DentaQuest**.

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

HSAG Review Team	Title
Sarah Lambie	Senior Project Manager
Kim Elliott	Executive Director
Lauren Gomez	Project Manager I
Crystal Brown	Project Manager I
DQ Participants	**Title**
Nate McIntosh	Utilization Management Auditing Coordinator, Utilization Management Administration
Michaelle Schrank	Manager, Utilization Management and Appeal Compliance, Utilization Management and Quality Management
Jennifer Labishak	Senior Manager, Provider Partner, Provider Engagement—West/Midwest
Katherine Mulligan	Director, Provider Management, Provider Engagement—West/Midwest
Logan Horn	Client Partner—CHP+ Program Manager, Client Engagement—West
Diane Natale	Manager, User Experience, Customer Experience
Jeanine Rank	Operations Audit Coordinator II, Appeals, Complaints and Grievances
Michael Duhamel	Director, Member Enrollment and Benefits, Operations—Corporate
Tanya Corprue	Supervisor, Client Data Management, Member Enrollment and Support
Maureen Hartlaub	Managing Client Partner, Client Engagement—West
Ciara Thomas	Supervisor, Utilization Management, Utilization Management and Quality Management
Troy Boothe	Utilization Management Auditing Coordinator, Utilization Management Administration
Chad Jacquart	Contract Implementation and Compliance Specialist II, Compliance
Will Anderson	Member Enrollment Analyst, Senior, Member Enrollment and Support
Tim Gorter	Business Systems Analyst, Member Enrollment and Support

Department Observers	Title
Helen Desta	Quality Section Manager
Russell Kennedy	Quality and Compliance Specialist
Yvonne Castillo	Dental Plan Contract Manager

Appendix D. Corrective Action Plan Template for FY 2022–2023

If applicable, the MCE 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 MCE must identify the planned interventions, training, monitoring and follow-up activities, and proposed documents in order to 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 MCE 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 MCE will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final compliance review report via email or through the file transfer protocol (FTP) site, with an email notification to HSAG and the Department. The MCE 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, monitoring and follow-up activities, and final evidence to be submitted following the completion of the planned interventions.	
Step 2	**Prior approval for timelines exceeding 30 days**
If the MCE is unable to submit the CAP proposal (i.e., the outline of the plan to come into compliance) 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: • Review and approve the planned interventions and instruct the MCE to proceed with implementation, or • Instruct the MCE to revise specific planned interventions, training, monitoring and follow-up activities, and/or documents to be submitted as evidence of completion and also to proceed with resubmission.	
Step 4	**Documentation substantiating implementation**
Once the MCE has received Department approval of the CAP, the MCE will have a time frame of 90 days (three months) to complete proposed actions and submit documents. The MCE will submit documents as evidence of completion one time only on or before the 90-day deadline for all required actions in the CAP. If any revisions to the planned interventions are deemed necessary by the MCE during the 90 days, the MCE should notify the Department and HSAG. If the MCE is unable to submit documents of completion for any required action on or before the three-month deadline, it must obtain approval in advance from the Department to extend the deadline.	

Step	Action
Step 5	**Technical assistance**
At the MCE's request or at the recommendation of the Department and HSAG, technical assistance (TA) calls/webinars are available. The session may be scheduled at the MCE's discretion at any time the MCE 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 MCE 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 resubmission established by the Department. HSAG will continue to work with the MCE until all required actions are satisfactorily completed.	

The CAP template follows on the next page.

Table D-2—FY 2022–2023 Corrective Action Plan for DentaQuest

Standard I—Coverage and Authorization of Services
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
10. The Contractor adheres to the following time frames for making standard and expedited authorization decisions: • For standard authorization decisions—as expeditiously as the member's condition requires and not to exceed 10 calendar days following the receipt of the request for service. • If the provider indicates, or the Contractor determines, that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization determination and provides notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service. *42 CFR 438.210(d)(1–2)* Contract Amendment 5: Exhibit B-1—4.6.1 10 CCR 2505-10 8.209.4.A.3.c
Findings
DentaQuest's *UM08-INS-Authorization Review* policy and procedure includes authorization time frames as follows: Unless specified differently by the plan or regulation, determinations are completed within the following time frames from the receipt of the request: • Standard: 14 calendar days. • Emergent/urgent: 72 hours.
Required Actions
DentaQuest must update its policies and procedures to align with the federal regulations and the Department's contract requirements including: • For standard authorization decisions—as expeditiously as the member's condition requires and not to exceed 10 calendar days following the receipt of the request for service.

Standard I—Coverage and Authorization of Services
• If the provider indicates, or the Contractor determines, that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization determination and provides notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service. DentaQuest indicated that it was able to track the date and time authorization requests were received and should use this information to implement monitoring and oversight processes. DentaQuest should ensure that reasonable time is spent assessing clinical documentation and outreaching providers during the 10 calendar days to ensure that the case review is sufficient before closing the case.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard I—Coverage and Authorization of Services
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
12. The notice of adverse benefit determination must be written in language easy to understand, available in state-established prevalent non-English languages in the region, and available in alternative formats for persons with special needs. *42 CFR 438.404(a)* Contract Amendment 5: Exhibit B-1—4.7.1-4 10 CCR 2505-10 8.209.4.A.1
Findings
Nine out of 10 sample files included member communications at or around the sixth-grade reading level. However, denial sample file #2 included the denied service codes and clinical explanation of the service but did not include a plain language explanation regarding which services were denied (e.g., lower left quadrant, surgical flap). Many denial notices cited "CCR" but did not explain or define the abbreviation to members.
Required Actions
DentaQuest must ensure that any clinical terminology or abbreviations include an easy-to-understand explanation.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:

Standard I—Coverage and Authorization of Services
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard I—Coverage and Authorization of Services
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
13. The notice of adverse benefit determination must explain the following: • The adverse benefit determination the Contractor has made or intends to make. • The reasons for the adverse benefit determination, including the right of the member to be provided upon request (and free of charge), reasonable access to and copies of all documents, and records relevant to the adverse benefit determination (includes medical necessity criteria and strategies, evidentiary standards, or processes used in setting coverage limits). • The member's (or member's designated representative's) right to request one level of appeal with the Contractor and the procedures for doing so. • The member's right to request a State fair hearing after receiving an appeal resolution notice from the Contractor that the adverse benefit determination is upheld. • The procedures for exercising the right to request a State fair hearing. • The circumstances under which an appeal process can be expedited and how to make this request. *42 CFR 438.404(b)* Contract Amendment 5: Exhibit B-1—4.7.1.5-10; 4.7.1.12 10 CCR 2505-10 8.209.4.A.2
Findings
DentaQuest's *UM04-INS-Notice of Action Letters* policy states that the notice of action (NOA) or integrated denial letter (IDN) includes: • State fair hearing request information, if applicable. • A reference to the external appeal process available for all final adverse [benefit] determinations. The policy did not reference the requirement that the notice include the circumstances under which an appeal process can be expedited and how to make this request. The policy did not fully include the requirement that the State fair hearing can be requested by the member after receiving an appeal resolution notice that the adverse benefit determination is upheld, or the member is informed of the process to exercise their right to a State fair hearing.

Standard I—Coverage and Authorization of Services
A review of 10 sample case files identified that DentaQuest had not implemented these requirements in any of its member notices. All 10 sample denial cases included incorrect information regarding appeal acknowledgements and resolutions and incomplete information regarding expedited requests and extension procedures. None of the 10 sample denial cases stated that the member could request reasonable access to and copies of all documents (only stated that the review criteria were available).
Required Actions
DentaQuest must update its policies, procedures, and notice of adverse benefit determination (NABD) templates to explain all required details. It is recommended that DentaQuest review policies and procedures and make updates to ensure consistent use of NABD rather than NOA to align with the Medicaid Managed Care Rule terminology.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard I—Coverage and Authorization of Services
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
14. The Contractor mails the notice of adverse benefit determination within the following time frames: • For termination, suspension, or reduction of previously authorized CHP+-covered services, as defined in 42 CFR 431.211, 431.213, and 431.214 (see below). • For denial of payment, at the time of any denial affecting the claim. • For standard service authorization decisions that deny or limit services, no later than 10 calendar days after receipt of request for service. • For expedited service authorization decisions, no later than 72 hours after receipt of request for service. • For extended service authorization decisions, no later than the date the extension expires. • For service authorization decisions not reached within the required time frames, on the date the time frames expire. *42 CFR 438.404(c)* *42 CFR 438.210(d)* Contract Amendment 5: Exhibit B-1—4.6.1 10 CCR 2505-10 8.209.4.A.3
Findings
All sample denials reviewed were mailed within timeliness standards. However, DentaQuest's *UM08-INS-Authorization Review* policy states that the time frames for completing determinations include: • Standard: 14 calendar days; which should be 10 calendar days. DentaQuest's *Exhibit P – Colorado CHP* states time frames for prior authorizations are determined within the following time frames from the receipt of the request for service: • Expedited: Within two business days; which should be 72 hours.

Standard I—Coverage and Authorization of Services
Required Actions
DentaQuest must update its policies and procedures to include the process and time frame for mailing the standard, expedited, and extended notices to the member; mailing a notice at the time of any denial affecting the claim; for extended service authorization decisions, the requirement to mail the notice no later than the date the extension expires; and, for service authorization decisions not reached within the required time frames, on the date the time frames expire. DentaQuest must also update its policies to consistently state that that for standard service authorization decisions that deny or limit services, a notice of adverse benefit determination will be mailed to the member no later than 10 calendar days after receipt of the request for service.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard I—Coverage and Authorization of Services
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement

15. For reduction, suspension, or termination of a previously authorized CHP+-covered service, the Contractor gives notice at least 10 days before the intended effective date of the proposed adverse benefit determination except:
    - The Contractor gives notice on or before the intended effective date of the proposed adverse benefit determination if:
        - The Contractor has factual information confirming the death of a member.
        - The Contractor receives a clear written statement signed by the member that the member no longer wishes services or gives information that requires termination or reduction of services and indicates that the member understands that this must be the result of supplying that information.
        - The member has been admitted to an institution where the member is ineligible under the plan for further services and the Department notifies the Contractor of this change.
        - The member's whereabouts are unknown, and the post office returns Contractor mail directed to the member indicating no forwarding address.
        - The Contractor establishes that the member has been accepted for CHP+ services by another local jurisdiction, state, territory, or commonwealth and the Department notifies the Contractor of this change.
        - A change in the level of dental services is prescribed by the member's dentist.
    - If probable member fraud has been verified, the Contractor gives notice five calendar days before the intended effective date of the proposed adverse benefit determination.

42 CFR 438.404(c)
42 CFR 431.211
42 CFR 431.213
42 CFR 431.214

Contract Amendment 5: Exhibit B-1—4.7.3.1-2; 4.7.4.1-4
10 CCR 2505-10 8.209.4.A.3(a)

Standard I—Coverage and Authorization of Services
Findings
DentaQuest's *UM-08-INS-Authorization Review* policy states that authorizations approved by DentaQuest cannot be retrospectively denied except for fraud or abuse, or misinformation and/or incomplete information from the provider, subject to the eligibility and coverage provisions of the contract, and therefore the requirement is not applicable. DentaQuest's policies and procedures do not state that it gives notice on or before the intended effective date of the proposed adverse benefit determination in the specific circumstances listed in this requirement.
Required Actions
DentaQuest must update its policies and procedures to include the requirement that DentaQuest gives notice on or before the intended effective date of the proposed adverse benefit determination in the specific circumstances listed in this requirement.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard II—Adequate Capacity and Availability of Services
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
1. The Contractor maintains and monitors a statewide network of oral healthcare providers sufficient to provide access to all covered services to all members, including those with limited English proficiency or physical or mental disabilities. The provider network includes the following types of providers: general dentists, orthodontists, periodontists, prosthodontists, endodontists, pediatric dentists, oral surgeons, and dental hygienists. *42 CFR 438.206(b)(1)* Contract Amendment 5: Exhibit B-1—4.1.2.1; 4.1.2.3.2
Findings
Although many policies and procedures stated that monitoring and oversight were performed, specifically the *NET05-INS Provider Network Adequacy* policy states that results of monitoring efforts are "*documented and presented to the Quality Oversight Committee for review,*" and the ORM states that DentaQuest "*administers a Quality Improvement Program that includes quarterly quality indicator tracking (i.e., appointment waiting time, access to care, etc.).*" However, staff members were not able to describe or produce evidence of such oversight or monitoring through any regular internal reporting, meetings, committees, or results of quarterly provider surveys to indicate that the network is being monitored.
Required Actions
DentaQuest must enhance its internal policies, procedures, and monitoring of its network to identify gaps and to assess, act on, and address any ongoing trends related to access to care for all contracted provider types. Examples of evidence may include additional oversight reporting or committee review.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:

Standard II—Adequate Capacity and Availability of Services
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard II—Adequate Capacity and Availability of Services
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
6. The Contractor ensures that its dental network complies with time and distance standards as follows: • General and pediatric dentists – Urban—30 miles and/or 30 minutes – Rural—45 miles and/or 45 minutes – Frontier—60 miles and/or 60 minutes • Orthodontists and Oral Surgeons – Urban—60 miles and/or 60 minutes – Rural—75 miles and/or 75 minutes – Frontier—90 miles and/or 90 minutes *42 CFR 438.206(a)* Contract Amendment 5: Exhibit B-1—4.1.2.3.1
Findings
The September 2022 *CO CHIP Network Analysis* report did not include accurate time and distance standards for general and pediatric dentists in urban, rural, and frontier counties (i.e., 60, 75, 90 miles and minutes instead of 30, 45, 60 miles and minutes). The results in the report showed that the majority of time and distance standards were not met. The September 2022 *CO CHIP Network Analysis* report submitted by DentaQuest indicated: • In rural counties: – 60.8 percent of members without access to oral surgeons – 7.5 percent of members without access to orthodontists – 6.3 percent of members without access to a pediatric dentist

Standard II—Adequate Capacity and Availability of Services
• In frontier counties: – 71 percent of members without access to oral surgeons – 23 percent of members without access to orthodontists – 10 percent of members without access to pediatric dentists The December 2022 *CO CHIP Network Analysis* report submitted by DentaQuest indicated: • In rural counties: – 32 percent of members without access to pediatric dentists – 57.7 percent of members without access to oral surgeons • In frontier counties: – 34.2 percent of members without access to pediatric dentists – 66.2 percent of members without access to oral surgeons – 17.8 percent of member without access to orthodontists Additionally, the HSAG FY 2021–2022 NAV results stated that DentaQuest did not meet the minimum time and distance network requirements for more than half of its contracted counties for oral surgeons and pediatric dentists.
Required Actions
DentaQuest must update internal reports and associated procedures to include the correct time and distance standards for general and pediatric dentists in urban, rural, and frontier counties. Monitoring efforts should include ongoing demonstration of the correct time and distance standards through future quarterly reports. While HSAG acknowledges a shortage of providers in rural and frontier counties, DentaQuest must increase its efforts to recruit and add orthodontists and oral surgeons in rural and frontier counties to the provider network. Evidence of an improved provider network may be demonstrated in quarterly NAV reports that show an improvement in access percentages and a reduction in "compliance mismatch" rows. In instances where a general dentist may be able to perform services (e.g., oral surgeon), DentaQuest should consult with the Department about how this can be reflected in data and reports.
Planned Interventions:
Person(s)/Committee(s) Responsible:

Standard II—Adequate Capacity and Availability of Services
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard II—Adequate Capacity and Availability of Services
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
10. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. This includes: • Developing and providing cultural competency training programs, as needed, to network providers and Contractor staff regarding: – Healthcare attitudes, values, customs, and beliefs that affect access to and benefit from healthcare services. – Oral health risks associated with the member population's racial, ethnic, and socioeconomic conditions. • Identifying members whose cultural norms and practices may affect their access to healthcare. • Establishing and maintaining policies to reach out to specific cultural and ethnic members for prevention, oral health education, and treatment for oral diseases prevalent in those groups. *42 CFR 438.206(c)(2)* Contract Amendment 5: Exhibit B-1—4.1.2.5; 4.1.12
Findings
Related to cultural competency, policies and procedures described staff and provider training expectations and how staff members are expected to offer assistance to members who do not speak English as a primary language. The August 2022 *Colorado Summit* newsletter reminded providers of National Standards on Culturally and Linguistically Appropriate Services (CLAS), and staff members reported that provider cultural capabilities are collected through a quarterly credentialing survey. The *DentaQuest Enterprise Cultural Competency Plan* stated that DentaQuest will "periodically review current and emergent demographic trends, and identify and acquire knowledge about health beliefs and practices of emergent or new populations in service delivery areas." However, when asked for specific details regarding efforts focused on the Colorado CHP+ population, staff members were not able to describe or submit additional evidence of efforts.

Standard II—Adequate Capacity and Availability of Services
Required Actions
DentaQuest must enhance its cultural competency program or other related efforts to: • Identify members whose cultural norms and practices may affect their access to dental care. • Establish and maintain policies specific to Colorado CHP+ dental outreach for specific cultural and ethnic members for prevention, oral health education, and treatment for oral diseases prevalent in those groups.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
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)* Contract Amendment 5: Exhibit B-1—4.6.5.1 10 CCR 2505-10 8.209.2. D, 8.209.4. A.3.c.i
Findings
DentaQuest described processes where customer service representatives received calls from members which were categorized as inquiries. DentaQuest indicated that although the call may have been initiated as a complaint or grievance, it was categorized as an inquiry. DentaQuest did not provide a process that ensured complaints or grievances received by customer services were included in the grievance and appeal system. The description identified that when the customer service representative categorized the call as an inquiry, it remained in the customer service system. During the interview session, DentaQuest was unable to confirm that grievances received anywhere in the organization were included in its grievance and appeal system, were tracked and trended, or included in is quarterly reporting to the Department. Furthermore, the UM Program Description includes the term "formal complaint."
Required Actions
DentaQuest must develop and implement processes to ensure that all grievances received by customer services, including those categorized as an inquiry, are included in the grievance and appeal system, and tracked, trended, and included in its quarterly reporting to the Department. Additionally, DentaQuest must update the UM Program Description to remove the word "formal" in reference to complaints.
Planned Interventions:

Standard VI—Grievance and Appeal Systems
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
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 acting on behalf of the member.* *42 CFR 438.402(c)* Contract Amendment 5: Exhibit B-1—4.4.9.1; 4.6; 4.7 ; 4.8.5
Findings
DentaQuest's *CGA06-INS Member Complaints/Grievances* policy states that members have the right to submit a grievance to DentaQuest at any time. It also states that the member must provide written consent for the representative, which may include the provider, to act on their behalf during the grievance, including the filing of the grievance. DentaQuest's *CGA09-INS-MCDCHIP Member Appeals* policy states that members have the right to submit an appeal to DentaQuest. It also states that members have the right to assign a representative. The representative can be any individual of the member's choosing including spouse, family member, attorney, provider, power of attorney, guardian, etc. This may also include the legal representative of a deceased member's estate. It also states that the member must provide written consent for the representative to act on their behalf during the appeal, including requesting the appeal. For a request for a State fair hearing, the *Appeals* policy indicates that members, providers, or member representatives have 120 calendar days from the date of the notice of the appeal resolution from DentaQuest to file a request for a State fair hearing. The policy does not state that the member's written consent is needed to file a State fair hearing request on behalf of the member. The policy does state that the member's written consent is needed for someone else to be the member's representative at a State fair hearing.
Required Actions
DentaQuest must update its policies and procedures to state that providers or member representatives may file a State fair hearing request on behalf of the member with the member's written consent.

Standard VI—Grievance and Appeal Systems
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
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 TeleTYpe/Telecommunications Device for the Deaf (TTY/TDD) and interpreter capabilities. *42 CFR 438.406(a)* Contract Amendment 5: Exhibit B-1—4.6.3 10 CCR 2505-10 8.209.4.C
Findings
DentaQuest submitted the *CS09-INS-Customer Service-Member Access with LEP* policy, which describes the processes to ensure that there is a mechanism for customer services to be accessible to all members. The policy provides the procedure for members with limited English proficiency and the availability of interpretation services through a contracted vendor. The policy also describes assistance for speech or hearing-impaired individuals by contacting DentaQuest's customer service at 800-466-7566 via an Ultratec machine and use of the National Relay Service 711. The policy describes fulfillment of member material requests in alternative formats. DentaQuest also submitted the July 2022 Member Handbook. The handbook includes information on how to access customer service through a toll-free number at 1-888-307-6561, TTY 711, and for the deaf and hearing impaired, it describes how DentaQuest offers free aids and services to people with disabilities such as qualified sign language interpreters and written information in other formats such as large print, audio, and accessible electronic formats. The handbook also describes availability of free language services to people whose primary language is not English using qualified interpreters and information in other languages. Documentation submitted did not describe the process for members to receive reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal.
Required Actions
DentaQuest must update its policies, procedures, and the CHP+ member handbook to describe how DentaQuest gives members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal.
Planned Interventions:

Standard VI—Grievance and Appeal Systems
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
7. The Contractor ensures that the individuals who make decisions on grievances and appeals are individuals who: • Were not involved in any previous level of review or decision-making nor a subordinate of any such individual. • Have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if deciding any of the following: – An appeal of a denial that is based on lack of medical necessity. – A grievance regarding the denial of expedited resolution of an appeal. – A grievance or appeal that involves clinical issues. *42 CFR 438.406(b)(2)* Contract Amendment 5: Exhibit B-1—4.6.5.4; 4.8.4 10 CCR 2505-10 8.209.5.C, 8.209.4.E
Findings
DentaQuest's *CGA06-INS Member Complaints/Grievances* policy states that all grievances that are clinical in nature, including quality of care and expedited review denials, are reviewed and determined by a dental consultant. DentaQuest clarified during the virtual review that dental consultants had expertise in the field of dental medicine that was appropriate for the services at issue and hold an active, unrestricted license or certification to practice medicine. The policy also states that the dental director for grievances was not involved in the decision process for a service authorization request. DentaQuest's *CGA09-INS-MCDCHIP Member Appeals* policy states that all appeals that are clinical in nature are reviewed and determined by a dental consultant. The dental consultant for appeal determinations is not involved in the decision process for a service authorization request. The dental consultant for appeal determinations is not a subordinate to the dental consultant involved in the previous decision. A dental consultant is a licensed dentist with expertise in the field of dental medicine that is appropriate for the services at issue that is of same or similar specialty and holds an active, unrestricted license or certification to practice medicine or a health profession in a state or territory of the United States. A review of a sample of case files found that appeal sample file #8 did not provide evidence of the credentials of the reviewer nor that the decision-maker was not involved in the previous level of review and samples #3 and #5 were also difficult to determine whether this requirement was upheld.

Standard VI—Grievance and Appeal Systems
Required Actions
DentaQuest must enhance its process to document in appeal case files that the reviewer has the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease as well as the credentials of the reviewer and that the reviewer was not involved in any previous level of review or decision-making nor a subordinate of any such individual.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
11. The Contractor sends the member a written acknowledgement of each grievance within two working days of receipt. *42 CFR 438.406(b)(1)* Contract Amendment 5: Exhibit B-1—4.6.5.3 10 CCR 2505-10 8.209.5.B
Findings
DentaQuest's *CGA06-INS Member Complaints/Grievances* policy stated that DentaQuest sends the member a written acknowledgement of each grievance within two working days of receipt. A review of a sample case files found that in three out of 10 cases, the acknowledgement notice was not sent within two working days of receipt.
Required Actions
DentaQuest must enhance its procedures to send the member a written acknowledgement of each grievance within two working days of receipt. DentaQuest must implement an ongoing process to monitor that the timelines are met.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:

Standard VI—Grievance and Appeal Systems
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
12. The Contractor must resolve each grievance and provide written notice of the resolution as expeditiously as the member's health condition requires, and within 15 working days of when the member files the grievance. • Notice to the member must be in a format and language that may be easily understood by the member. *42 CFR 438.408(a); (b)(1); and (d)(1)* Contract Amendment 5: Exhibit B-1—4.6.5.5; 4.6.5.8 10 CCR 2505-10 8.209.5.D
Findings
A review of a sample case files found that in three of 10 cases, the resolution notice was not sent within 15 working days of when the member filed the grievance. All acknowledgement letters incorrectly stated resolutions would be completed within 30 days.
Required Actions
DentaQuest must enhance its procedures to resolve each grievance and provide written notice of the resolution as expeditiously as the member's health condition requires, and within 15 working days of when the member files the grievance. DentaQuest must update its acknowledgement letters to include the correct time frames.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:

Standard VI—Grievance and Appeal Systems
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
16. The member may file an appeal either orally or in writing, and the Contractor must treat oral appeals in the same manner as appeals received in writing. The Contractor may not require that oral requests for an appeal be followed with a written request. *42 CFR 438.402(c)(3)(ii)* *42 CFR 438.406 (b)(3)* Contract Amendment 5: Exhibit B-1—4.8.5.2; 4.8.6 10 CCR 2505-10 8.209.4.F
Findings
DentaQuest's *CGA09-INS-MCDCHIP Member Appeals* policy states that members have the right to submit an appeal to DentaQuest within 60 calendar days from the date of the notice of action. The appeal can be verbal or written. Written appeals policies and procedures are available, upon request, to any patient, provider, or facility rendering service and through oral interpretive services. The DentaQuest *CHP+ Office Reference Manual* states that members have the right to appeal any adverse determination made on a claim or pre-authorization, whether in whole or in part. An appeal request must be submitted within 60 days of the date of the original explanation of benefits (EOB). The CHP+ member handbook, page 9, states that DentaQuest recommends that the member's appeal request be submitted in writing and must be within 60 days of the date of the original explanation of benefits. It does not state that the appeal may be submitted orally. The notice of adverse benefit determination letter template informs the member that to appeal, the member, the member's authorized representative, or the member's dentist can contact DentaQuest at its mailing address or customer service phone number. It also states that if DentaQuest receives the request verbally, DentaQuest may ask the member to send it in writing. It states that if the member requests an expedited appeal, the member does not need to notify DentaQuest in writing. The member appeal request form attached to the notice of adverse benefit determination specifies that the member should complete the form and return it to the appeals department. Appeal sample file #3 stated, "Because your request was received verbally, we need you to also submit it in writing." And appeal sample file #8 includes staff member notes stating, "cannot accept verbal appeals."

Standard VI—Grievance and Appeal Systems
Required Actions
DentaQuest must update and implement its policies, procedures, member handbook, and notice of adverse benefit determination templates to state that the member may file an appeal either orally or in writing, and DentaQuest must treat oral appeals in the same manner as appeals received in writing. DentaQuest may not require that oral requests for an appeal be followed with a written request.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
17. The Contractor sends written acknowledgement of each appeal within two working days of receipt, unless the member or designated representative requests an expedited resolution. *42 CFR 438.406(b)(1)* Contract Amendment 5: Exhibit B-1—4.6.1; 4.8.3 10 CCR 2505-10 8.209.4.D
Findings
DentaQuest's *CGA09-INS-MCD CHIP Member Appeals* policy states that upon receipt of the member appeal, an acknowledgement letter will be forwarded to the member, provider, or authorized representative within two business days from receipt. The policy does not address the time frame for sending notice if the expedited appeal is denied but did state DentaQuest will follow the notice timelines for a standard appeal. A review of a sample case files found that in six of 10 cases, DentaQuest did not send a written acknowledgement of each appeal within two working days of receipt. Within the sample case files reviewed for denials, the notices described the appeal acknowledgement process "within five business days of receiving your appeal, we will send you a letter acknowledging that we received it." DentaQuest's *CGA09-INS-MCD CHIP Member Appeals* policy, in some cases, delegated notice to providers or provider representatives (section 5.e.i). The policy also indicate that DentaQuest may leave voicemail notices to members on voicemail systems (5.e.iii.). The Department confirmed that these processes are not approved.
Required Actions
DentaQuest must enhance its procedures to send a written acknowledgement of each appeal within two working days of receipt, unless the member or designated representative requests an expedited resolution. DentaQuest must update member-facing communications to be consistent with the two working day timeline.

Standard VI—Grievance and Appeal Systems
DentaQuest must update its policies and procedures to remove language regarding delegating expedited appeal notices to providers and also processes to leave voicemail messages for members related to grievances or appeals on member voicemail systems.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
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 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 the member disagrees with that decision. *42 CFR 438.410(c)* Contract Amendment 5: Exhibit B-1—4.8.15.2.2 10 CCR 2505-10 8.209.4.S
Findings
The notices of adverse benefit determination in the sample denial files did not indicate that DentaQuest will make a reasonable effort to give the member prompt oral notice of a denial to expedite an appeal or inform the member that they have the right to file a grievance if they disagree with the decision not to expedite the appeal.
Required Actions
DentaQuest must update related policies, procedures, and member communications to include the member's right to a prompt oral notice and the right to file a grievance if DentaQuest denies a request to expedite the appeal resolution. Evidence of completing this required action should include procedural and documentation enhancements and staff member training.
Planned Interventions:
Person(s)/Committee(s) Responsible:

Standard VI—Grievance and Appeal Systems
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
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)(i)* *42 CFR 438.10* Contract Amendment 5: Exhibit B-1—4.8.15.1 10 CCR 2505-10 8.209.4.J.1
Findings
The notices of adverse benefit determination in the sample denial files stated, "DentaQuest will make a decision and notify you within 20 business days from the date we received your appeal." One of the sample appeal files did not include accurate dates on member letters and compliance with the appeal resolution could not be determined.
Required Actions
DentaQuest must update related policies, procedures, and member communications to include the correct time frame for appeal resolutions. Furthermore, DentaQuest must enhance its quality checks to ensure letters include correct dates.
Planned Interventions:
Person(s)/Committee(s) Responsible:

Standard VI—Grievance and Appeal Systems
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
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Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
23. For an expedited appeal, the Contractor must resolve the appeal and provide written notice of disposition to affected parties within 72 hours after the Contractor receives the appeal. • For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. *42 CFR 438.408(b)(3) and (d)(2)(ii)* Contract Amendment 5: Exhibit B-1—4.8.15.2.3 10 CCR 2505-10 8.209.4.J.2, 8.209.4.L
Findings
DentaQuest's *CGA09-INS-MCD-CHIP Member Appeals* policy states that the expedited appeal resolution notice will be sent within 72 hours of the appeal request. Verbal notification of determination will be provided within 72 hours of receipt of the expedited appeal request. DentaQuest will make reasonable efforts to give verbal notice of expedited appeals to the member or member's authorized representative, provider or provider's representative, or provider or provider's representative where the provider has agreed to be responsible for promptly notifying the member or authorized representative of the determination. Reasonable effort is defined as two or more attempts by phone. DentaQuest will wait until someone answers the phone, the call goes to voicemail, or 10 rings have occurred. If the call goes to voicemail, a message will be left. A review of a sample of case files found no evidence that DentaQuest made a reasonable effort to provide oral notice of the expedited resolution to the member.
Required Actions
DentaQuest must update policies and procedures to ensure privacy rules are followed and do not include a process to delegate member notice requirements to providers or provider representatives. DentaQuest must update is policies, procedures, and processes to ensure that notices of an expedited resolution are not left on member voicemails. DentaQuest must also implement a process and document its reasonable effort to provide oral notice of the resolution of the expedited appeal to the member.
Planned Interventions:

Standard VI—Grievance and Appeal Systems
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
25. If the Contractor extends the time frames for a grievance or appeal, 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 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 the member disagrees with that decision. • Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires (14 days following the expiration of the original grievance or appeal resolution time frame). *42 CFR 438.408(c)(2)* Contract Amendment 5: Exhibit B-1—4.6.5.7; 4.8.15.2.5 10 CCR 2505-10 8.209.4.L, 8.209.4.K, 8.209.4.A. 3.C(ii), 8.209.5.E
Findings
DentaQuest's *CGA06-INS Member Complaints/Grievances* policy and the *CGA09-INS-MCDCHIP Member Appeals* policy do not include the requirement of making reasonable efforts to give the member prompt oral notice of the delay; or how DentaQuest resolves the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires (14 days following the expiration of the original grievance or appeal resolution time frame). Three of 10 sample grievance cases reviewed included an extension, and two of these three cases still did not meet resolution time frames. The case files showed that DentaQuest did not, within two 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 the member disagrees with that decision. Additionally, in the denial sample case files reviewed, the NOA did not include that DentaQuest will make reasonable efforts to give the member prompt oral notice of the delay.
Required Actions
DentaQuest must update its policies, procedures, monitoring practices, and member communications to ensure its process to make a reasonable effort to give the member prompt oral notice of the delay or need for an extension and to provide written notice within two calendar days. The policy must also be updated to describe the process used to resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires (14 days following the expiration of the original grievance or appeal resolution time frame).

Standard VI—Grievance and Appeal Systems
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
31. 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 that is adverse to the member. • The availability of assistance in the filing processes. *42 CFR 438.414* Contract Amendment 5: Exhibit B-1—4.4.9.1; 4.6.4.1 10 CCR 2505-10 8.209.3.B
Findings
The ORM did not include grievance time frames on page 36 or that DentaQuest will assist the member in filing a grievance.
Required Actions
DentaQuest must update the ORM to include grievance time frames and inform the member of the availability of assistance in the grievance process. Lastly, HSAG recommends updating "appeal notice" to "appeal resolution notice" in the paragraph above "How to submit an ALJ appeal."
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:

Standard VI—Grievance and Appeal Systems
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

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 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 desk request forms, compliance 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 reviewers to ensure consistency in scoring across MCEs.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided MCEs with proposed review dates, group technical assistance, and training, as needed. • HSAG confirmed a primary MCE contact person for the review and assigned HSAG reviewers to participate in the review. • Sixty days prior to the scheduled date of the review, HSAG notified the MCE in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and review agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards and the review activities. Thirty days prior to the review, the MCE provided documentation for the desk review, as requested. • Documents submitted for the review consisted of the completed desk review form, the compliance monitoring tool with the MCE's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. • The MCEs also submitted lists denials, grievances, and appeals that occurred between January 1, 2022, and December 31, 2022 (to the extent available at the time of the review). MCEs submitted the lists to HSAG 10 days following receipt of the desk review request. HSAG used a random sampling technique to select records for the review. HSAG notified the MCE five days following receipt of the lists of records regarding the sample records selected.

For this step,	HSAG completed the following activities:
	• The HSAG review team reviewed all documentation submitted prior to the review and prepared a request for further documentation and an interview guide to use during the review.
Activity 3:	**Conduct the Review**
	• During the review, HSAG met with groups of the MCE's key staff members to obtain a complete picture of the MCE's compliance with federal healthcare regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the MCE's performance. • HSAG requested, collected, and reviewed additional documents as needed. • At the close of the review, HSAG provided MCE staff and Department personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2022–2023 Department-approved Compliance Review Report template to compile the findings and incorporate information from the pre-review and 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 Compliance Review Report to the MCE and the Department for review and comment. • HSAG incorporated the MCE 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 MCE and the Department.