CHP+

Child Health Plan *Plus*

Fiscal Year 2023–2024 Compliance Review Report

for

DentaQuest

January 2024

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Summary of Results

Based on conclusions drawn from the review activities, Health Services Advisory Group, Inc. (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.

DentaQuest demonstrated improvement in two standards compared with the prior review. DentaQuest showed strong understanding and compliance with the Subcontractual Relationships and Delegation standard and moderate compliance with the other three standards under review, as HSAG identified opportunities for improvement and required actions in each of these areas.

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

Table 1-1—Summary of Scores for the Standards

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
V. Member Information Requirements	20	18	16	2	0	2	89%^
VII. Provider Selection and Program Integrity	16	15	13	2	0	1	87%~
IX. Subcontractual Relationships and Delegation	4	4	4	0	0	0	100%~
X. Quality Assessment and Performance Improvement (QAPI)**	16	16	13	3	0	0	81%^
Totals	**56**	**53**	**46**	**7**	**0**	**3**	**87%**

*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.

v Indicates that the score decreased compared to the previous review year.

^ Indicates that the score increased compared to the previous review year.

~ Indicates that the score remained unchanged compared to the previous review year.

**The full name of Standard X is Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems.

Standard V—Member Information Requirements

Evidence of Compliance and Strengths

DentaQuest used a process to provide member information to members during initial enrollment as well as when requested, at no cost, in English and prevalent non-English languages. Member materials were provided in alternative formats such as, printed in large font size (18-point), braille, and audio. DentaQuest staff members reported that the Customer Service department assists members by providing material in a digital format or mail and guides members through the online platform to demonstrate how they can obtain the information by downloading or by printing. To ensure easy-to-understand member material, the material is processed through a tool used to generate results based on the required sixth-grade reading level. Member material that is sent to members upon enrollment consisted of a member welcome letter, identification cards, and a member handbook.

HSAG located the provider directory on DentaQuest's website in a location that is prominent and readily accessible. The provider directory could be reviewed online, searched, downloaded, or printed. Staff members reported during the interview that the provider directory was current and updated based on information that is received upon initial contact when the provider joins the network and additionally through semi-annual contact with the provider.

DentaQuest submitted an accessibility policy that described testing procedures for Section 508 compliance. Within its policies, DentaQuest described how testing was conducted upon the launch of new webpages and new content, and establishing a standardized practice quarterly. Staff members noted during the interview that when errors were reported to the team, the errors were prioritized by three different critical levels and resolved in a timely fashion. DentaQuest used a third-party vendor, HealthSparq One, to conduct testing on its website to ensure compliance with Web Content Accessibility Guidelines (WCAG). HSAG tested the content located on the website by the Web Accessibility Evaluation Tool (WAVE) and found a low number of errors.

Opportunities for Improvement and Recommendations

To improve the readability of critical member material, HSAG strongly encourages DentaQuest to implement a mechanism for member testing using the Department of Health Care Policy & Financing's (the Department's) Member Experience Committee to gather member feedback on member materials.

Required Actions

DentaQuest staff members reported that members use a tool to test member materials to ensure ease of understanding. HSAG used the Flesch-Kincaid editorial instrument in Microsoft Word to test the

reading grade level of the member handbook and found that while some of the language scored at or around the eighth-grade reading level and was easily understood, other sections were not and were deemed too complicated for a member to understand. DentaQuest must review the entire member handbook to identify where it does not include easily understood language and then must implement changes necessary to obtain language at or around an eight-grade reading level in a format that is easy to follow. Although, the current fiscal year (FY) 2023–2024 prepaid ambulatory health plan (PAHP) contract states the language must be at a sixth-grade reading level, HSAG is aware the new contract adjusted the requirement to an eighth-grade reading level.

DentaQuest's member handbook listed member rights and protections but did not include all required member right' content. DentaQuest must update the member handbook to include the member's right to be furnished healthcare services in accordance with requirements for access, coverage, and coordination of medically necessary services.

Standard VII—Provider Selection and Program Integrity

Evidence of Compliance and Strengths

DentaQuest's Network Management team described processes for the selection and retention of providers. During the interview, DentaQuest staff members explained how DentaQuest is in a continuous recruitment mode. New graduates are frequently brought into the network, particularly those who are recent dental school graduates and those brought in as a result of gap recruitment. Gap recruitment is particularly prominent in the rural and pioneer areas of Colorado, specifically in the Eastern Plains and the Western Slope areas.

The Network Management team described a process for credentialing that included the required pre-hire vetting. In addition, DentaQuest provided details about its onboarding process, including signing the provider agreement, gaining access to the office reference manual (ORM), and conducting new hire trainings, including trainings for fraud, waste, and abuse.

For provider retention, DentaQuest conducted provider surveys to assess provider satisfaction. Topics of the survey included general satisfaction with DentaQuest, likeliness to remain in the provider network, how DentaQuest compares with competitors, and the level of ease providers experience when working with DentaQuest. Specific questions concerned the providers' perception of the timeframe and accuracy of payments, the onboarding process, the authorization process, and customer service. In most areas surveyed, DentaQuest had documented improvement year-over-year for the past four years. In addition, when surveyed, providers perceived a decrease in "problems" with DentaQuest consistently over the past four years.

During the period under review, DentaQuest maintained a Compliance Committee, which consisted of the compliance officer, executive leadership, members of the fraud team, and other pertinent individuals totaling 10–12 members. During the interview, a DentaQuest staff member described a close working relationship between the fraud, waste, and abuse team; the special investigations unit; and the

compliance team which showed effective lines of communication. DentaQuest detailed a complex system of monitoring and auditing data analytic reports to identify outliers that could suggest the potential for fraud, waste, or abuse. DentaQuest described activities to prevent, detect, and investigate fraud. DentaQuest mandates compliance training within 30 days of hire and annually. In addition, the compliance officer maintains up-to-date knowledge on topics in healthcare compliance.

Opportunities for Improvement and Recommendations

To ensure that services represented to have been delivered by network providers were received by members, DentaQuest used a survey process that prompted members who used the customer service line to answer questions about prior visits. If the prior visit detailed in the member's health record was different from the visit described by the member (or if the member reported no prior visit), the survey reponse and encounter were flagged for investigation. While this process does capture members, it is limited in scope to those members who are proactive in dental care and outreach custormer service. HSAG suggests that DentaQuest consider a method that also will include members who have less interaction with customer service to cast a wider net for the survey.

Required Actions

While DentaQuest provided evidence of a process for the retention of providers, this process was not documented within its written policies. DentaQuest must document its provider retention process within its written policies.

DentaQuest provided a policy that referenced "relief" if a whistleblower were retaliated against, but there is no language specific to the protection of whistleblowers. DentaQuest provided a policy that referenced notifying the Department immediately of suspected fraud, but there is no specific language in the policy indicating that DentaQuest will report waste and abuse. DentaQuest must update its policies to include language pertaining to reporting waste and abuse and to protecting whistleblowers.

Standard IX—Subcontractual Relationships and Delegation

Evidence of Compliance and Strengths

DentaQuest submitted multiple contracts with a Microsoft Excel spreadsheet that listed all vendors as evidence of delegation. American Directions Research Group performs member surveys. BANCTEC performs data processing, Cathedral prints and mails explanation of benefits (EOB). Inbound call centers are Ibex, Optomi, and SAGILITY. Credentialing and recredentialing are conducted by Provider Trust. Trackmar and Veritas is delegated for fulfillment. DentaQuest performs grievances and appeals and utilization management.

DentaQuest recorded risk levels on a "scorecard" in which performance, engagement, communication, and innovation were measured. While each delegate did not score on the high-risk level, if they would

have scored as high-risk, additional conversations and possible actions may have been pursued. DentaQuest staff members reported that if DentaQuest had gaps and there was a need for a particular vendor, and the vendor resulted in a high-risk score, the risk would be mitigated on a "need-be" basis with additional oversight. Vendor oversight is accomplished by participating in a biweekly meeting to review and discuss contracting issues. Additionally, a Delegation Oversight Committee meeting takes place quarterly to discuss vendors who may be falling below metrics and the reasons for falling below metrics, contract statuses, and approvals for new vendors and subcontractors.

Opportunities for Improvement and Recommendations

HSAG identified no recommendations.

Required Actions

HSAG identified no required actions.

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems

Evidence of Compliance and Strengths

DentaQuest demonstrated a QAPI program that included a comprehensive work plan, National Quality Improvement Committee with Colorado Child Health Plan *Plus* (CHP+) PAHP participation, quarterly reports, and a mechanism to seek feedback from leadership. Through the interviews, staff members described reports that monitored overutilization and underutilization, the development of performance improvement projects, and ongoing efforts regarding performance measures. Staff members reported a focus on initiatives to improve the number of members who have a primary care physician and increase preventive dental services. Overutilization monitoring included reporting on the top 10 dental codes used and underutilization monitoring included outreach to members through interactive voice response (IVR) if the member had not received services in the last six months. During the review period, DentaQuest reported adding a new position in member outreach.

The Peer Review Committee Charter showed that in addition to dental directors, dental consultants reviewed and approved clinical practice guidelines and staff members described methods for accepting and considering network provider feedback. DentaQuest referenced valid and reliable clinical evidence throughout its documentation. The Clinical Algorithms policy demonstrated that DentaQuest commonly referenced valid and reliable clinical evidence, such as the American Association of Prosthodontics and American Dental Association; the American Society of Endodontics and American Dental Association; the Center for Devices and Radiological and the American Dental Association; and others. Meeting minutes confirmed that DentaQuest adhered to its policy to regularly review and update guidelines.

Policies, procedures, and workflow diagrams outlined DentaQuest's health information system, based on its proprietary WindWard system. Submitted documents described the claims adjudication process and data maintenance, while staff member interviews described both automated and manual monitoring and editing procedures. DentaQuest and the Department reported improvements in data acceptance rates, which improved from the high 80's to high 90's and consistently maintained an acceptance rate of 96 percent or higher.

Opportunities for Improvement and Recommendations

Although DentaQuest submitted a procedure that outlined how staff members would document and assess members with special health care needs, DentaQuest had not identified any members with special health care needs during the review period. HSAG recommends that DentaQuest expand its mechanisms for identifying members with special health care needs to ensure members receive support and care coordination, when needed.

Health Information System documentation submitted by DentaQuest was minimal. HSAG continues to suggest that DentaQuest develop additional documentation regarding its overall data system, monitoring methods, and reporting procedures.

The Colorado CHP+ Member Survey Results presentation showed high levels of member satisfaction. However, DentaQuest has an opportunity to further evaluate these results against grievance, appeal, and other available customer service data as part of a comprehensive QAPI program. Furthermore, DentaQuest has an opportunity to evaluate members who disenroll against its utilization management (UM), claims, grievance, and appeal data.

Required Actions

Although DentaQuest completed an annual evaluation in February 2023, the evaluation did not include all aspects of the QAPI program or document an assessment of the outcome and impact of QAPI activities. The Annual Improvement Plan consisted of one page that contained contract references, medical loss ratio reports, described a recruitment goal, and a goal to update policies, but did not assess QAPI activity outcomes. The Quality Improvement Work Plan documented activities for each quarter during the review period, but did not include any outcomes or assessment of progress. The Quality Improvement Evaluation for calendar year (CY) 2022 occurred in February 2023. The Colorado CHP+ PAHP specific component of the evaluation consisted of two pages. The evaluation stated the performance improvement plan (PIP) topic, described outreach campaigns, summarized compliance audit results, summarized overutilization reports and results, and noted staffing changes. The evaluation lacked an assessment (e.g., strengths, opportunities for improvement, goals achieved, goals abandoned, etc.) of QAPI activities (e.g., performance measures, PIPs, underutilization, etc.). DentaQuest must develop a more robust QAPI evaluation that includes all key components of the QAPI program. The evaluation must include an assessment of the QAPI activities impact and outcomes. For example, documenting strengths, opportunities, and goals.

The Clinical Algorithms policy which was submitted as evidence for clinical practice guidelines (CPGs) and associated exhibits focused on provider documentation standards, authorization procedures, and claims payments. DentaQuest did not include CPGs as defined by CMS in which "CPGs seek to close the gap between the clinician and relevant literature by providing information, recommendations, and/or best practices on healthcare for specific circumstances, diagnostic and treatment options, or patient management."[2-1] Further, the Institute of Medicine defines CPGs as "statements that include recommendations, intended to optimize patient care, that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options."[2-2] DentaQuest must develop a distinct list of CPGs for review and approval by the Peer Review Committee that are separate from UM criteria. HSAG encourages DentaQuest that as part of this process, participating network providers are consulted as part of the review and approval process (if not already part of the Peer Review Committee).

DentaQuest included a reference to CPGs in its provider agreement and additional details within its ORM, which is accessible to providers through the DentaQuest website. However, during the interview, staff members reported that, in general, there is no mechanism to post or send updates regarding guidelines to the provider network, and additional staff members described the clinical practice guidelines as an internal resource that is not typically shared externally. DentaQuest must disseminate its CPGs to all affected providers.

[2-1] Centers for Medicare & Medicaid Services. *Measure Management & You*, Newsletter, February 2018.
[2-2] Institute of Medicine. *Clinical Practice Guidelines We Can Trust*; 2011.

3. Background and Overview

Background

The PAHP is responsible for providing a statewide oral healthcare network and services under Colorado's 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 December 2020 and February 2023. 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 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), 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 FY 2023–2024 was CY January 1, 2023, through December 31, 2023. This report documents results of the FY 2023–2024 compliance review activities for DentaQuest. Section 1 includes the summary of scores for each of the standards reviewed this year. Section 2 contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 3 describes the background and methodology used for the FY 2023–2024 compliance monitoring review. Section 4 describes follow-up on the corrective actions required as a result of the FY 2022–2023 compliance review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B lists HSAG, PAHP, and Department personnel who participated in some way in the compliance review process. Appendix C describes the corrective action plan (CAP) process the PAHP will be required to complete for FY 2023–2024 and the required template for doing so. Appendix D 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*, February 2023.[3-1]

[3-1] 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*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: July 21, 2023.

Overview of FY 2023–2024 Compliance Monitoring Activities

For the FY 2023–2024 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 V—Member Information Requirements, Standard VII—Provider Selection and Program Integrity, Standard IX—Subcontractual Relationships and Delegation, and Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems. 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 December 2020 and February 2023. 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 CY January 1, 2023, through December 31, 2023. HSAG reviewed materials submitted prior to the compliance review activities, materials requested during the compliance review, and considered interviews with key PAHP personnel to determine compliance with federal managed care regulations and contract requirements. Documents consisted of policies and procedures, staff training materials, reports, committee meeting minutes, and member and provider informational materials.

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*, February 2023. Appendix D 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 2023–2024 compliance reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services; Standard II—Adequate Capacity and Availability of Services; Standard III—Coordination and Continuity of Care; Standard IV—Member Rights, Protections, and Confidentiality; Standard VI—Grievance and Appeal Systems; Standard VIII—Credentialing and Recredentialing; and Standard XII—Enrollment and Disenrollment.

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, timeliness, and accessibility of 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.

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

FY 2022–2023 Corrective Action Methodology

As a follow-up to the FY 2022–2023 compliance review, each MCE 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 MCE 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 MCE and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with the MCE until it completed each of the required actions from the FY 2022–2023 compliance monitoring review.

Summary of FY 2022–2023 Required Actions

For FY 2022–2023, HSAG reviewed 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.

Related to Standard I—Coverage and Authorization of Services, DentaQuest was required to complete five required actions:

- Update the UM Authorization Review policy and procedure to include authorization time frames.
- Revise denial service codes and clinical explanation located in the notice of adverse benefit determination (NABD) to be in an easy-to-understand explanation.
- Update policies, procedures, and NABD templates to explain all required details.
- Update policies and procedures to include the process and time frame for mailing the standard, expedited, and extended notices.
- Update its policies and procedures to include the requirement that gives notice on or before the intended effective date of the proposed adverse benefit determination.

Related to Standard II—Adequate Capacity and Availability of Services, DentaQuest was required to complete three required actions:

- 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.
- Update and monitor internal reports and associated procedures to include the correct time and distance standards for general and pediatric dentists in urban, rural, and frontier counties.

- Enhance its cultural competency program.

Related to Standard VI—Grievance and Appeal Systems, DentaQuest was required to complete 13 required actions:

- 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 for tracking and trending purposes.
- 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 and the CHP+ member handbook to describe how DentaQuest gives members reasonable assistance in completing any forms and taking other procedural steps related to grievances or appeals.
- Enhance its process to document in appeal case files that the reviewer has the appropriate clinical expertise.
- Enhance its procedures to send the member a written acknowledgement of each grievance within two working days of receipt and implement an ongoing process to monitor that the timelines are met.
- 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 and update its acknowledgement letter to include the correct time frames.
- 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 not require oral requests for an appeal to be followed with a written request.
- Enhance its procedures to send a written acknowledgement of each appeal within two working days of receipt and update member-facing communications to be consistent with the two working day timeline.
- Update its policies and procedures to remove language regarding delegating expedited appeal notices to providers.
- 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 the request to expedite the appeal resolution is denied.
- Update related policies, procedures, and member communications to include the correct time frame for appeal resolutions.
- Update its 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; and implement processes to ensure that notices of an expedited resolution are not left on member voicemails.
- Update its policies, procedures, monitoring practices, and member communications to ensure its process to: (1) make a reasonable effort to give the member prompt oral notice of the delay or need for an extension and (2) provide written notice within two calendar days and 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.

- Update the ORM to include grievance time frames and inform the member of the availability of assistance in the grievance process.

Related to Standard XII—Enrollment and Disenrollment, HSAG identified no required actions.

Summary of Corrective Action/Document Review

DentaQuest submitted a proposed CAP in March 2023. HSAG and the Department reviewed and approved the proposed CAP and responded to DentaQuest. DentaQuest submitted final documentation and completed the CAP in October 2023.

Summary of Continued Required Actions

DentaQuest successfully completed the FY 2022–2023 CAP, resulting in no continued corrective actions.

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor provides all required member information to members in a manner and format that may be easily understood and is readily accessible by members. *Note: Readily accessible means electronic information which complies with 508 guidelines, Section 504 of the Rehabilitation Act, and World Wide Web Consortium Web Content Accessibility Guidelines 2.0 Level AA and successor versions.* *42 CFR 438.10(c)(1)* Contract Amendment 7: Exhibit B-3—4.4.6.6	**Suggested Documents:** Member materials (e.g., welcome letters, pamphlets, guides, member letters, and newsletters) Member handbooks Policies/Procedures **Submitted Documents:** Member Handbook Welcome Letter MKT04-Health Literacy See P&P UM04-INS-Notice of Action Letters: • Page 1 – Procedure, paragraph 1 • Page 2 – Section A (Approval Notification) 4h, 4i and Section B (Denial Notification) 2d • Page 3 – Section B (Denial Notification) 2l,2m,2n,2p	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: DentaQuest staff members reported member material is placed through a tool to test format to ensure easy-to-understand material. HSAG tested the member handbook through the Microsoft Word Flesch-Kincaid test and found some of the language would be easily understood. However, some parts were not easily understood and deemed complicated for members to understand.		
Required Actions: DentaQuest must review the member handbook to identify where it does not include easily understood language and must implement changes necessary to obtain language at or around eight-grade reading level. Although, the current FY 2023–2024 PAHP contract states the language must be at a sixth-grade reading level, HSAG is aware that the new contract adjusted the requirement to an eighth-grade reading level.		

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The Contractor has in place a mechanism to help members understand the requirements and benefits of the plan. *42 CFR 438.10(c)(7)* Contract Amendment 7: Exhibit B-3—4.4.6.6-10	**Suggested Documents:** Member handbooks Policies/Procedures Newsletters Member materials Staff training **Submitted Documents:** Member Handbook Welcome Letter	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. For consistency in the information provided to members, the Contractor uses the following as developed by the State: • Definitions for managed care terminology, including appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. • Model member handbooks and member notices. *42 CFR 438.10(c)(4)* Contract Amendment 7: Exhibit B-3—4.4.6.6	**Suggested Documents:** Member handbooks Member notices **Submitted Documents:** Member Handbook	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • Written materials that are critical to obtaining services include, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices. • All written materials for members must: – Use easily understood language and format. – Use a font size no smaller than 12 point. – Be available in alternative formats and through provision of auxiliary aids and service that takes into consideration the special needs of members with disabilities or limited English proficiency. – Include taglines in conspicuously visible font size and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDY customer service number, and availability of materials in alternative formats. *42 CFR 438.10(d)(2-3) and (d)(6)* Contract Amendment 7: Exhibit B-3—4.4.6	**Suggested Documents:** Member handbooks Member materials (e.g., welcome letters, pamphlets, guides, member letters, and newsletters) Provider directory Grievance and appeal notice templates Policies/Procedures **Submitted Documents:** Member Handbook MKT04-Health Literacy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. If the Contractor makes information available electronically—Information provided electronically must meet the following requirements: • The format is readily accessible (see definition of readily accessible above). • The information is placed in a website location that is prominent and readily accessible. • The information can be electronically retained and printed. • The information complies with content and language requirements. • The member is informed that the information is available in paper form without charge upon request and is provided within five (5) business days. *42 CFR 438.10(c)(6)* Contract Amendment 7: Exhibit B-3—4.4.6.6	**Suggested Documents:** Electronic or downloadable member information (PDFs) Website link Policies/Procedures **Submitted Documents:** Website: Colorado Medicaid Child Health Plan Plus (dentaquest.com)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The Contractor makes available to members in electronic or paper form information about its formulary: • Which medications are covered (both generic and name brand). • What tier each medication is on. • Formulary drug list must be available on the Contractor's website in a machine readable file and format. *42 CFR 438.10(h)(4)(i)* Contract Amendment 7: Exhibit B-3—4.4.6.6	**Suggested Documents:** Formulary Website where the formulary is available **Submitted Documents:** The is not applicable to DentaQuest. Was communicated with HSAG (8.28.23) prior to this compliance tool.	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor makes interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and written translation is available in prevalent languages, and how to access them. • This includes oral interpretation and use of auxiliary aids such as TTY/TDY and American Sign Language. *42 CFR 438.10(d)(4)* Contract Amendment 7: Exhibit B-3—4.4.5.4	**Suggested Documents:** Policies/Procedures Provider/Staff training Language line business agreements Language line sample utilization reports **Submitted Documents:** Member Handbook CS09-INS-CS Member Access with LEP	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor notifies members that auxiliary aids and services are available upon request and at no cost for members with disabilities, and how to access them. *42 CFR 438.10(d)(5)* Contract Amendment 7: Exhibit B-3—4.4.5.3	**Suggested Documents:** Member handbook Newsletters Member materials **Submitted Documents:** Member Handbook	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor provides each member with a member handbook in both electronic and paper format within a reasonable time after receiving notification of the member's enrollment. *42 CFR 438.10(g)(1)* Contract Amendment 7: Exhibit B-3—4.2.18.1.2.1.2	**Suggested Documents:** Member handbook Policies/Procedures Printing vendor agreement **Submitted Documents:** MKT03-INS-COMM-Member Communication Distribution	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor gives members written notice of any significant change (as defined by the State) in the information required at 438.10(g) at least 30 days before the intended effective date of the change. *42 CFR 438.10(g)(4)* Contract Amendment 7: Exhibit B-3—4.4.6.6	**Suggested Documents:** Member handbook Provider directory Website Sample communication Policies/Procedures **Submitted Documents:** MKT03-INS-COMM-Member Communication Distribution	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice or 30 days prior to the effective date of the termination, whichever is later, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. *42 CFR 438.10(f)(1)* Contract Amendment 7: Exhibit B-3—4.4.6.4	**Suggested Documents:** Policies/Procedures Training Notice of termination template or sample **Submitted Documents:** CORR01-INS-Member Notifications of provider Termination	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor makes a provider directory available to members, in paper or electronic form, which includes the following information about contracted network physicians (including specialists), hospitals, pharmacies, and behavioral health providers, and LTSS providers (as applicable): • The provider's name and group affiliation, street address(es), telephone number(s), website URL,	**Suggested Documents:** Provider directory Website Policies/Procedures **Submitted Documents:** NET17-INS-SOP	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
specialty (as appropriate), whether the providers will accept new members. • The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office, and whether the provider has completed cultural competency training. • Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment. *Note: Information included in a paper provider directory must be updated at least monthly and quarterly for a mobile enabled or electronic directory.* *Electronic provider directories must be updated no later than 30 calendar days after the Contractor receives updated provider information.* *42 CFR 438.10(h)(1-3)* Contract Amendment 7: Exhibit B-3—4.1.6.15-18; 4.1.6.15.20	Find a Dentist (dentaquest.com) Online Provider Directory Policies and SOP 2022 HCSC-WAS Product Accessibility - DentaQuest	
13. Provider directories are made available on the Contractor's website in a machine readable file and format. *42 CFR 438.10(h)(4)* Contract Amendment 7: Exhibit B-3—4.1.6.19	**Suggested Documents:** Website **Submitted Documents:** https://www.dentaquest.com/en/find-a-dentist	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The member handbook provided to members following enrollment includes: • The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled. • Procedures for obtaining benefits, including authorization requirements and/or referrals for specialty care and for other benefits not furnished by the member's primary care provider. The process of selecting and changing the member's primary care provider. • Any restrictions on the member's freedom of choice among network providers. • In the case of a counseling or referral service or CHP+ covered benefit that the Contractor does not cover due to moral or religious objections, the Contractor informs the member that the service is not covered because of moral or religious objections and how and where the member can obtain the services. *42 CFR 438.10(g)(2)(ii, iii, iv, vi, x)* Contract Amendment 7: Exhibit B-3—4.2.18.1.2.1	**Suggested Documents:** Member handbook Policies/Procedures **Submitted Documents:** Member Handbook	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
15. The member handbook provided to members following enrollment includes the following member rights and protections as specified in 42 CFR 438.100. Members have the right to:	**Suggested Documents:** Member handbook **Submitted Documents:**	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for his or her dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding his or her health care, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. • Request and receive a copy of his or her medical records, and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for access, coverage, and coordination of medically necessary services. • Freely exercise his or her rights, and the exercising of those rights will not adversely affect the way the Contractor, its network providers, or the State Medicaid agency treats the member. *42 CFR 438.10(g)(2)(ix)* Contract Amendment 7: Exhibit B-3—4.4.8	Member Handbook	
Findings: Within its member handbook, DentaQuest listed the members' rights and protections but did not include all member rights.		
Required Actions: DentaQuest must update the member handbook to include the members' right to be furnished healthcare services in accordance with requirements for access, coverage, and coordination of medically necessary services.		

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The member handbook provided to members following enrollment includes the following information regarding the grievance, appeal, and State fair hearing procedures and time frames: • The right to file grievances and appeals. The requirements and time frames for filing a grievance or appeal. • The right to a request a State fair hearing after the Contractor has made a determination on a member's appeal which is adverse to the member. • The availability of assistance in the filing process. *42 CFR 438.10(g)(2)(xi)* Contract Amendment 7: Exhibit B-3—4.2.18.1.2.1	**Suggested Documents:** Member handbook **Submitted Documents:** Member Handbook	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
17. The member handbook provided to members following enrollment includes the extent to which and how after-hours and emergency coverage are provided, including: • What constitutes an emergency medical condition and emergency services. • The fact that prior authorization is not required for emergency services. • The fact that the member has the right to use any hospital or other setting for emergency care. *42 CFR 438.10(g)(2)(v)* Contract Amendment 7: Exhibit B-3—4.1.8.1.3.8; 4.2.18.1.2.1.2	**Suggested Documents:** Member handbook **Submitted Documents:** Member Handbook	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. The member handbook provided to members following enrollment includes: • Cost-sharing, if any is imposed under the State plan. • How and where to access any benefits that are available under the State plan but not covered under the CHP+ managed care contract. • How transportation is provided. • The toll-free telephone number for member services, medical management, and any other unit providing services directly to members. • Information on how to report suspected fraud or abuse. • How to access auxiliary aids and services, including information in alternative formats or languages. *42 CFR 438.10(g)(2)(ii, viii, xiii, xiv, xv)* Contract Amendment 7: Exhibit B-3—4.4.4.3.1.6, 4.4.4.3.1.7, 4.4.7.3; 4.2.18.1.2.1; 4.4.9.1.2	**Suggested Documents:** Member handbook **Submitted Documents:** Member Handbook	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
19. The Contractor provides member information by either: • Mailing a printed copy of the information to the member's mailing address. • Providing the information by email after obtaining the member's agreement to receive the information by email. • Posting the information on the Contractor's website and advising the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost. • Providing the information by any other method that can reasonably be expected to result in the member receiving that information. *42 CFR 438.10(g)(3)* Contract Amendment 7: Exhibit B-3—4.2.18.1.2.1.2	**Suggested Documents:** Website Welcome materials Policies/Procedures Printing vendor agreement **Submitted Documents:** MKT03-INS-COM Member Communications Distribution	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
20. The Contractor must make available to members, upon request, any physician incentive plans in place. *42 CFR 438.10(f)(3)* Contract Amendment 7: Exhibit B-3—None	**Suggested Documents:** Member handbook Website Policies/Procedures **Submitted Documents:** The is not applicable to DentaQuest. Was communicated with HSAG (8.28.23) prior to this compliance tool	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable

Results for Standard V—Member Information Requirements							
Total	Met	=	16	X	1.00	=	16
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	2	X	NA	=	NA
Total Applicable		=	18	**Total Score**		=	16
				Total Score ÷ Total Applicable		=	89%

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements written policies and procedures for selection and retention of providers. *42 CFR 438.214(a)* Contract Amendment 7: Exhibit B-3—4.1.2.7	**Suggested Documents:** Policies/Procedures Website **Submitted Documents:** Net01- INS Network Development, Maintenance and Use	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: While DentaQuest provided evidence of a process for the retention of providers, this process was not documented in its written policies.		
Required Actions: DentaQuest must document its provider retention process within its written policies.		
2. The Contractor follows a documented process for credentialing and recredentialing of network providers. *42 CFR 438.214(b) and (e)* Contract Amendment 7: Exhibit B-3—4.1.2.8	**Submitted Documents:** PEC01 and PEC04	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor's provider selection policies and procedures include provisions that the Contractor does not: • Discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification.	**Suggested Documents:** Policies/Procedures Provider manual (office reference manual [ORM]) Provider newsletters **Submitted Documents:** PEC01-INS Net01- INS Network Development, Maintenance and Use	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42 CFR 438.12(a)(1) and (2)* *42 CFR 438.214(c)* Contract Amendment 7: Exhibit B-3—4.1.2.11 and 4.1.2.12		
4. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This is not construed to: • Require the Contractor to contract with providers beyond the number necessary to meet the needs of its members. • Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. • Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members. *42 CFR 438.12(a-b)* Contract Amendment 7: Exhibit B-3—4.1.2.13	**Submitted Documents:** Please see sample denial letters and term letters	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor has a signed contract or participation agreement with each provider. *42 CFR 438.206(b)(1)* Contract Amendment 7: Exhibit B-3—4.1.2.17	**Suggested Documents:** Provider contract/agreement template Policies/Procedures **Submitted Documents:** NET04- Provider Contract Template Administration 221223 CO CHP MC- Provider Agreement	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The Contractor does not employ or contract with providers or other individuals or entities excluded for participation in federal health care programs under either Section 1128 or 1128 A of the Social Security Act. • The Contractor performs monthly monitoring against HHS OIG's List of Excluded Individuals. *(This requirement also requires a policy.)* *42 CFR 438.214(d)* *42 CFR 438.610* Contract Amendment 7: Exhibit B-3—4.3.15.13.2.3 and 4.3.15.14.1	**Suggested Documents:** Policies/Procedures **Submitted Documents:** PEC01 and PEC04 COM12-ENT-OIG-GSA Exclusion Review Letter - July Employee Sanction Results 2023 Letter - August 2023 Employee Sanction Results Letter - September Employee Sanction Results 2023	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The Contractor may not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner (owning 5 percent or more of the Contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities	**Suggested Documents:** Policies/Procedures **Submitted Documents:** COM12-ENT-OIG-GSA Exclusion Review	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
under federal acquisition regulation or Executive Order 12549. *42 CFR 438.610* Contract Amendment 7: Exhibit B-3—4.3.15.14.2.3	COM23-ENT-Client Notifications Policy-Key Personnel	
8. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: • The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered. • Any information the member needs in order to decide among all relevant treatment options. • The risks, benefits, and consequences of treatment or non-treatment. • The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. *42 CFR 438.102(a)(1)* Contract Amendment 7: Exhibit B-3—4.1.2.12	**Suggested Documents:** Provider agreement Provider/Member newsletters or other forms of messaging **Submitted Documents:** 221223 CO CHP MC- Provider Agreement • Pg 2. (d) Non-discrimination. • Pg 6. (b) Appropriate Treatment Office Reference Manual (ORM) file (Colorado Child Health Plan Plus (CHP+)) sections on Member and provider rights.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: • To the State upon contracting or when adopting the policy during the term of the contract. • To members before and during enrollment. • To members within 90 days after adopting the policy with respect to any particular service. *42 CFR 438.102(a)(2)-(b)* Contract Amendment 7: Exhibit B-3—4.1.6.27.5	**Suggested Documents:** Policies/Procedures Member communications (if applicable) **Submitted Documents:** COM15-ENT-Nondiscrimination Compliance Program 221223 CO CHP MC- Provider Agreement • Pg 2. Non-discrimination.	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
10. The Contractor has administrative and management arrangements or procedures, including a compliance program to detect and prevent fraud, waste, and abuse and includes: • Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal, State, and contract requirements. • The designation of a compliance officer who is responsible for developing and implementing policies, procedures and practices to ensure compliance with requirements of the contract and reports directly to the Chief Executive Officer and Board of Directors. • The establishment of a Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program.	**Suggested Documents:** Compliance plan Policies/Procedures Code of conduct Committee meeting minutes Organizational chart Staff training (fraud, waste, abuse) Disciplinary guidelines **Submitted Documents:** **See the following Compliance Program policies, procedures, and documentation**: Compliance Program Overview COM01-ENT-Policy Management and Control COM03-ENT-Code of Conduct Standards Code of Conduct_DentaQuest	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Training and education of the compliance officer, management, and organization's staff members for the federal and State standards and requirements under the contract. • Effective lines of communication between the compliance officer and the Contractor's employees. • Enforcement of standards through well-publicized disciplinary guidelines. • Implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks. • Procedures for prompt response to compliance issues as they are raised, investigation of potential compliance problems identified in the course of self-evaluation and audits, corection of such problems quickly and thoroughly to reduce the potential for reoccurence, and ongoing compliance with the requirements under the contract. *42 CFR 438.608(a)(1)* Contract Amendment 7: Exhibit B-3—4.3.15.2	COM05-ENT-Chief Ethics & Compliance Officer Compliance Committee Charter Redacted Compliance Committee Minutes Q1 2023 COM06-ENT-Compliance Monitoring and Communication COM07-ENT-Training and Education COM14-ENT-Enforcement and Discipline COM09-ENT-Duty to Report Noncompliance; Non-retaliation COM13-ENT-Compliance Investigation COM16-ENT-Corrective Action Plans COM17-ENT-CAP Coordination 2022_Compliance Training_Completion_Report_HSAG-09222023	
11. The Contractor's administrative and management procedures to detect and prevent fraud, waste, and abuse include: • Written policies for all employees, subcontractors or agents that provide detailed information about the False Claims Act, including the right of employees to be protected as whistleblowers.	**Suggested Documents:** Policies/Procedures Compliance program description **Submitted Documents:** Code of Conduct_DentaQuest	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Provisions for prompt referral of any potential fraud, waste, or abuse to the Department and any potential fraud to the State Medicaid Fraud Control Unit. • Provisions for suspension of payments to a network provider for which the State determines there is credible allegation of fraud (in accordance with 455.23). *42 CFR 438.608 (a)(6-8)* Contract Amendment 7: Exhibit B-3—4.3.15.2.2.8, 4.3.14.11.1, and 4.3.14.12.1	COM10-ENT-False Claims Act Information FPR01-INS-DENT-FPR Program- FINAL- entire document FPR05-INS-MCD- Credible Allegation of Faud Hold- FINAL- entire document HR-EIH-44-Anonymous Disclosure_ False Claims Act	
Findings: DentaQuest provided a policy that referenced "relief" if a whistleblower were retaliated against, but there is no language specific to the protection of whistleblowers. DentaQuest provided a policy that referenced notifying the Department immediately of suspected fraud, but there is no specific language in the policy indicating that DentaQuest will report waste and abuse.		
Required Actions: DentaQuest must update its policies to include language pertaining to reporting waste and abuse and to protecting whistleblowers.		
12. The Contractor's Compliance Program includes: • Provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying the overpayments due to potenial fraud. • Provision for prompt notification to the State about member circumstances that may affect the member's eligibility, including change in residence and member death. • Provision for notification to the State about changes in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care	**Suggested Documents:** Policies/Procedures Compliance program description Sample of member verification communications and/or reports **Submitted Documents:** Credentialing PEC01, PEC04 #3 PEC01 Procedure A 1. g ii	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
program, including termination of the provider agreement with the Contractor. • Provision for a method to verify on a regular basis, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. *42 CFR 438.608 (a)(2-5)* Contract Amendment 7: Exhibit B-3—4.3.14.1, 4.3.15.5.1, 4.3.15.6.1, and 4.3.15.8.4 10 CCR 2505-10, Section 8.076	FPR01-INS-DENT-FPR Program- FINAL- entire document	
13. The Contractor ensures that all network providers are enrolled with the State as CHP+ providers consistent with the provider disclosure screening, and enrollment requirements of the State. • The Contractor may execute network provider agreements pending the outcome of the State's screening and enrollment process of up to one-hundred and twenty (120) days, but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one one-hundred and twenty (120)-day period without enrollment of the provider, and notify affected members. *42 CFR 438.608 (b)* Contract Amendment 7: Exhibit B-3—4.1.2.2	**Suggested Documents:** Policies/Procedures Desktop procedure **Submitted Documents:** Credentialing PEC01 and PEC04	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor has procedures to provide to the State: • Written disclosure of any prohibited affiliation (as defined in 438.610). • Written disclosure of ownership and control (as defined in 455.104) • Identification within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract. *42 CFR 438.608(c)* Contract Amendment 7: Exhibit B-3—4.3.15.14.3, 4.3.15.18.4.4, and 4.3.15.4.1.1	**Suggested Documents:** Policies/Procedures Compliance program description Desktop procedure **Submitted Documents:** Credentialing PEC01, PEC04 COM12-ENT-OIG-GSA Exclusion Review COM23-ENT-Client Notifications Policy-Key Personnel Ownership - Control Disclosure Form	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
15. The Contractor has a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days of identifying the overpayment, and to notify the Contractor in writing of the reason for the overpayment. • The Contractor reports annually to the State on recoveries of overpayments. *42 CFR 438.608(d)(2) and (3)* Contract Amendment 7: Exhibit B-3—4.3.15.4.1.1-2 and 4.3.15.4.1.3	**Suggested Documents:** Policies/Procedures Compliance program description **Submitted Documents:** **Sample EOB with Overpayment**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The Contractor provides that members are not held liable for: • The Contractor's debts in the event of the Contractor's insolvency. • Covered services provided to the member for which the State does not pay the Contractor. • Covered services provided to the member for which the State or the Contractor does not pay the health care provider that furnishes the services under a contractual, referral, or other arrangement. • Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly. *42 CFR 438.106* Contract Amendment 7: Exhibit B-3—None	**Suggested Documents:** Policies/Procedures Provider messaging (e.g., manual, contracts, agreements, newsletters, and flyers) Member messaging (e.g., handbook) **Submitted Documents:** 221223 CO CHP MC- Provider Agreement • b) Hold Harmless.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. Notwithstanding any relationship(s) with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. *42 CFR 438.230(b)(1)* Contract Amendment 7: Exhibit B-3—3.3.5.6.6	**Submitted Documents:** **In folder: Standard IX—Subcontractual Relationships and Delegation** 1) Vendor Management Program Document 2) DentaQuest Delegation Process 3) Please see the score cards for each vendor. "Vendor name_Scorecards_2023" 4) See each vendor agreement "Vendor name_DSA_Date"	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. All contracts or written arrangements between the Contractor and any subcontractor specify— • The delegated activities or obligations and related reporting responsibilities. • That the subcontractor agrees to perform the delegated activities and reporting responsibilities. • Provision for revocation of the delegation of activities or obligations or specify other remedies in instances where the Contractor determines that the subcontractor has not performed satisfactorily. *Note: Subcontractor requirements do not apply to network provider agreements. In addition, wholly-owned subsidiaries of the health plan are not considered subcontractors.* *42 CFR 438.230(b)(2) and (c)(1)*	**In folder: Standard IX—Subcontractual Relationships and Delegation** **Submitted Documents:** 1) CO Vendor Subdel List 2) See each vendor agreement "Vendor name_DSA_Date" See in section: Section 2.2 Delegated Services; Article III Standards for Service - Section 3.1 A; and B; 4.3 Access to Records; and Section 7.2 Termination	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract Amendment 7: Exhibit B-3—None		
3. The Contractor's written agreement with any subcontractor includes: • The subcontractor's agreement to comply with all applicable CHP+ laws, regulations, including applicable sub regulatory guidance and contract provisions. *42 CFR 438.230(c)(2)* Contract Amendment 7: Exhibit B-3—3.3.6.6 and 3.3.5.6.7	**In folder: Standard IX—Subcontractual Relationships and Delegation** **Submitted Documents:** 1) See each vendor agreement "Vendor name_DSA_Date" Section 3.4 Compliance and Licensure specifically & 3.7 Subcontracting.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The written agreement with the subcontractor includes: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State. – The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems related to CHP+ members. – The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.	**In folder: Standard IX—Subcontractual Relationships and Delegation** **Submitted Documents:** 1) See each vendor agreement "Vendor name_DSA_Date" See in section: 4.3 Access to Records and 4.5 Delegated Service records.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. *42 CFR 438.230(c)(3)* Contract Amendment 7: Exhibit B-3—4.3.15.16		

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

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. *42 CFR 438.330(a)(1)* Contract Amendment 7: Exhibit B-3—4.3.18.1	**Suggested Documents:** QAPI program description Committee meeting minutes Workplans Progress tracking or sample reports **Submitted Documents:** National Quality Improvement Program 2023 National Quality Improvement Program Evaluation 2022_CO 2023 Quality Improvement Workplan_CO	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor's QAPI Program includes conducting and submitting (to the State) annually and when requested by the Department, one performance improvement project (PIP) that focus on both clinical and nonclinical areas. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. Each PIP includes the following: • Measurement of performance using objective quality indicators. • Implementation of interventions to achieve improvement in the access to and quality of care. • Evaluation of the effectiveness of the interventions based on the objective quality indicators. • Planning and initiation of activities for increasing or sustaining improvement.	**Suggested Documents:** PIP reports from the review period **Submitted Documents:** National QIC Committee Meeting Minutes_CO CO PIP Module 4	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.330(b)(1) and (d)(2) and (3) Contract Amendment 7: Exhibit B-3—4.3.18.1 and 4.1.10.5		
3. The Contractor's QAPI Program includes collecting and submitting (to the State) annually: • Performance measure data using standard measures identified by the State. • Data, specified by the State, which enable the State to calculate the Contractor's performance using the standard measures identified by the State. • A combination of the above activities. *42 CFR 438.330(b)(2) and (c)* Contract Amendment 7: Exhibit B-3—4.3.18.1 and 4.3.18.2	**Suggested Documents:** Log/Report that is submitted to the State annually **Submitted Documents:** Annual Improvement Plan National QIC Committee Meeting Minutes	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42 CFR 438.330(b)(3)* Contract Amendment 7: Exhibit B-3—4.3.18.1 and 4.3.12.1.4	**Suggested Documents:** QAPI plan QAPI program description Policies/Procedures Sample reports Committee meeting minutes **Submitted Documents:** Utilization Management Program Description - Page 10 (Utilization Review Program : Over Utilization and Under Utilization)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	FPR04-DENT-SOP-Utilization Oversight Process-FINAL National Quality Improvement Program 2023	
5. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. *Note: Persons with special health care needs shall mean persons having ongoing health conditions that have a biological, psychological, or cognitive basis; have lasted or are estimated to last for at least one year; and produce one or more of the following: (1) a significant limitation in areas of physical, cognitive, or emotional function; (2) dependency on medical or assistive devices to minimize limitation of function or activities; (3) for children: significant limitation in social growth or developmental function; need for psychological, educational, medical, or related services over and above the usual for the child's age; or special ongoing treatments such as medications, special diets, interventions, or accommodations at home or at school.* *42 CFR 438.330(b)(4)* Contract Amendment 7: Exhibit B-3—4.3.18.1	**Suggested Documents:** QAPI plan Policies/Procedures Sample reports Committee meeting minutes **Submitted Documents:** NET 15-INS SOP Coordination and Continuity of Care for Enrolled Members National QIC Committee Meeting Minutes_CO National Quality Improvement Program 2023	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program at least annually. *42 CFR 438.330(e)(2)* Contract Amendment 7: Exhibit B-3—4.3.18.2.1.1-2	**Suggested Documents:** QAPI plan Policies/Procedures Report/Log/Tracking Committee meeting minutes	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Submitted Documents: National Quality Improvement Program Evaluation 2022_CO 2023 Quality Improvement Workplan Annual Improvement Plan	
Findings: Although DentaQuest completed an annual evaluation in February 2023, the evaluation did not include all aspects of the QAPI program or document an assessment of the outcome and impact of QAPI activities. The Annual Improvement Plan consisted of one page that contained contract references, medical loss ratio reports, described a recruitment goal, and a goal to update policies, but did not assess QAPI activity outcomes. The Quality Improvement Work Plan documented activities for each quarter during the review period, but did not include any outcomes or assessment of progress. The Quality Improvement Evaluation for calendar year 2022 occurred in February 2023. The Colorado CHP+ PAHP-specific evaluation component consisted of two pages. The evaluation stated the PIP topic, described outreach campaigns, summarized compliance audit results, summarized overutilization reports and results, and noted staffing changes. The evaluation lacked an assessment (e.g., strengths, opportunities for improvement, goals achieved, goals abandoned, etc.) of QAPI activities (e.g., performance measures, PIPs, underutilization, etc.).		
Required Actions: DentaQuest must develop a more robust QAPI evaluation that includes all key components of the QAPI program. The evaluation must include an assessment of the QAPI activities impact and outcomes. Examples include documenting strengths, opportunities, and goals.		
7. The Contractor adopts or develops practice guidelines that meet the following requirements: • Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. • Consider the needs of the Contractor's members. • Are adopted in consultation with participating providers. • Are reviewed and updated as appropriate (at least every two years). *42 CFR 438.236(b)* Contract Amendment 7: Exhibit B-3—4.3.12.1.8	**Suggested Documents:** Practice guidelines Committee meeting minutes **Submitted Documents:** UM01-INS- Clinical Algorithms Clinical Criteria Review 2023 PRC Addendum-Clinical Criteria Review 2023	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: DentaQuest commonly referenced valid and reliable clinical evidence throughout its documentation. The *Clinical Algorithms* policy referenced the American Association of Prosthodontics and American Dental Association, the American Society of Endodontics and American Dental Association, the Center for Devices and Radiological and the American Dental Association, and others. Meeting minutes confirmed that DentaQuest adhered to its policy to regularly review and update guidelines at the Peer Review Committee. However, the policy and associated exhibits focused on provider documentation standards, authorization procedures, and claims payments. DentaQuest did not include CPGs as defined by CMS in which "CPGs seek to close the gap between the clinician and relevant literature by providing information, recommendations, and/or best practices on healthcare for specific circumstances, diagnostic and treatment options, or patient management."[A-1] Further, the Institute of Medicine defines CPGs as "statements that include recommendations, intended to optimize patient care, that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options."[A-2]		
Required Actions: DentaQuest must develop a distinct list of CPGs for review and approval by the Peer Review Committee that are separate from UM criteria. HSAG encourages DentaQuest that as part of this process, participating network providers are consulted as part of the review and approval process (if not already part of the Peer Review Committee).		
8. The Contractor disseminates the guidelines to all affected providers and, upon request, members and potential members. *42 CFR 438.236(c)* Contract Amendment 7: Exhibit B-3—4.1.2.19 and 4.4.7.4	**Suggested Documents:** Newsletters Website Provider agreement Policies/Procedures **Submitted Documents:** National Quality Improvement Program 2023 Utilization Management Program Description	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

[A-1] Centers for Medicare & Medicaid Services. *Measure Management & You*, Newsletter, February 2018.
[A-2] Institute of Medicine. *Clinical Practice Guidelines We Can Trust*; 2011.

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: DentaQuest included a reference to CPGs in its provider agreement and additional details within its ORM, which is accessible to providers through the DentaQuest website. However, during the interview, staff members reported that, in general, there is no mechanism to post or send updates regarding guidelines to the provider network and additional staff members described the clinical practice guidelines as an internal resource that is not typically shared externally.		
Required Actions: DentaQuest must disseminate its CPGs to all affected providers.		
9. The Contractor ensures that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42 CFR 438.236(d)* Contract Amendment 7: Exhibit B-3—4.3.12.1.8.2	**Suggested Documents:** Committee meeting minutes Policies/Procedures **Submitted Documents:** UM01-INS-Clinical Algorithms - Page 2 (Procedure) A11 Utilization Management Program Description - Page 11 (Member Utilization)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data. *42 CFR 438.242(a)* Contract Amendment 7: Exhibit B-3—4.1.1.11.5	**Suggested Documents:** System/Data structure **Submitted Documents:** Utilization Management Program Description - Page 14 (Information Systems) National Quality Improvement Program 2023 – page 11 (Information Management)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor's health information system provides information about areas, including but not limited to utilization, claims, grievances and appeals, and disenrollment for other than loss of CHP+ eligibility. *42 CFR 438.242(a)* Contract Amendment 7: Exhibit B-3—4.1.1.1	**Suggested Documents:** System/Data structure diagram **Submitted Documents:** National Quality Improvement Program 2023 – page 11 (Information Management)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor's claims processing and retrieval systems collect data elements necessary to enable the mechanized claims processing and information retrieval systems operated by the State. • Contractor electronically submits encounter claims data in the interChange ANSI X12N 837 format directly to the Department's fiscal agent using the Department's data transfer protocol. The 837-format encounter claims (reflecting claims paid, adjusted, and/or denied by the Contractor) shall be submitted via a regular batch process. *42 CFR 438.242(b)(1)* Contract Amendment 7: Exhibit B-3—4.1.6.13	**Suggested Documents:** Policies/Procedures Desktop procedure System/Data structure diagram **Submitted Documents:** National Quality Improvement Program 2023	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor collects data on member and provider characteristics and on services furnished to members through an encounter data system (or other methods specified by the State). *42 CFR 438.242(b)(2)* Contract Amendment 7: Exhibit B-3—4.1.1.3	**Suggested Documents:** System/Data structure diagram **Submitted Documents:** National Quality Improvement Program 2023	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor ensures that data received from providers are accurate and complete by: • Verifying the accuracy and timeliness of reported data, including data from network providers compensated through capitation payments. • Screening the data for completeness, logic, and consistency. • Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies used for CHP+ quality improvement and care coordination efforts. *42 CFR 438.242(b)(3) and (4)* Contract Amendment 7: Exhibit B-3—4.1.1.5	**Suggested Documents:** Policies/Procedures Sample reports **Submitted Documents:** National Quality Improvement Program 2023	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. The Contractor: • Collects and maintains sufficient member encounter data to identify the provider who delivers any items or services to members. • Submits member encounter data to the State in Accredited Standards Committee (ASC) X12N 837, National Council for Prescription Drug Programs (NCPDP), and ASC X12N 835 formats as appropriate. • Submits member encounter data to the State at the level of detail and frequency specified by the State. *42 CFR 438.242(c)* Contract Amendment 7: Exhibit B-3—4.1.1.6-7, 4.1.6.4, and 4.2.27	**Suggested Documents:** Policies/Procedures Reports/Tracking **Submitted Documents:** National Quality Improvement Program 2023	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. The Contractor monitors members' satisfaction, including complaints, appeals, and grievance log information. Contract Amendment 7: Exhibit B-3—4.3.18.1.2.6 and 5.1.2.3.1.3	**Suggested Documents:** Policies/Procedures QAPI plan Committee meeting minutes Sample report **Submitted Documents:** CO CHIP Provider Summary Report 2022 CO CHIP Member Report 2022	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems							
Total	Met	=	13	X	1.00	=	13
	Partially Met	=	3	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	16	**Total Score**		=	13
				Total Score ÷ Total Applicable		=	81%

Appendix B. Compliance Review Participants

Table B-1 lists the participants in the FY 2023–2024 compliance review of DentaQuest.

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

HSAG Review Team	Title
Gina Stepuncik	Associate Director
Crystal Brown	Project Manager I
Sarah Lambie	Associate Director
Cynthia Moreno	Project Manager III
DentaQuest Participants	**Title**
Maureen Hartlaub	Associate Director, Client Partner
Deseray Backman	Credentialing Delegated Auditor
Sarah Black	Senior Client Engagement Representative
Chad Jacquart	Senior Internal Audit Specialist, Compliance, DentaQuest
Jennifer Labishak	Senior Manager, Provider Partner
Nicholas Messuri	Senior Manager, Provider Partner
Michaelle Schrank	Associate Director, Utilization Management and Appeals Compliance
Kristen Scott	Director, Quality and Outreach
Christopher Tellarico	Senior Strategic Sourcing Consultant
Quiana Thomas	Quality Specialist, Compliance, DentaQuest
Sheila Schmidt	Senior Manager, Customer Service
Logan Horn	CHP+ Project Manager
Emily Knezic	Utilization Management, Auditing Specialist
Luci Berardi	Utilization Management, Auditing Specialist
Abigail McGinty	Human Resource Governance, Compliance and Risk Consultant
Ugonna Onyekwu	Associate Director, Contracts and Regulatory Compliance
Diane Natale	Senior User Experience Consultant
Michael Duhamel	Director, Member Enrollment and Benefits
Kathlene Gruettner	Associate Director, Fraud Prevention and Recovery
Katherine Mulligan	Director, Provider Management
Matthew Henning	Assistant Vice President, Senior Counsel
Dr. Neil Williams	Director, Dental Training and Quality
Scott Schweitzer	Senior Manager, Software Quality Assurance

DentaQuest Participants	Title
William Munns	Associate Director, Corporate Information Services
Chelsea Cutino	Analyst, Market Research
Troy Boothe	Utilization Management, Auditing Specialist
Thomas Yang	Utilization Management, Auditing Specialist
Department Observers	**Title**
Russell Kennedy	Quality Program Manager
Yvonne Castillo	Dental Plan Contract Manager

Appendix C. Corrective Action Plan Template for FY 2023–2024

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 C-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 C-2—FY 2023–2024 Corrective Action Plan for DentaQuest

Standard V—Member Information Requirements
☐ 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 provides all required member information to members in a manner and format that may be easily understood and is readily accessible by members. *Note: Readily accessible means electronic information which complies with 508 guidelines, Section 504 of the Rehabilitation Act, and World Wide Web Consortium Web Content Accessibility Guidelines 2.0 Level AA and successor versions.* *42 CFR 438.10(c)(1)* Contract Amendment 7: Exhibit B-3—4.4.6.6
Findings
DentaQuest staff members reported member material is placed through a tool to test format to ensure easy-to-understand material. HSAG tested the member handbook through the Microsoft Word Flesch-Kincaid test and found some of the language would be easily understood. However, some parts were not easily understood and deemed complicated for members to understand.
Required Actions
DentaQuest must review the member handbook to identify where it does not include easily understood language and must implement changes necessary to obtain language at or around eight-grade reading level. Although, the current FY 2023–2024 PAHP contract states the language must be at a sixth grade reading level, HSAG is aware that the new contract adjusted the requirement to an eighth-grade reading level.
Planned Interventions
Person(s)/Committee(s) Responsible

Standard V—Member Information Requirements
Training Required
Monitoring and Follow-Up Activities Planned
Documents to Be Submitted as Evidence of Completion
HSAG Initial Review:
Documents Included in Final Submission: ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)***
Date of Final Evidence:

Standard V—Member Information Requirements
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
15. The member handbook provided to members following enrollment includes the following member rights and protections as specified in 42 CFR 438.100. Members have the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for his or her dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding his or her health care, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. • Request and receive a copy of his or her medical records, and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for access, coverage, and coordination of medically necessary services. • Freely exercise his or her rights, and the exercising of those rights will not adversely affect the way the Contractor, its network providers, or the State Medicaid agency treats the member. *42 CFR 438.10(g)(2)(ix)* Contract Amendment 7: Exhibit B-3—4.4.8
Findings
Within its member handbook, DentaQuest listed the members' rights and protections but did not include all member rights.
Required Actions
DentaQuest must update the member handbook to include the members' right to be furnished healthcare services in accordance with requirements for access, coverage, and coordination of medically necessary services.

Standard V—Member Information Requirements
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: ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)***
Date of Final Evidence:

Standard VII—Provider Selection and Program Integrity
☐ 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 implements written policies and procedures for selection and retention of providers. *42 CFR 438.214(a)* Contract Amendment 7: Exhibit B-3—4.1.2.7
Findings
While DentaQuest provided evidence of a process for the retention of providers, this process was not documented in its written policies.
Required Actions
DentaQuest must document its provider retention process within its written policies.
Planned Interventions
Person(s)/Committee(s) Responsible
Training Required

Standard VII—Provider Selection and Program Integrity
Monitoring and Follow-Up Activities Planned
Documents to Be Submitted as Evidence of Completion
HSAG Initial Review:
Documents Included in Final Submission: ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)***
Date of Final Evidence:

Standard VII—Provider Selection and Program Integrity
☐ 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's administrative and management procedures to detect and prevent fraud, waste, and abuse include: • Written policies for all employees, subcontractors or agents that provide detailed information about the False Claims Act, including the right of employees to be protected as whistleblowers. • Provisions for prompt referral of any potential fraud, waste, or abuse to the Department and any potential fraud to the State Medicaid Fraud Control Unit. • Provisions for suspension of payments to a network provider for which the State determines there is credible allegation of fraud (in accordance with 455.23). *42 CFR 438.608 (a)(6-8)* Contract Amendment 7: Exhibit B-3—4.3.15.2.2.8, 4.3.14.11.1, and 4.3.14.12.1
Findings
DentaQuest provided a policy that referenced "relief" if a whistleblower were retaliated against, but there is no language specific to the protection of whistleblowers. DentaQuest provided a policy that referenced notifying the Department immediately of suspected fraud, but there is no specific language in the policy indicating that DentaQuest will report waste and abuse.
Required Actions
DentaQuest must update its policies to include language pertaining to reporting waste and abuse and to protecting whistleblowers.
Planned Interventions

Standard VII—Provider Selection and Program Integrity
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: ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)***
Date of Final Evidence:

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information 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. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program at least annually. *42 CFR 438.330(e)(2)* Contract Amendment 7: Exhibit B-3—4.3.18.2.1.1-2
Findings
Although DentaQuest completed an annual evaluation in February 2023, the evaluation did not include all aspects of the QAPI program or document an assessment of the outcome and impact of QAPI activities. The Annual Improvement Plan consisted of one page that contained contract references, medical loss ratio reports, described a recruitment goal, and a goal to update policies, but did not assess QAPI activity outcomes. The Quality Improvement Work Plan documented activities for each quarter during the review period but did not include any outcomes or assessment of progress. The Quality Improvement Evaluation for calendar year 2022 occurred in February 2023. The Colorado CHP+ PAHP-specific evaluation component consisted of two pages. The evaluation stated the PIP topic, described outreach campaigns, summarized compliance audit results, summarized overutilization reports and results, and noted staffing changes. The evaluation lacked an assessment (e.g., strengths, opportunities for improvement, goals achieved, goals abandoned, etc.) of QAPI activities (e.g., performance measures, PIPs, underutilization, etc.).
Required Actions
DentaQuest must develop a more robust QAPI evaluation that includes all key components of the QAPI program. The evaluation must include an assessment of the QAPI activities impact and outcomes. Examples include documenting strengths, opportunities, and goals.
Planned Interventions
Person(s)/Committee(s) Responsible

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information 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: ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)***
Date of Final Evidence:

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information 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 adopts or develops practice guidelines that meet the following requirements: • Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. • Consider the needs of the Contractor's members. • Are adopted in consultation with participating providers. • Are reviewed and updated as appropriate (at least every two years). *42 CFR 438.236(b)* Contract Amendment 7: Exhibit B-3—4.3.12.1.8
Findings
DentaQuest commonly referenced valid and reliable clinical evidence throughout its documentation. The *Clinical Algorithms* policy referenced the American Association of Prosthodontics and American Dental Association, the American Society of Endodontics and American Dental Association, the Center for Devices and Radiological and the American Dental Association, and others. Meeting minutes confirmed that DentaQuest adhered to its policy to regularly review and update guidelines at the Peer Review Committee. However, the policy and associated exhibits focused on provider documentation standards, authorization procedures, and claims payments. DentaQuest did not include CPGs as defined by CMS in which "CPGs seek to close the gap between the clinician and relevant literature by providing information, recommendations, and/or best practices on healthcare for specific circumstances, diagnostic and treatment options, or patient management."[C-1] Further, the Institute of Medicine defines CPGs as "statements that include recommendations, intended to optimize patient care, that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options."[C-2]

[C-1] Centers for Medicare & Medicaid Services. *Measure Management & You*, Newsletter, February 2018.
[C-2] Institute of Medicine. *Clinical Practice Guidelines We Can Trust*; 2011.

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems
Required Actions
DentaQuest must develop a distinct list of CPGs for review and approval by the Peer Review Committee that are separate from UM criteria. HSAG encourages DentaQuest that as part of this process, participating network providers are consulted as part of the review and approval process (if not already part of the Peer Review Committee).
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:

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems
Documents Included in Final Submission: ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)***
Date of Final Evidence:

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
8. The Contractor disseminates the guidelines to all affected providers and, upon request, members and potential members. *42 CFR 438.236(c)* Contract Amendment 7: Exhibit B-3—4.1.2.19 and 4.4.7.4
Findings
DentaQuest included a reference to CPGs in its provider agreement and additional details within its ORM, which is accessible to providers through the DentaQuest website. However, during the interview, staff members reported that, in general, there is no mechanism to post or send updates regarding guidelines to the provider network and additional staff members described the clinical practice guidelines as an internal resource that is not typically shared externally.
Required Actions
DentaQuest must disseminate its CPGs to all affected providers.
Planned Interventions
Person(s)/Committee(s) Responsible
Training Required

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems
Monitoring and Follow-Up Activities Planned
Documents to Be Submitted as Evidence of Completion
HSAG Initial Review:
Documents Included in Final Submission: ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)***
Date of Final Evidence:

Appendix D. 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*, February 2023.

Table D-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, 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, reports, minutes of key committee meetings, and member and provider informational materials. • 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.

For this step,	HSAG completed the following activities:
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 2023–2024 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.