Oregon Health Authority

2022 Compliance Monitoring Review Report

for

Capitol Dental Care, Inc.

December 2022

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Overview

Background

According to Title 42 of the Code of Federal Regulations (42 CFR) §438.358, which describes external quality review (EQR) activities, the state Medicaid agency, an external quality review organization (EQRO), or the state's agent that is not a Medicaid managed care organization (MCO), prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), or primary care case management (PCCM) entity must conduct a review within each three-year period to determine the MCOs', PIHPs', PAHPs', and PCCM entities' compliance with federal managed care regulations and state contract standards.

The State of Oregon, Oregon Health Authority (OHA), contracted with Health Services Advisory Group, Inc. (HSAG) as its EQRO to:

- Conduct the calendar year (CY) 2022 compliance monitoring reviews (CMRs) for each of its coordinated care organizations (CCOs) and dental care organizations (DCOs), collectively referred to as managed care entities (MCEs), across four operations-focused standards for the review period of January 1, 2021–December 31, 2021.
- Prepare a report of findings with respect to each MCE's performance strengths and areas requiring corrective action or performance improvement.
- Conduct a follow-up reevaluation of any MCEs that require implementation of corrective actions in order to attain full compliance.

HSAG is an EQRO that meets the competency and independence requirements of 42 CFR §438.354(b) and (c). HSAG has extensive experience and expertise in conducting reviews to evaluate MCO, PIHP, PAHP, and PCCM entity compliance with the Medicaid managed care regulations and associated state contract requirements. HSAG uses the information and data it derives from the reviews to reach conclusions and make recommendations about the quality, timeliness, and accessibility of care and services the State's MCEs provide. Table 1-1 depicts assignment of the standards reviewed in CY 2022 to the domains of care.

Table 1-1—Assignment of CMR Standards to the Quality, Timeliness, and Access Domains

CMR Standard	Quality	Timeliness	Access
Standard VIII—Confidentiality	✓		
Standard IX—Enrollment and Disenrollment		✓	✓
Standard XII—Quality Assessment and Performance Improvement	✓	✓	✓
Standard XIII—Health Information Systems	✓	✓	✓

In 2022, OHA contracted with 16 CCOs to provide Medicaid-covered primary and acute physical, behavioral, and oral health services to over 1 million Oregon Health Plan (OHP) members. The State also contracted with five DCOs to provide oral health services to over 50,000 members enrolled in Medicaid fee-for-service (FFS).

2. Review Methodology

Introduction

The CMRs assess MCE compliance with federal compliance review standards outlined in 42 CFR §438.358(b)(1)(iii) and related State contract requirements. HSAG followed the guidelines set forth in the Centers for Medicare & Medicaid Services' (CMS') EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019 (EQR Protocol 3),[2-1] to create the process, tools, and interview questions used for the CY 2022 CMR.

Objectives

The objective of the CMRs is to provide meaningful information to OHA and the MCEs regarding:

- The MCEs' compliance with federal managed care regulations, Oregon Administrative Rules (OARs), and contract requirements with the standard areas reviewed.
- Strengths, opportunities for improvement, recommendations, or required actions to bring the MCEs into compliance with federal managed care regulations and State requirements with the standard areas reviewed.
- The quality, timeliness, and accessibility of care and services furnished by the MCEs, as addressed within the specific areas reviewed.
- Possible additional interventions recommended to improve the quality of the MCEs' care provided and services offered related to the areas reviewed.

To accomplish its objectives and based on the results of its collaborative planning with OHA, HSAG developed data collection tools to assess and document the MCEs' compliance with certain federal Medicaid managed care regulations, State rules, and the associated OHA contractual requirements. Beginning in CY 2020, OHA requested that HSAG conduct compliance reviews over a three-year cycle with one-third of the standards being reviewed each year. The division of standards over the three years is outlined in Table 2-1. Table 2-2 describes the requirements that address the performance areas included in this year's review (CY 2022).

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Mar 16, 2022.

Table 2-1—CMR Three-Year Cycle

Compliance Monitoring Standard	Year One (CY 2020)	Year Two (CY 2021)	Year Three (CY 2022)
Standard I—Availability of Services		✓	
Standard II—Assurances of Adequate Capacity and Services		✓	
Standard III—Coordination and Continuity of Care	✓		
Standard IV—Coverage and Authorization of Services	✓		
Standard V—Provider Selection		✓	
Standard VI—Subcontractual Relationships and Delegation		✓	
Standard VII—Member Rights and Protections	✓		
Standard VIII—Confidentiality			✓
Standard IX—Enrollment and Disenrollment			✓
Standard X—Grievance and Appeal Systems	✓		
Standard XI—Practice Guidelines		✓	
Standard XII—Quality Assessment and Performance Improvement			✓
Standard XIII—Health Information Systems			✓
Standard XIV—Member Information	✓		

Table 2-2—CY 2022 CMR Standards and Descriptions

Standard	Description
Standard VIII—Confidentiality *42 CFR §438.224*	Requires the MCE to have written policies and procedures addressing applicable privacy requirements including the use, disclosure, and confidentiality of individually identifiable health information.
Standard IX—Enrollment and Disenrollment *42 CFR §438.3 and §438.56*	Requires the MCE to have written policies and procedures that support enrollment of members in a non-discriminatory manner. The MCE must provide written evidence of processes for disenrolling members.
Standard XII—Quality Assessment and Performance Improvement *42 CFR §438.330*	Requires the MCE to establish a quality assessment and performance improvement (QAPI) program with mechanisms for detecting under- and overutilization and assess the quality and appropriateness of care furnished to members with special health care needs (SHCN) and members receiving long-term services and supports (LTSS).
Standard XIII—Health Information Systems *42 CFR §438.242*	Requires the MCE to have established processes that support a system that collects, analyzes, integrates, and reports accurate and complete member, provider, and service data.

The information and findings that resulted from HSAG's review of standards and files were used by OHA and each MCE to:

- Evaluate the degree to which the MCE's operations are in compliance with the State contract and federal managed care requirements.
- Evaluate the MCE's organizational strengths and identify areas for improvement.
- Identify, implement, and monitor interventions to improve MCE compliance and the quality, timeliness, and accessibility of health care services furnished by the MCE.

Technical Methods of Data Collection

Before beginning the CMR, HSAG developed data collection tools to document the review. The requirements in the tools were selected based on applicable federal and State regulations and requirements set forth in the contract between OHA and the MCE as they relate to the scope of the review. HSAG conducted the following pre-onsite, virtual onsite, and post-onsite activities:

Pre-Onsite Activities

Pre-onsite activities included:

- Developing the CMR tools.
- Preparing and forwarding the CMR Protocol, tools, and applicable guidance for completing and submitting the requested documentation to HSAG for its desk review.
- Hosting a pre-review preparation session with the MCEs.
- Conducting a desk review of key documents and other information obtained from OHA, and of documents the MCE submitted to HSAG. The desk review enables HSAG reviewers to increase their knowledge and understanding of the MCE's operations, identify areas needing clarification, and begin compiling information before the virtual onsite review.
- Scheduling the virtual onsite review.
- Developing the agenda for the one-day virtual onsite review.
- Providing the detailed agenda to the MCE to facilitate preparation for HSAG's virtual onsite review.

Virtual Onsite Activities

Virtual onsite activities included:

- Conducting an opening conference, with introductions and a review of the agenda and logistics for HSAG's one-day review activities.
- Reviewing the HSAG-requested documents made available by the MCE during the interview sessions.

- Reviewing the data systems used in the MCE's operations such as utilization management, care coordination, and enrollment and disenrollment.
- Conducting interviews with the MCE's key administrative and program staff members.
- Conducting a closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.

Post-Onsite Activities

Post-onsite activities included:

- Collecting supplemental information identified during the virtual onsite visit.
- Compiling data and information obtained from the desk review and onsite interviews.
- Analyzing and aggregating all review findings to produce final compliance determinations.
- Preparing and publishing draft and final compliance reports.

Description of Data Obtained

To assess the MCE's compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by each organization, including the following:

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- Management/monitoring reports and audits.
- Staff training materials and documentation of training attendance.
- Narrative and/or data reports across a broad range of performance and content areas.
- MCE's online member handbook and provider manual.
- Applicable sample correspondence or template communications.
- Interviews with key MCE staff members.

Data Aggregation and Analysis

HSAG reviewers used ratings of *Met*, *Partially Met*, and *Not Met* to indicate the degree to which the MCE's performance complied with the requirements. This scoring methodology is in alignment with CMS' EQR Protocol 3. HSAG compiled all submitted documentation and conducted a final review, considering the intent of the regulations, and applied a rating for each element based on the following definitions:

Met indicates full compliance, defined as:

- All documentation listed under a regulatory provision, or component thereof, is present; and
- MCE staff provide responses to reviewers that are consistent with each other and with the documentation.

Partially Met indicates partial compliance, defined as:

- There is compliance with all documentation requirements, but MCE staff are unable to consistently articulate evidence of compliance during interviews; or
- MCE staff can describe and verify the existence of compliant practices during the interview, but documentation is found to be incomplete or inconsistent with practice.

Not Met indicates noncompliance, defined as:

- No documentation is present, and staff members have minimal or no knowledge of processes or issues addressed by the regulatory provisions; or
- No documentation is present and staff members have little or no knowledge of processes or issues that comply with key components (as defined by OHA) of a multi-component regulatory provision, regardless of compliance determinations for remaining, non-key components of a regulatory provision.

From the scores it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each of the four standards and an overall percentage-of-compliance score across the four standards. HSAG calculated the total score for each standard by totaling the number of *Met* (1 point) elements, the number of *Partially Met* (0.5 points) elements, and the number of *Not Met* (0 points) elements, then dividing the summed score by the total number of applicable elements for that standard.

HSAG determined the overall percentage-of-compliance score across the areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the total values of the scores and dividing the result by the total number of applicable elements).

How Data Were Aggregated and Analyzed

To draw conclusions about the quality, timeliness, and accessibility of care and services the MCEs provided to members, HSAG aggregated and analyzed the data resulting from its desk and virtual onsite review activities. The data that HSAG aggregated and analyzed included:

- Documented findings describing each MCE's progress in achieving compliance with State and federal requirements.
- Scores assigned to each MCE's performance for each requirement.
- The total percentage-of-compliance score calculated for each of the standards.

- The overall percentage-of-compliance score calculated across the standards.
- Documentation of the actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Partially Met* and *Not Met*.

Based on the results of the data aggregation and analysis, HSAG prepared and forwarded draft reports to OHA and each MCE for their review and comment prior to issuing final reports.

Compliance With Review Standards

HSAG's findings for the CY 2022 CMR were determined from its:

- Desk review of the documents Capitol Dental Care, Inc. (CDC) submitted to HSAG prior to the onsite portion of the review.
- Review of the MCE's information systems capabilities assessment (ISCA).
- Virtual onsite activities that included reviewing additional documents and records, interviewing key CDC administrative and program staff members, and system demonstrations.

For each of the individual elements (i.e., requirements) within each standard, HSAG assigned a score of *Met*, *Partially Met*, or *Not Met* based on the results of its findings. HSAG then calculated a total percentage-of-compliance score for each of the four standards and an overall percentage-of-compliance score across the four standards.

Table 3-1 presents a summary of CDC's performance results. Details of the scoring methodology are described in *Section 2. Review Methodology*.

Table 3-1—Standards and Compliance Scores for CDC

Standard	Total # of Elements	# Met	# Partially Met	# Not Met	CDC Compliance Score	Statewide DCO Compliance Score
Standard VIII—Confidentiality	4	3	1	0	**88%**	**95%**
Standard IX—Enrollment and Disenrollment	6	0	6	0	**50%**	**53%**
Standard XII—Quality Assessment and Performance Improvement	7	3	4	0	**71%**	**63%**
Standard XIII—Health Information Systems	8	8	0	0	**100%**	**99%**
Overall Compliance Score	**25**	**14**	**11**	**0**	**78%**	**77%**

***Total # of Elements*:** The total number of elements in each standard.

***Total # of Applicable Elements*:** The total number of elements within each standard minus any elements that received a score of *Not Applicable (NA)*.

***Total Compliance Score*:** The percentages obtained by adding the number of elements that received a score of *Met* to the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

The findings from the CMR show how well an MCE interpreted State and federal regulations and the MCE contract requirements and developed the necessary policies, procedures, and plans to carry out the required functions of the MCE. CDC achieved full compliance in one of the standards reviewed, demonstrating strengths and adherence to all requirements measured in the area of *Health Information Systems (HIS)*. The remaining three standards have identified opportunities for improvement.

Of the 25 elements, CDC received *Met* scores for 14 elements, *Partially Met* scores for 11 elements, and *Not Met* scores for 0 elements, with an overall compliance score of 78 percent.

The areas with opportunity for improvement were related to *Confidentiality*, *Enrollment* and *Disenrollment*, and *Quality Assessment and Performance Improvement (QAPI)* as these areas received performance scores less than 100 percent. These findings suggest that CDC did not consistently establish and implement the necessary policies, procedures, and plans to operationalize the required elements of its contract and regulatory provisions, and did not always demonstrate compliance with the expectations of the contract. Further, CDC staff interviews showed that staff members were not consistently knowledgeable about the requirements of the contract and the policies and procedures that the MCE employed to meet contractual and regulatory requirements.

Detailed findings for each element within each standard reviewed, including program enhancements and required actions, are documented in *Appendix A. Evaluation Tool*.

Summary of Overall Strengths and Areas Requiring Improvement

Standard VIII—Confidentiality

Performance Strengths

Strength: CDC demonstrated robust policies regarding the technical safeguards in place to ensure the privacy and security of its member's protected health information (PHI) consistent with applicable security rules. **[Quality]**

Area(s) Requiring Improvement

Area(s) requiring improvement: CDC received a score of 88 percent in the *Confidentiality* standard due to deficiencies in its operational structure impacting the MCE's ability to ensure the privacy and security of records consistent with applicable security rules. **[Quality]**
Rationale: CDC could not fully demonstrate oversight of its subcontractors to ensure staff were being advised of the applicable security rules.
Required action(s): CDC must ensure oversight of its subcontractors to ensure staff are being advised of the applicable security rules.

Standard IX—Enrollment and Disenrollment

Performance Strengths

Strength: No strengths were identified for the *Enrollment and Disenrollment* standard.

Area(s) Requiring Improvement

Area(s) requiring improvement: CDC received a score of 50 percent in the *Enrollment and Disenrollment* standard due to lack of operational structure and failure to conduct appropriate monitoring activities impacting the MCE's ability to ensure that members were enrolled in a non-discriminatory manner and that the MCE met federal and State regulatory requirements for disenrollment. **[Timeliness and Access]**
Rationale: CDC's policies and procedures, member-facing documents, and training provided to staff contained incorrect information and did not align with federal and State requirements. Additionally, CDC failed to monitor disenrollment requests to ensure compliance with the regulatory requirements.
Required action(s): CDC must revise its policies and procedures, potential member-facing documents, and training provided to staff to align with federal and State requirements. CDC must also demonstrate oversight and monitoring of disenrollment reasons to ensure compliance with the regulatory requirements.

Standard XII—Quality Assessment and Performance Improvement

Performance Strengths

Strength: No strengths were identified for the *QAPI* standard.

Area(s) Requiring Improvement

Area(s) requiring improvement: CDC received a score of 71 percent in the *QAPI* standard due to failure to establish and implement a comprehensive and descriptive program description and workplan that met applicable federal, State, and contractual requirements. In addition, CDC failed to demonstrate appropriate oversight of its QAPI program impacting the MCE's ability to monitor and evaluate the quality and appropriateness of services furnished to its members consistent with the needs and priorities of the MCE's member population. **[Quality, Timeliness, and Access]**
Rationale: CDC's QAPI program structure, including evaluation of the QAPI program, inclusion of performance metrics and improvement programs, and

proper components of a Quality Improvement Committee (QIC), did not fully comply with federal and State requirements for a QAPI program.
Required action(s): CDC must revise its QAPI program structure to align with federal and State requirements for a QAPI program.

Standard XIII—Health Information Systems

Performance Strengths

Strength: CDC achieved full compliance for the *HIS* standard, demonstrating the MCE had established processes to maintain a health information system that collects, analyzes, integrates, and reports accurate and complete member, provider, and services data. **[Quality, Timeliness, and Access]**

Area(s) Requiring Improvement

Area(s) requiring improvement: No areas requiring improvement were identified for the *HIS* standard.

Information Systems Capabilities Assessment

The purpose of the ISCA was to support the assessment of MCE's compliance with federal and State health information standards and provide a general assessment of the MCE's information systems, data processing, and reporting procedures. Specifically, the ISCA was conducted to determine the extent to which the MCE maintained the capacity to manage the health care of its members and support the collection, management, and use of valid and reliable data. Although not a mandatory EQR activity, states do perform system reviews as part of other mandatory EQR activities. Additionally, 42 CFR §438.242 requires that the MCEs maintain health information systems that collect, analyze, integrate, and report data for areas including, but not limited to, utilization, grievances and appeals, and disenrollment.[3-1]

For the following review, the term "information systems" was used broadly to include CDC's databases and software environment, electronic/manual data collection procedures, applicable supplemental systems and incoming databases, and reporting databases. HSAG focused specifically on aspects of CDC's systems pertaining to how information systems were used to collect, process, and manage data in support of the MCE's Medicaid operations. HSAG's objective with the Information Systems Capabilities Assessment Tool (ISCAT) was to understand and document each MCE's information systems infrastructure; its policies, procedures, and data quality control processes; and to formulate a determination of an MCE's ability to support the accurate and reliable extraction and collection of data for OHA.

Based on the results from its desk review of CDC's information systems and processes, HSAG determined CDC had sufficient systems and processes in place to manage the health care of its members and support the collection, management, and use of valid and reliable data.

[3-1] Centers for Medicare and Medicaid Services. External Quality Review Protocols, Appendix A: Information System Capabilities Assessment. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Mar 18, 2022.

Improvement Plan Review

CDC was required to implement an Improvement Plan (IP) for all elements scored *Partially Met* or *Not Met* during the 2021 CMR and continue to address unresolved findings from the 2020 CMR. To ensure the MCE had implemented plans of action to remediate the CMR findings, HSAG conducted follow-up reviews to evaluate the MCE's compliance with requirements.

Table 3-2 presents CDC's resolution status for the IP elements reviewed.

Table 3-2—Summary of Findings for CDC From the 2020 and 2021 IP Follow-Up Reviews

Standard	Total # of Findings	# Resolved	# Unresolved	Percent Resolved
Standard I—Availability of Services	1	0	1	0%
Standard II—Assurances of Adequate Capacity and Services	0	NA	NA	NA
Standard III—Coordination and Continuity of Care	6	3	3	50%
Standard IV—Coverage and Authorization of Services	2	1	1	50%
Standard V—Provider Selection	1	0	1	0%
Standard VI—Subcontractual Relationships and Delegation	4	2	2	50%
Standard VII—Member Rights and Protections	1	0	1	0%
Standard X—Grievance and Appeal Systems	2	1	1	50%
Standard XI—Practice Guidelines	2	1	1	50%
Standard XIV—Member Information	3	0	3	0%
Total	**22**	**8**	**14**	**36%**

Appendix A. Evaluation Tool

Following this page is the completed compliance with standards review tool HSAG used to evaluate CDC's performance for each requirement.

Standard VIII—Confidentiality (42 CFR §438. 224)		
Requirement	**Evidence as Submitted by the DCO**	**Score**
1. The DCO develops, implements, and adheres to written policies and procedures for maintaining the privacy and security of records and authorizing the use and disclosure of records, as required by the Health Insurance Portability and Accountability Act (HIPAA) in 45 CFR parts 160 and 164, subparts A and E, as applicable. *42 CFR §438.224* *DCO Contract Exhibit E (6)*	• VIII-Master - InterDent - IT Security Policies_Final – Page 58 • VIII-Master - InterDent - IT Security Policies_Final – Page 25 • VIII-Master - InterDent - IT Security Policies_Final – Page 64 • VIII-Master - InterDent - IT Security Policies_Final – Page 73 • VIII-Master - InterDent - IT Security Policies_Final – Page 41 • VIII-Confidentiality 2021.06	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
2. The DCO complies and requires all subcontractors to comply with HIPAA, including: a. Protecting individually identifiable health information about specific individuals from unauthorized use or disclosure consistent with the requirements of HIPAA. b. Exchanging individually identifiable health information relating to specific individuals between the DCO and OHA for purposes directly related to the provisions in the contract. c. Ensuring disclosures of individually identifiable health information relating to specific individuals does not violate HIPAA Privacy Rules in 45 CFR Parts 160 and 164, OHA Privacy Rules, OAR Chapter 407 Division	• VIII-2021 CDC Provider Agreement rev 08.30.2021.rev • VIII-CDC Business Associate Agreement Template • VIII-CDC_Notice_of_Privacy • VIII-CDC-2021-Member-Handbook • VIII-CDC-2022-MemberHandbook • VIII-PHI CDC Website Screenshot • VIII-Provider-Manual-CDC-2022.03.10	☒ Met ☐ Partially Met ☐ Not Met

Standard VIII—Confidentiality (42 CFR §438. 224)		
Requirement	**Evidence as Submitted by the DCO**	**Score**
014, or OHA Notice of Privacy Practices, if done by OHA. *42 CFR §438.224* *DCO Contract Exhibit E (6)(a)*		
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
3. The DCO and subcontractors adopt and employ reasonable administrative safeguards consistent with the security rules in 45 CFR Part 164 to ensure member information is used or disclosed in a manner consistent with applicable State and federal laws and the terms and conditions in the DCO contract. *42 CFR §438.224* *DCO Contract Exhibit E (6)(b)*	• VIII-CDC 2021 Workforce Training Plan • VIII-CDC Facility Site Visit and Evaluation 03.18.21 • VIII-CDC HIPAA Training Report – 2021 • VIII-CDC_MDCO Newsletter Q1 2021 • VIII-CDC_MDCO Newsletter Q2 2021 • VIII-CDC_MDCO Newsletter Q3 2021 • VIII-CDC_Notice_of_Privacy • VIII-Confidentiality 2021.06 • VIII-IT Microsoft Patches • VIII-IT Ransomware Alerts • VIII-Mandatory Compliance Training Policy • VIII-Master - InterDent - IT Security Policies_Final – page 42 • VIII-PH TECH Information Security Policy Summary • VIII-PHI CDC Website Screenshot • VIII-Provider-Manual-CDC-2022.03.10	☐ Met ☒ Partially Met ☐ Not Met

Standard VIII—Confidentiality (42 CFR §438. 224)		
Requirement	**Evidence as Submitted by the DCO**	**Score**
	• VIII-RA 122 Workforce Training Policy 2021 • VIII-Site Visit Statement • VIII-Records Private CDC Website Screenshot • VIII-Site Visits Policy 2021.08	

HSAG Findings: CDC's *Confidentiality* policy asserted that CDC is to employ reasonable administrative safeguards to protect the confidentiality of member information including the following:

- *Provider contracts and clinic agreements required providers and staff to protect the confidentiality of the member.*
- *The provider handbook further advised and educated providers and staff of the need to protect confidentiality.*
- *The employee handbook advised and educated employees of the need to protect confidentiality.*
- *The CDC QIC advised each new committee member of the need to protect confidentiality. Each new committee member was required to acknowledge and agree to that policy as a condition of participation.*
- *Through the CDC website, as well as hard copy distribution, CDC's provider and member newsletters advised providers and members of any changes or new additions regarding confidentiality standards and practices.*
- *All CDC providers and staff were required to complete HIPAA training upon employment and annually thereafter. The CDC compliance officer also encouraged additional trainings as issues and trends developed in this area.*

CDC demonstrated employing the following administrative safeguards:

- HIPAA training was provided.
- Education of providers through the provider manual.
- Business associate agreements ensured subcontractors agreed to follow policies and procedures for maintaining the privacy and security of records and authorizing the use and disclosure of records.
- Use of appropriate Notice of Privacy Practices.
- Advisement of confidentiality practices posted on the website.

CDC demonstrated employing the following physical safeguards:

Standard VIII—Confidentiality (42 CFR §438. 224)		
Requirement	**Evidence as Submitted by the DCO**	**Score**
• Facility site visit forms ensured a secure and confidential filing system and assessed whether dental charts/records were maintained in accordance with HIPAA regulations, including protection from public view. • Interdent building workplace security measures. CDC demonstrated employing the following technical safeguards: • IT policies asserting the following: – Encryption – Passwords and logon controls – Identification and authentication requirements – User logon IDs – Termination of user accounts – Firewalls and malicious code – Information system review activities and audit controls CDC provided evidence of the appropriate policies and reasonable safeguards in place to ensure member information would be used or disclosed in a manner consistent with applicable State and federal laws and the terms and conditions in the DCO contract. CDC's subcontractor, PH TECH, was delegated to perform administrative services for CDC and was required by the contract to maintain HIPAA confidentiality. PH TECH's policies demonstrated the appropriate safeguards. During the virtual "onsite" review, CDC asserted that PH TECH would require its staff to undergo HIPAA Security training as well. However, CDC was unable to provide documentation that confirmed the subcontractor staff completed the required trainings. CDC also provided its *Site Visits* policy, which asserted that the DCO is to complete site visits for any provider entering into a contract with the DCO; however, the DCO provided a statement that site visits were not completed in 2021 due to the public health emergency. This requirement was *Partially Met*.		
Required Actions: CDC must ensure that its subcontractors employ the appropriate safeguards and adhere to their policies and procedures. CDC must demonstrate evidence that the subcontractors adhered to their policies, including providing confidentiality/HIPAA training to PH TECH staff.		
4. The DCO and subcontractors comply with HIPAA standards for electronic transactions. *42 CFR §438.224*	• VIII-Access Control to Sensitive Data and Systems • VIII-Claims Adjudication Procedure	☒ Met ☐ Partially Met ☐ Not Met

Standard VIII—Confidentiality (42 CFR §438. 224)		
Requirement	**Evidence as Submitted by the DCO**	**Score**
DCO Contract Exhibit E (6)(c)	• VIII-Electronic Claim Receipt • VIII-PH TECH Information Security Policy Summary	
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		

Results for Standard VIII—Confidentiality							
Total	Met	=	3	X	1.0	=	3.0
	Partially Met	=	1	X	0.5	=	0.5
	Not Met	=	0	X	0.0	=	0.0
Total Applicable		=	4	**Total Score**		=	3.5

Total Score ÷ Total Applicable	=	**88%**

Standard IX—Enrollment and Disenrollment (42 CFR §438.3 and §438.56)		
Requirement	**Evidence as Submitted by the DCO**	**Score**
1. The DCO accepts individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by CMS), up to the limits set under the contract. *42 CFR §438.3(d)(1)* *OAR 410-141-3805(15)(b)* *DCO Contract Exhibit B Part 3(8)(b)*	• IX-Oregon Medicaid Enrollment & Disenrollment • IX-Daily 834 Reconciliation • IX-Monthly 834 Reconciliation Audit • IX-Coordination of Benefits • IX-Action Plan for OHP Members, Aspects of Care 2021.06 • IX-Monitoring Plan 2022.02 • IX-Extracted Disenrollment pages from CDC_MemberHandbook_v04_20220323_Approved • IX-CAPITOL DENTAL 2021-4-8 834_Reconciliation • IX-CAPITOL DENTAL 2021-5-8 834_Reconciliation • IX-CDC 2021-04 Enrollment Discrepancies Found • IX-CDC 2021-05 Enrollment Discrepancies Found • IX-Enrollment Reconciliation Notes_Screenshot	☐ Met ☒ Partially Met ☐ Not Met
HSAG Findings: CDC delegated all enrollment and disenrollment functions to its subcontractor and submitted PH TECH's *Oregon Medicaid Enrollment and Disenrollment* policy, which addressed enrollment and disenrollment processes and activities. While the document provided an overview of PH TECH's policy for managing enrollment through receipt of daily 834 transaction files from OHA, the policy did not state that members were enrolled in the order in which they applied without restriction (unless authorized by CMS) up to the limits set under the contract. Further, the policy did not outline the steps necessary to ensure the processing of member enrollment in the order received. However, CDC was		

Standard IX—Enrollment and Disenrollment (42 CFR §438.3 and §438.56)		
Requirement	**Evidence as Submitted by the DCO**	**Score**
able to confirm these processes during the virtual "onsite" review and later during a separate information systems session with PH TECH staff. During the virtual "onsite" review, CDC also asserted that eligibility for enrollment would be determined by OHA, although the policy described manual enrollment procedures that occurred only when a member needed access to services immediately. Additionally, although this policy was submitted to support DCO enrollment processes, PH TECH's policy only referenced CCOs. The *Monthly 834 Reconciliation Audit* policy specified the process for reconciling the enrollment report from OHA against the Community Integration Manager (CIM) system to identify discrepancies between the OHA eligibility Medicaid Management Information System (MMIS) and CIM. CDC provided a sample list of import error codes used to identify errors in eligibility identified by the CIM system. CDC described its process which relied on staff who worked the errors identified during the import process to reconcile the members identified on the 834 file provided by OHA. CDC demonstrated that the appropriate reconciliation reports were completed. This requirement was *Partially Met.*		
Required Actions: CDC must ensure its subcontractor's policy, *Oregon Medicaid Enrollment and Disenrollment*, aligns with the federal requirement to accept individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by CMS), up to the limits set under the contract. Additionally, the policy should be updated to reflect applicability to CDC, as a DCO, in addition to the CCOs.		
Recommendations: As a best practice, HSAG recommends that CDC develop a corporate policy which outlines how it complies with federal enrollment and disenrollment requirements to ensure staff and delegated vendors understand both regulatory requirements and procedures necessary to manage CDC's enrollment/disenrollment processes.		
2. The DCO does not discriminate against individuals eligible to enroll and will not use any policy or practice that has the effect of discriminating on the basis of health status or need for health care services, race, color, or national origin, religion, sex, sexual orientation, marital status, age, gender identity, or disability. *42 CFR §438.3(d)(3-4)* *DCO Contract Exhibit B Part 3(8)(c)*	• IX-Oregon Medicaid Enrollment & Disenrollment • IX-Daily 834 Reconciliation • IX-Monthly 834 Reconciliation Audit • IX-CAPITOL DENTAL 2021-4-8 834_Reconciliation • IX-CAPITOL DENTAL 2021-5-8 834_Reconciliation • IX-CDC 2021-04 Enrollment Discrepancies Found • IX-CDC 2021-05 Enrollment Discrepancies Found	☐ Met ☒ Partially Met ☐ Not Met

Standard IX—Enrollment and Disenrollment (42 CFR §438.3 and §438.56)		
Requirement	**Evidence as Submitted by the DCO**	**Score**
	• IX-Enrollment Reconciliation Notes_Screenshot	
HSAG Findings: During the virtual "onsite" review, CDC asserted that eligibility would be determined by OHA, the DCO would accept members as they were assigned, and that CDC would not discriminate. CDC also provided its *Nondiscrimination* policy which stated that CDC would not exclude, deny benefits to, or otherwise discriminate against any person on the basis of sex, sexual orientation, marital status, race, color, national origin, disability, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by CDC directly or through its network of providers or any other entity which arranged to carry out its programs and activities. The policy did not include the requirement to not discriminate on the basis of health status or need for health care services or gender identity. CDC also provided a screen shot of The Right to Receive Services without Discrimination section on the Member Rights page of its website and asserted during the virtual "onsite" review that this section was directed to individuals eligible to enroll; however, the statement on the website only mentioned members and did not address individuals who were eligible to enroll. CDC also provided examples of reconciliation reports which demonstrated that discrepancies for enrollment did not include the aforementioned reasons. This requirement was *Partially Met.*		
Required Actions: CDC must update its *Nondiscrimination* policy to include the requirement of the DCO to not discriminate on the basis of health status or need for health care services or gender identity. CDC must also update the discrimination section on the Member Rights page of its website to include a statement that its non-discrimination is inclusive of members as well as individuals eligible to enroll. If CDC contracts with a CCO to provide dental services to Medicaid enrollees after its DCO contract ends, CDC must also align its non-discrimination policies with the CCO's non-discrimination policies.		
Recommendations: As a best practice, HSAG recommends that CDC ensure its delegate includes the appropriate non-discrimination statement within the *Oregon Medicaid Enrollment and Disenrollment* policy to ensure all required enrollment/disenrollment requirements are present in core policies and procedures. Additionally, while CDC's non-discrimination policies were applicable to "any person," HSAG recommends that CDC incorporate federal language to clearly state that policies apply to "individuals eligible to enroll" as well as members.		
3. The DCO may only request disenrollment of members for one or more of the following reasons: • Is uncooperative or disruptive, except where this is a result of the member's special needs or disability • Commits fraudulent or illegal acts • Makes credible threats of or commits acts of violence	• IX-Oregon Medicaid Enrollment & Disenrollment • IX-Coordination of Benefits • IX-Action Plan for OHP Members, Aspects of Care 2021.06 – Page 4 • IX-Monitoring Plan 2022.02	☐ Met ☒ Partially Met ☐ Not Met

Standard IX—Enrollment and Disenrollment (42 CFR §438.3 and §438.56)		
Requirement	**Evidence as Submitted by the DCO**	**Score**
42 CFR §438.56(b)(1) *OAR 410-141-3810* *DCO Contract Exhibit B Part 3(9)*	• IX-Extracted Disenrollment pages from CDC_MemberHandbook_v04_20220323_Approved	
HSAG Findings: The *Oregon Medicaid Enrollment & Disenrollment* policy asserted that members are to be disenrolled from the plan for "various" reasons such as the member is no longer eligible or the member moved from the plan's service area. However, the policy did not discuss the aforementioned reasons in which CDC can request disenrollment of members. This requirement was *Partially Met*.		
Required Actions: CDC must ensure the *Oregon Medicaid Enrollment and Disenrollment* policy aligns with state-established reasons that DCOs may request disenrollment of a member.		
4. The DCO may not request disenrollment of a member because of an adverse change in the member's health status or because of the member's: a. Utilization of health services. b. Physical, intellectual, developmental, or mental disability. c. Uncooperative or disruptive behavior resulting from the member's special needs, disability or any condition that is a result of their disability. d. Being in the custody of DHS/Child Welfare. e. Prior to receiving any services, including, without limitation, anticipated placement in or referral to a psychiatric residential treatment facility. f. A member's decision regarding their own medical care with which the contractor disagrees. g. Filing a grievance or exercising any appeal or contested case hearing rights. *42 CFR §438.56(b)(2)* *OAR 410-141-3810(4)(c)* *DCO Contract Exhibit B Part 3(9)(d)*	• IX-Oregon Medicaid Enrollment & Disenrollment • IX-Action Plan for OHP Members, Aspects of Care 2021.06 • IX-Monitoring Plan 2022.02 • IX-Extracted Disenrollment pages from CDC_MemberHandbook_v04_20220323_Approved •	☐ Met ☒ Partially Met ☐ Not Met

Standard IX—Enrollment and Disenrollment (42 CFR §438.3 and §438.56)		
Requirement	**Evidence as Submitted by the DCO**	**Score**
HSAG Findings: The *Oregon Medicaid Enrollment & Disenrollment* policy did not address the inability to request disenrollment for the aforementioned reasons. In addition, CDC lacked evidence of monitoring disenrollment requests to ensure compliance with the regulatory requirements. This requirement was *Partially Met*.		
Required Actions: CDC must ensure the *Oregon Medicaid Enrollment and Disenrollment* policy aligns with state-established reasons that DCOs may not request disenrollment of a member.		
Recommendations: CDC should also demonstrate it is monitoring reasons for disenrollment, other than loss of eligibility, when/if disenrollment of members occurs. Evidence of monitoring may include standard reports and/or QIC meeting minutes that address enrollment changes, including whether or not disenrollment requests were received.		
5. The DCO has a process that allows members to disenroll **without cause** for any of the following reasons: a. OHP clients auto-enrolled or manual-enrolled in error may change plans, if another plan is available, within thirty (30) days of the member's enrollment. b. Newly eligible members may change plans, if another plan is available within ninety (90) days of their initial plan enrollment. c. A member may request to change plans, after six (6) months of their initial plan enrollment. d. A member may request disenrollment during "OHP eligibility renewal," which is typically twelve (12) months. e. Full benefit dual eligible members and members who are American Indian/Alaska Native beneficiaries may change plans or disenroll to Fee-for-Service at any time. f. Upon automatic re-enrollment (e.g., a recipient who is automatically re-enrolled after being disenrolled, solely because such recipient loses Medicaid eligibility for a period of two (2) months or less), if the temporary loss	• IX-Oregon Medicaid Enrollment & Disenrollment • IX-Monitoring Plan 2022.02 • IX-Extracted Disenrollment pages from CDC_MemberHandbook_v04_20220323_Approved	☐ Met ☒ Partially Met ☐ Not Met

Standard IX—Enrollment and Disenrollment (42 CFR §438.3 and §438.56)		
Requirement	**Evidence as Submitted by the DCO**	**Score**
of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity. g. Whenever the member's eligibility is re-determined by OHA. h. When OHA has imposed sanctions on the DCO, including the suspension of all new enrollment (consistent with 42 CFR 438.702(a)(4). i. Members have one additional opportunity to request a plan change during the eligibility period if none of the above options can be applied. *42 CFR §438.56(c)(2) and (g)* *OAR 410-141-3810(1)(b)(A)* *DCO Contract Exhibit B Part 3(9)(c)(1)(a)*		

HSAG Findings: CDC's *Oregon Medicaid Enrollment & Disenrollment* policy asserted that members may request disenrollment from the DCO without cause (30 days from enrollment or reenrollment, after six months of enrollment, or by member choice); however, the policy did not specify all reasons members may request disenrollment without cause.

The 2021 member handbook informed members they may request disenrollment from the DCO for the following without cause reasons:

- *You are new to OHP, and it is within the first 90 days.*
- *You are returning to OHP, and it is within the first 30 days.*
- *You are renewing your OHP coverage (usually once per year).*
- *You have been enrolled already for 6 months.*
- *You have another reason (up to one time per year).*

However, the 2021 member handbook did not inform members that they may request disenrollment without cause for the following reasons:

- OHP clients auto-enrolled or manual-enrolled in error may change plans, if another plan is available, within 30 days of the member's enrollment.
- Full benefit dual eligible members and members who are American Indian/Alaska Native beneficiaries may change plans or disenroll to FFS at any time.

Standard IX—Enrollment and Disenrollment (42 CFR §438.3 and §438.56)		
Requirement	**Evidence as Submitted by the DCO**	**Score**
• Upon automatic reenrollment (e.g., a recipient who is automatically reenrolled after being disenrolled, solely because such recipient loses Medicaid eligibility for a period of two months or less), if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity. • When OHA has imposed sanctions on the DCO, including the suspension of all new enrollment (consistent with 42 CFR §438.702(a)(4). CDC submitted its revised 2022 member handbook, which included the following reasons members may request disenrollment without cause: • *Members may request to change their DCO enrollment within 30 calendar days of the Authority's automatic or manual enrollment error. If approved the change would happen during the next weekly enrollment cycle.* • *Members may request to change their DCO enrollment within 90 calendar days of the initial DCO enrollment or during the 90 days following the date OHA sends the member notice of that enrollment, whichever is later if another plan is available in the member's service area. If approved, the change would happen during the next weekly enrollment cycle.* • *At least once every 12 months thereafter.* • *Members may request to change their DCO enrollment after they have been enrolled with that DCO for at least six months. If approved, the change would happen at the end of the month.* • *A member may request to change their DCO enrollment at their OHP eligibility renewal, usually once per year.* • *Full benefit dual eligible members and members who are American Indian/Alaska Native beneficiaries may change plans or disenroll to FFS at any time.* However, the 2022 member handbook did not include: • When OHA has imposed sanctions on the DCO, including the suspension of all new enrollment (consistent with 42 CFR §438.702(a)(4). • Members have one additional opportunity to request a plan change during the eligibility period if none of the above options can be applied. This requirement was *Partially Met*.		
Required Actions: CDC must ensure *the Oregon Medicaid Enrollment and Disenrollment* policy aligns with state-established reasons that members may request disenrollment without cause. Although the member handbook was also out of compliance for the current review period, due to the DCO program ending in December 2022, OHA will not require corrective action for the member handbook.		
6. The DCO has a process to allow members to disenroll **with cause** for any of the following reasons: a. The member moves out of the DCO's service area;	• IX-Oregon Medicaid Enrollment & Disenrollment	☐ Met ☒ Partially Met

Standard IX—Enrollment and Disenrollment (42 CFR §438.3 and §438.56)		
Requirement	**Evidence as Submitted by the DCO**	**Score**
b. The DCO does not, because of moral or religious objections, cover the service the member seeks; c. The member needs related services to be performed at the same time, not all related services are available from the DCO's plan, and the member's primary care dentist (or another provider) determines that receiving the services separately would subject the member to unnecessary risk; d. Other reasons, including poor quality of care or lack of access to services covered under the contract or providers experienced with dealing with the member's specific needs. Examples include: • Services not provided in the member's preferred language; • Services not provided in a culturally appropriate manner; • It would be detrimental to the member's health to continue enrollment; • For continuity of care. *42 CFR §438.56(c)* *OAR 410-141-3810(1)(b)(B)* *DCO Contract Exhibit B Part 3(9)(c)(1)(b)*	• IX-Daily 834 Reconciliation • IX-Monthly 834 Reconciliation Audit • IX-Coordination of Benefits • IX-Action Plan for OHP Members, Aspects of Care 2021.06 • IX-Monitoring Plan 2022.02 • IX-Extracted Disenrollment pages from CDC_MemberHandbook_v04_20220323_Approved • IX-CAPITOL DENTAL 2021-4-8 834_Reconciliation • IX-CAPITOL DENTAL 2021-5-8 834_Reconciliation • IX-CDC 2021-04 Enrollment Discrepancies Found • IX-CDC 2021-05 Enrollment Discrepancies Found • IX-Enrollment Reconciliation Notes_Screenshot	☐ Not Met
HSAG Findings: The *Oregon Medicaid Enrollment & Disenrollment* policy asserted that members may request disenrollment from the DCO with cause (quality of care and/or access issues, the member is Native American or Alaskan Native); however, it did not specify all reasons that members may request disenrollment with cause. The 2021 member handbook informed members that they may request disenrollment for the DCO for one with cause reason: • *You move somewhere that Capitol Dental Care doesn't serve.* However, the 2021 member handbook did not inform members that they may request disenrollment with cause for the following:		

Standard IX—Enrollment and Disenrollment (42 CFR §438.3 and §438.56)		
Requirement	**Evidence as Submitted by the DCO**	**Score**

- The DCO does not, because of moral or religious objections, cover the service the member seeks.
- The member needs related services to be performed at the same time, not all related services are available from the DCO's plan, and the member's primary care dentist (or another provider) determines that receiving the services separately would subject the member to unnecessary risk.
- Other reasons, including poor quality of care or lack of access to services covered under the contract or providers experienced with dealing with the member's specific needs. Examples include:
  - Services not provided in the member's preferred language.
  - Services not provided in a culturally appropriate manner.
  - It would be detrimental to the member's health to continue enrollment.
  - For continuity of care.

In 2022 CDC updated the member handbook to include the following reasons members may request disenrollment with cause:

- *The member moves out of Capitol Dental Care's service area; or*
- *Due to moral or religious objections the DCO does not cover the service the member seeks;*
- *When the member needs related services to be performed at the same time and:*
  - *Not all related services are available within the provider network.*
  - *Your PCD or another provider determines that receiving the services separately would subject the member to unnecessary risk.*
- *Other reasons including poor quality of care, lack of access to covered services, or lack of access to participating providers who are experienced in dealing with the specific member's health care needs.*
  - *Examples of sufficient cause include:*
    - *The member moves out of the service area;*
    - *Services are not provided in the member's preferred language;*
    - *Services are not provided in a culturally appropriate manner;*
    - *It would be detrimental to the member's health to continue enrollment; or*
    - *For purposes of continuity of care.*

This requirement was *Partially Met*.

Standard IX—Enrollment and Disenrollment (42 CFR §438.3 and §438.56)		
Requirement	**Evidence as Submitted by the DCO**	**Score**
Required Actions: CDC must ensure the *Oregon Medicaid Enrollment and Disenrollment* policy aligns with state-established reasons that members may request disenrollment with cause. Although the member handbook was also out of compliance for the current review period, due to the DCO program ending in December 2022, OHA will not require corrective action for the member handbook.		

Results for Standard IX—Enrollment and Disenrollment							
Total	Met	=	0	X	1.0	=	0.0
	Partially Met	=	6	X	0.5	=	3.0
	Not Met	=	0	X	0.0	=	0.0
Total Applicable		=	6	**Total Score**		=	3.0

Total Score ÷ Total Applicable	=	**50%**

Standard XII—Quality Assessment and Performance Improvement (42 CFR §438.330)		
Requirement	**Evidence as Submitted by the DCO**	**Score**
1. The DCO has an ongoing comprehensive quality assessment and performance improvement (QAPI) program for the services it furnishes to its members. • The scope of the QAPI program includes all populations served, services covered, and is consistent with identified priority areas. *42 CFR §438.330(a)* *OAR 410-141-3525(5)* *DCO Contract Exhibit B Part 10 (3)*	• XII-2021 CE Utilization measures for QIM and WH targets • XII-2021 CE Utilization measures • XII-CDC 2021 QAPI Workplan • XII-CDC QI Dashboard 2021_02.15.2022 • XII-Grievances - By Type Chart • XII-Grievances - By Type • XII-CDC Metric Utilization 2021-12 • XII-Quality Improvement Committee 2021.08 • XII-Utilization Management Policy 2022.02 • XII-Utilization Reporting Template-Extract	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
2. The DCO's QAPI program includes conducting and submitting performance improvement projects (PIPs), at least annually. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction and includes the following elements: a. Measurement of performance using objective quality indicators. b. Implementation of interventions to achieve improvement in the access to and quality of care. c. Evaluation of the effectiveness of the interventions based on performance measures.	• XII-Quality Improvement Committee 2021.08 • XII-CDC 2021 QAPI Workplan • HSAG will review performance improvement projects submitted in 2021 (*MCE does not need to re-submit PIP*)	☐ Met ☒ Partially Met ☐ Not Met

Standard XII—Quality Assessment and Performance Improvement (42 CFR §438.330)		
Requirement	**Evidence as Submitted by the DCO**	**Score**
d. Planning and initiation of activities for increasing or sustaining improvement. *42 CFR §438.330(b)(1) and (d)(1)(2)(i-iv)* *OAR 410-141-3525(5)(f)* *DCO Contract Exhibit B Part 10(2)(a)*		
HSAG Findings: HSAG validated CDC's PIP conducted in 2021; however, CDC's QAPI program documents did not describe conducting and submitting the PIP, at least annually, or discuss how PIPs are designed or the required elements. CDC's QI workplan included a goal to increase outreach within the PIP project interventions; however, it lacked detail to demonstrate compliance with the aforementioned elements. This requirement was *Partially Met*.		
Required Actions: Although this element was out of compliance for the current review period, due to the DCO program ending in December 2022, OHA will not require corrective action for this element because the DCOs will no longer be responsible for direct reporting of PIPs to OHA. If CDC contracts with a CCO to provide dental services to Medicaid enrollees after its DCO contract ends, CDC should align with the CCO's QAPI program moving forward.		
3. The DCO's QAPI program includes annually collecting and submitting (to the State): • Performance measure data using standard measures identified by the State; • Data, specified by the State, which enables the State to calculate the DCO's performance using the standard measures identified by the State; or • A combination of the above activities. *42 CFR §438.330(b)(2) and (c)(2)(i-iii)* *CCO Contract Exhibit B Part 10(3)*	• XII-Quality Improvement Committee 2021.08 • XII-CDC 2021 QAPI Workplan • XII-CDC QI Dashboard 2021_02.15.2022 • XII-CDC Metric Utilization 2021-12	☐ Met ☒ Partially Met ☐ Not Met
HSAG Findings: CDC provided a report that demonstrated the collection of performance metric data within the QI Dashboard and the Metric Utilization report. However, neither the *Quality Improvement Committee* policy nor the QI workplan described the DCO's process for annually collecting performance measures or data or identified the performance measures used. This requirement was *Partially Met*.		
Required Actions: CDC must demonstrate that the QAPI program includes annually collecting performance measure data within the program description or workplan.		

Standard XII—Quality Assessment and Performance Improvement (42 CFR §438.330)		
Requirement	**Evidence as Submitted by the DCO**	**Score**
4. The DCO's QAPI program includes mechanisms to detect both underutilization and overutilization of services. *42 CFR §438.330(b)(3)* *OAR 410-141-3525(5)(a)* *DCO Contract Exhibit B Part 10(3)*	• XII-2021 CE Utilization measures for QIM and WH targets • XII-2021 CE Utilization measures • XII-CDC 2021 QAPI Workplan • XII-CDC QI Dashboard 2021_02.15.2022 • XII-Grievances - By Type Chart • XII-Grievances - By Type • XII-CDC Metric Utilization 2021-12 • XII-Quality Improvement Committee 2021.08 • XII-Utilization Management Policy 2022.02 • XII-Utilization Reporting Template-Extract	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
5. The DCO's QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. *42 CFR §438.330(b)(4)* *OAR 410-141-3525(5)(d)* *CCO Contract Exhibit B Part 10(2)(c)(3)*	• XII-CDC 2021 QAPI Workplan • XII-CDC QI Dashboard 2021_02.15.2022 • XII-Grievances - By Type Chart • XII-Grievances - By Type • XII-CDC Metric Utilization 2021-12 • XII-Quality Improvement Committee 2021.08 • XII-Sample Member Survey Results 2021.01	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		

Standard XII—Quality Assessment and Performance Improvement (42 CFR §438.330)		
Requirement	**Evidence as Submitted by the DCO**	**Score**
6. The DCO conducts and submits to OHA an annual written evaluation of the QAPI program and member care as measured against the written procedures and protocols of member care. The QAPI and member care evaluation includes the following: • Assessment of annual activities conducted, including background and rationale • Plan of ongoing improvement activities to address gaps, which will ensure quality of care for members and overall effectiveness of the QAPI program *42 CFR §438.330(e)(2)* *OAR 410-141-3525(11)(c)*	• XII-CDC 2021 QAPI Annual Review - Draft	☐ Met ☒ Partially Met ☐ Not Met
HSAG Findings: CDC submitted its written evaluation of the 2021 QAPI program. The evaluation included an assessment of the activities conducted in 2021. However, the evaluation did not include an assessment for gaps or a plan of ongoing improvement activities to address any gaps to ensure quality of care for members and overall effectiveness of the QAPI program. This requirement was *Partially Met*.		
Required Actions: CDC must address gaps within its QAPI program and include a plan of ongoing improvement activities to address gaps to ensure quality of care for members and overall effectiveness of the QAPI program.		
Recommendations: CDC should include review of the written evaluation during the QIC meeting to ensure oversight and actions based on the results of the assessment.		
7. The DCO has a Quality Improvement (QI) committee that meets the following requirements: • Membership includes, at a minimum, the Medical/Dental Director, the QI Coordinator, and other health professionals who are representative of the scope of the services delivered • Maintains oversight and accountability of any delegated functions	• XII-CDC QIC Charter • XII-CDC QIC Meeting Minutes 2021.04 • XII-CDC QIC Meeting Minutes 2021.06.09 • XII-CDC QIC Meeting Minutes 2021.08.18 • XII-CDC QIC Meeting Minutes 2021.10.20 • XII-CDC QIC Meeting Minutes 2021.12.08	☐ Met ☒ Partially Met ☐ Not Met

Standard XII—Quality Assessment and Performance Improvement (42 CFR §438.330)		
Requirement	**Evidence as Submitted by the DCO**	**Score**
• Approves the annual quality strategy and retains oversight and accountability of quality efforts and activities performed by other DCO committees • Meets at least every two months and records minutes that include committee deliberations, recommendations regarding corrective actions to address issues identified, and review of results, progress, and effectiveness of corrective actions recommended at previous meetings *OAR 410-141-3525(11)* *DCO Contract Exhibit B Part 10(3)*		
HSAG Findings: CDC's QIC Charter outlined the committee structure, purpose, and membership. It also specified the committee membership, including Compliance and Quality Improvement, Member Services, Outreach, Operations, and clinic staff members. The charter also asserted that the committee would include providers from the provider network who were not necessarily CDC employees, and that ad hoc subject matter experts in a given area may be added to the committee as needed. The charter, however, did not include the medical/dental director in the membership. During the virtual "onsite" review, CDC provided the titles of the participants listed in the meeting minutes confirming that the appropriate membership attended the QIC meetings in 2021. CDC submitted meeting minutes from June, August, October, and December 2021; however, CDC reported that meetings did not occur in February or April 2021, which placed CDC out of compliance with the State regulatory requirement to meet every two months. Although the meeting minutes mentioned CDC's subcontractor, PH TECH, oversight of delegated quality functions was not clear within the minutes. The annual approval of the quality strategy was also not reflected in the meeting minutes, nor was the accountability of quality efforts and activities performed by other DCO committees. The meeting minutes included committee deliberations, discussions of reports, and some recommendations; however, the committee meeting minutes did not include discussion of the effectiveness of corrective actions recommended at previous meetings. This requirement was *Partially Met*.		
Required Actions: Although this element was out of compliance for the current review period, due to the DCO program ending in December 2022, OHA will not require corrective action for this element.		
Recommendations: CDC should ensure its QIC maintains oversight and accountability of delegated functions and other DCO committees, approves the annual quality strategy, and discusses the effectiveness of the corrective actions recommended at previous meetings.		

Results for Standard XII—Quality Assessment and Performance Improvement							
Total	Met	=	3	X	1.0	=	3.0
	Partially Met	=	4	X	0.5	=	2.0
	Not Met	=	0	X	0.0	=	0.0
Total Applicable		=	7	**Total Score**		=	5.0

Total Score ÷ Total Applicable	=	**71%**

Standard XIII—Health Information Systems (42 CFR §438.242)		
Requirement	**Evidence as Submitted by the DCO**	**Score**
1. The DCO: a. Maintains a health information system that collects, analyzes, integrates, and reports data. b. Makes all collected data available to the State and, upon request, to CMS. *42 CFR §438.242(a) and (b)(4)* *OAR 410-141-3520(8)* *DCO Contract Exhibit J(1)(a)*	• XIII-Claim Processing Procedure • XIII-Encounter Data Submission • XIII-PH TECH Community Integration Manager • XIII-Life of a Claim.drawing	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: CDC's documentation noted that administrative claims processing, encounter data submission, and enrollment functions would be delegated to PH TECH. Further, submitted policies and procedures outlined PH TECH's receipt and adjudication of administrative claims and its subsequent processing of encounter data for submission to OHA. CDC's responses in the ISCAT and during the virtual "onsite" review confirmed that PH TECH's Community Integration Managed (CIM) platform served as the DCO's core administrative and operational system. CIM not only supported the processing of operational data, it also supported member services; prior authorization coverage determinations; and tracking/reporting of grievances, appeals, and State hearings. Underlying SQL databases supporting CIM were used to transfer data to CDC weekly to support internal analyses. CDC also used custom Microsoft Access (MS Access) databases to track grievance and appeals data (including hearings) and prior authorization denials. An additional custom MS Access database was used to support provider credentialing and contracting. These corporate databases were used to support provider directory production and State grievance and appeal reporting. CDC also provided documentation supporting the submission of data to OHA and described its general process for addressing internal and external requests for data and reports, including from CMS, on request. This requirement was *Met*.		
Required Actions: None.		
Recommendation: In 2021, CDC's monitoring of claims and enrollment, as well as other health system processes, was based on PH TECH generated reports targeting CDC's overall DCO line of business, inclusive of CDC. Although the CDC membership was comparatively small, the DCO should manage its contracted member population independent of other lines of business. HSAG recommends that CDC work with its subcontractors to develop DCO-specific reporting to support CDC's oversight and management of the collection, integration, and reporting of CDC dental services data, especially in relation to clinical services and membership.		
2. The DCO's health information system provides information on areas including, but not limited to, the following:	• XIII-Claim Processing Procedure	☒ Met ☐ Partially Met

Standard XIII—Health Information Systems (42 CFR §438.242)		
Requirement	**Evidence as Submitted by the DCO**	**Score**
a. Utilization. b. Claims. c. Grievances and appeals. d. Disenrollments for reasons other than loss of Medicaid eligibility. *42 CFR §438.242(a)* *DCO Contract Exhibit J(1)(a)*	• XIII-Health information systems - Data Collection • XIII-Oregon Medicaid Enrollment & Disenrollment • XIII-PH TECH Community Integration Manager	☐ Not Met
HSAG Findings: CDC's documentation noted that its core HIS and processes were delegated to PH TECH, which used its proprietary, multi-tenant platform, CIM, to perform all core administrative functions. Through CDC's ISCAT responses, participation in the virtual "onsite" review, and PH TECH policies and procedures, the DCO demonstrated the ability of its HIS to collect data to support utilization management, claims and encounter data processing, grievances and appeals, and member enrollment/eligibility. However, while data on member disenrollment reasons were available via the 834 transaction files, the data element was only available in the archived version of the 834 files; member disenrollment data were not available in the CIM platform or CDC's member extract. As such, reporting or monitoring of member disenrollment was limited to ad hoc requests. This requirement was *Met*.		
Required Actions: None.		
Recommendation: Although enrollment was managed and directed by OHA, it is important to ensure the DCO understands factors contributing to disenrollment beyond the loss of eligibility. HSAG recommends that CDC ensure disenrollment reasons are captured and stored actively to support regular monitoring of member disenrollment.		
3. The DCO's claims processing and retrieval systems collect data elements necessary to enable the mechanized claims processing and information retrieval systems operated by the State. *42 CFR §438.242(b)(1)*	• XIII-Claim Processing Procedure • XIII-Encounter Data Submission Process	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
4. The DCO's health information system collects, analyzes, integrates and reports **member data** including the following:	• XIII-Oregon Medicaid Enrollment & Disenrollment	☒ Met ☐ Partially Met

Standard XIII—Health Information Systems (42 CFR §438.242)		
Requirement	**Evidence as Submitted by the DCO**	**Score**
a. Member enrollment. b. Names and phone numbers of the member's primary care dentist or clinic. *42 CFR §438.242(b)(2)* *DCO Contract Exhibit J(1)(a)*	• XIII-Primary Care Provider (PCP) Auto Assignment	☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
5. The DCO collects data on **provider characteristics** required to be collected for delivery system network requirements as specified in Contract Exhibit G. *42 CFR §438.242(b)(2)* *DCO Contract Exhibit J(1)(a)*	• XIII-Provider System Load • XIII-Provider Directory 2022.02 • XIII-Credentialing Policy 2021.10	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
6. The DCO's health information system collects, analyzes, integrates and reports **service data** including the following: a. Covered services provided to members, through encounter data system or other documentation system. b. All data required to be reported in connection with encounter data reporting. *42 CFR §438.242(b)(2)* *DCO Contract Exhibit J(1)*(a)	• XIII-Claim Processing Procedure • XIII-Encounter Data Submission • XIII-Encounter Data Submission Process	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
7. The DCO ensures data received from providers are accurate and complete by:	• XIII-Claim Processing Procedure • XIII-Electronic Claim Receipt	☒ Met ☐ Partially Met

Standard XIII—Health Information Systems (42 CFR §438.242)		
Requirement	**Evidence as Submitted by the DCO**	**Score**
a. Verifying the accuracy and timeliness of reported data, including data from network providers compensated through capitation payments. b. Screening the data for completeness, logic, and consistency. c. Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for Medicaid quality improvement and care coordination efforts. *42 CFR §438.242(b)(3)* *DCO Contract Exhibit J(1)(b)*	• XIII-Paper Claim Receipt and Data Conversion	☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
8. The DCO: a. Collects and maintains sufficient member encounter data to identify the provider who delivers any items or services to members. b. Submits member encounter data to the State at the frequency and level of detail specified by the State, including data required for the State to report to CMS. c. Submits all member encounter data, including allowed amount and paid amount, that the state is required to report to CMS under §438.818. d. Submits member encounter data to the State in standardized Accredited Standards Committee (ASC) X12N 837 and National Council for Prescription Drug	• XIII-CIM_Platform_Backup • XIII-Claim Processing Procedure • XIII-Claims Accounting Run Process Flow (PaySpan Process - Push Method).drawing • XIII-Cover_Page_-_CIM_Platform_Backup • XIII-Electronic Claim Receipt • XIII-Encounter Data Submission • XIII-Encounter Data Submission Process • XIII-Health information systems - Data Collection • XIII-Life of a Claim.drawing	☒ Met ☐ Partially Met ☐ Not Met

Standard XIII—Health Information Systems (42 CFR §438.242)		
Requirement	**Evidence as Submitted by the DCO**	**Score**
Programs (NCPDP) formats, and the ASC X12N 835 format as appropriate. *42 CFR §438.242(c)(1-4)* *DCO Contract Exhibit B Part 8(9-10)*	• XIII-Oregon Medicaid Enrollment & Disenrollment • XIII-Paper Claim Receipt and Data Conversion • XIII-PH TECH Community Integration Manager • XIII-Software Release Process	
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		

Results for Standard XIII—Health Information Systems							
Total	Met	=	8	X	1.0	=	8.0
	Partially Met	=	0	X	0.5	=	0.0
	Not Met	=	0	X	0.0	=	0.0
Total Applicable		=	8	**Total Score**		=	8.0

Total Score ÷ Total Applicable	=	**100%**

Appendix B. Improvement Plan

Due to the DCO program ending in December 2022, OHA will not require CDC to submit an IP to HSAG to address *Partially Met* or *Not Met* elements; however, it is recommended that the DCO develop an internal IP to guide implementation of all required actions and/or recommendations as OHA may review those elements for compliance. Implementation of interventions to resolve findings identified in this report should begin immediately in order to bring the organization into compliance with federal and State requirements.

Following this page is a document prepared by HSAG that CDC may use to support its development of an internal IP. The template includes each *requirement that was Partially Met* or *Not Met* and the MCE's findings and actions required to bring the organization's performance into full compliance with the requirement.

2020 Findings

Standard III—Coordination and Continuity of Care		
CMR Year	**Finding #**	**Element**
2020	1	The MCE ensures that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member. The member must be provided information on how to contact their care coordinator or other designated person or entity. *42 CFR §438.208(b)(1)* *Contract: Exhibit B Part 4 (2)(j)* *OAR 410-141-3860 (6)(b)*
Finding		
While the DCO's Care Coordination policy stated that it provides ongoing care appropriate to the needs of the member, no documentation was submitted to demonstrate a process for formally designating a care coordinator or a primary care dentist (PCD) and notifying its members of the associated contact information. The DCO reported that it is not outreaching to all members. PCDs are only assigned to members who contact the DCO and to members prioritized for outreach. Outreach attempts are focused on pregnant members, members diagnosed with diabetes, children who need sealants, and members with a recent ED visit.		
Required Action		
CDC must develop a process to formally designate a PCD for every member. Members with SHCN must be assigned additional supports, as appropriate. All members must be informed of the primary person/entity responsible for coordinating their care and provided with the associated contact information.		
DCO Action Plan	**Individual(s) Responsible**	**Proposed Completion Date**
CDC to submit evidence of Welcome Letter journey / assigning/designating a PCD for members. Document to submit = Welcome_Letter_Journey_CDC_MDCO_NMEDIR_Mailers_20210422	• Sarah Bell • Victor Kintz	9/30/2021
HSAG Assessment of Plan	11/19/21: Please submit the welcome letter for review. This finding remains **unresolved**.	
DCO Status Update	3/31/22: Welcome Letter attached designating a PCD.	

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Standard III—Coordination and Continuity of Care		
Documents submitted as evidence of implementation	2020-1_CDC General Welcome Letter State Direct Members	
HSAG Assessment of Resolution	CDC submitted a sample welcome letter with a placeholder designating a primary care dentist for the member with general contact information for questions. However, the letter did not include a placeholder to formally designate a person or entity responsible for coordinating the services accessed by the member or provide information on how to contact their designated person or entity, as required. In addition, the welcome letter did not meet the language and format requirements for written materials that are critical to obtaining services, including taglines in the prevalent non-English languages in the State and in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the information provided, information on how to request auxiliary aids and services, or include the toll-free and TTY/TDY telephone number of the MCO's, PIHP's, PAHP's, or PCCM entity's member/customer service unit. HSAG requested an example of an implemented welcome letter showing contact information included for the person or entity designated to coordinate services for the member. The DCO reported letters were auto-generated onto the template previously submitted to HSAG and submitted a screenshot of a list of welcome letter mailings; however, the document did not provide evidence that members were provided contact information for the person or entity designated to coordinate services accessed by the member. CDC must submit evidence of formally designating a person or entity responsible for coordinating the services accessed by the member, provide contact information, and ensure the welcome letter meets the language and format requirements for member-facing materials specified in 42 CFR 438.10(d). This finding remains **unresolved.**	
Status Update		
Documentation Submitted as Evidence		
Assessment of Resolution		☐ Resolved ☐ Resolved, with recommendations ☐ Not Resolved

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Standard III—Coordination and Continuity of Care		
CMR Year	**Finding #**	**Element**
2020	4	The MCE makes a best effort to conduct an initial health risk screening within 90 days of the effective date of enrollment. If the initial attempt to contact the member is unsuccessful, subsequent attempts are documented. *42 CFR §438.208(b)(3)* *Contract: Exhibit B Part 4 (1)* *OAR 410-141-3865 (2)(b)(A)*

Finding
The DCO submitted its policy on health risk screenings and a template assessment, which were in alignment with the 90-day time frame; however, the DCO submitted no evidence of implementation. During the webinar review, the DCO reported that the policy has not been implemented and that it has no plans to implement the policy at this time. DCO representatives reported that the DCO does not have the financial capacity, nor the bandwidth, to support the administrative burden of this requirement.
Required Action
CDC must implement an initial health risk screening for all new members within 90 days of enrollment, document all outreach attempts, and track that it is meeting the 90-day time frame.

DCO Action Plan	**Individual(s) Responsible**	**Proposed Completion Date**
CDC working with other DCO's on Oral Health Risk screening tool. CDC to submit updated screening tool and evidence of implementation.	• Sarah Bell • Victor Kintz	9/30/2021

HSAG Assessment of Plan	11/19/21: HSAG has received OHA's feedback on the collaborative oral health risk screening (HRS) form dated 10/6/21. Once the form is finalized, please submit a copy to demonstrate implementation. This finding remains **unresolved**.
DCO Status Update	3/31/22: The DCO Workgroup has been in the process of revising the HRS for almost the past year. It is still not yet OHA approved.
Documents submitted as evidence of implementation	N/A
HSAG Assessment of Resolution	CDC reported it has not implemented an oral health risk screening tool at the time of improvement plan submission. CDC must submit evidence of implementation of an oral health risk screening tool, which meets the 90-day requirement outlined in the standard. This finding remains **unresolved**.

2022 Improvement Plan for Capitol Dental Care, Inc.

Standard III—Coordination and Continuity of Care		
Status Update		
Documentation Submitted as Evidence		
Assessment of Resolution		☐ Resolved ☐ Resolved, with recommendations ☐ Not Resolved

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Standard III—Coordination and Continuity of Care		
CMR Year	**Finding #**	**Element**
2020	5	The MCE shares with the primary care dentist (PCD), state, or other MCEs serving the member the results of any identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR §438.208(b)(4)* *Contract: Exhibit B Part 4 (2)(e)(2)* *OAR 410-141-3865 (3)(c)*

Finding

Although the DCO's Health Risk Screening policy stated that the screening "should be shared with members' providers," the DCO reported that health risk screenings were not being conducted and that sharing information with the medical provider would be overly burdensome for the DCO. The DCO provided its Diabetic Dental Patient Pre- and Post-Visit Care Coordination form templates to show how information could be shared with the PCD for diabetic members; however, there was no evidence these forms were being utilized.

Required Action

After implementing health risk screenings, CDC must share with the PCD, state, or other MCEs serving members the results of any identification and assessment of members' needs.

DCO Action Plan	Individual(s) Responsible	Proposed Completion Date
CDC working with other DCO's on Oral Health Risk screening tool. CDC to submit updated screening tool and evidence of implementation.	• Sarah Bell • Victor Kintz	9/30/2021

HSAG Assessment of Plan	11/19/21: CDC must develop and implement a mechanism for sharing the results of the oral HRS with the member's PCD, State/care coordination subcontractor, or other DCOs. Please submit sample documentation as evidence of sharing HRS results. This finding remains **unresolved**.
DCO Status Update	3/31/22: The DCO Workgroup has been in the process of revising the HRS for almost the past year. It is still not yet OHA approved.
Documents submitted as evidence of implementation	N/A
HSAG Assessment of Resolution	CDC reported it has not implemented an oral health risk screening tool at the time of improvement plan submission. CDC must submit evidence of sharing results of the oral health risk assessments with the member's PCD, state, or other MCE serving the member. HSAG also recommends CDC develop a tracking oversight and monitoring process once the oral health risk screening tool is implemented to ensure compliance with the requirement. This finding remains **unresolved**.

2022 Improvement Plan for Capitol Dental Care, Inc.

Standard III—Coordination and Continuity of Care		
Status Update		
Documentation Submitted as Evidence		
Assessment of Resolution		☐ Resolved ☐ Resolved, with recommendations ☐ Not Resolved

Standard IV—Coverage and Authorization of Services		
CMR Year	**Finding #**	**Element**
2020	8	The MCE places appropriate limits on a service: a. On the basis of criteria applied under the state plan, such as dental necessity. b. For the purpose of utilization control, provided that: i. The services furnished can reasonably achieve their purpose. ii. The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the member's ongoing need for such services and supports. *42 CFR §438.210(a)(4)(i-ii)* *Contract: Exhibit B Part 2 (3)(b)(3)* *OAR 410-141-3835 (8)*

Finding
CDC's Prior Authorization policy did not provide evidence of authorization processes to specifically support the needs of its members with chronic conditions or who require LTCSS. Although CDC was able to provide examples of how it meets the requirement, it lacked a mechanism to ensure that this occurred.

Required Action
CDC must update its policy to include appropriate authorization processes that support the dental needs of its special needs members.

DCO Action Plan	**Individual(s) Responsible**	**Proposed Completion Date**
CDC to review updated Prior Authorization policy at upcoming QI meeting to ensure policy includes appropriate authorization processes that support the dental needs of its special needs members.	• Sarah Bell • Victor Kintz	8/31/2021

HSAG Assessment of Plan	11/19/21: Please submit CDC's updated *Prior Authorization* policy that details authorization processes to support the needs of its members with chronic conditions or who require LTCSS. This finding remains **unresolved**.
DCO Status Update	3/31/22: Updated Prior Authorization policy attached.
Documents submitted as evidence of implementation	2020-9_Prior Authorization 2021.06

Standard IV—Coverage and Authorization of Services		
HSAG Assessment of Resolution	CDC submitted its revised *Prior Authorization* policy; however, revisions to the policy were not identified by the DCO and the policy continued to assert "special considerations are afforded to LTCSS members as dentally appropriate and necessary under OAR 410-141-3835." The Revision Activity section of the policy indicated the last update occurred in 2019. The policy did not address limits placed on services or the processes followed to ensure services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the member's ongoing need for such services and supports. CDC must submit its policy or policies that address limits on services and/or coverage rules. This finding remains **unresolved**.	
Status Update		
Documentation Submitted as Evidence		
Assessment of Resolution		☐ Resolved ☐ Resolved, with recommendations ☐ Not Resolved

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Standard VII—Member Rights and Protections		
CMR Year	**Finding #**	**Element**
2020	9	The MCE has written policies regarding the following and shall allow each member the right to: a. Be actively involved in the development of treatment plans and have family involved in such treatment planning. b. Participate in decisions regarding such member's own health care, including the right to refuse treatment. c. Have the opportunity to execute a statement of wishes for treatment, including the right to accept or refuse dental, treatment. d. Execute directives and powers of attorney for health care established under ORS 127.505 to 127.660 and the Omnibus Budget Reconciliation Act of 1990 -- Patient Self-Determination Act. e. Exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCE, its staff, subcontractors, participating providers, or OHA, treat the member. The MCE shall not discriminate in any way against members when those members exercise their rights under the OHP. *42 CFR §438.100(b-c)* *Contract: Exhibit B Part 3 (2)(I,n)* *OAR 410-141-3590 (2)(f),(w)*
Finding		
Although CDC's policies addressed the members' right to be involved in the development of their treatment plans, the DCO reported that it has not yet implemented treatment plans. Furthermore, the ability for members to exercise their rights without retribution was not addressed by submitted policies.		
Required Action		
CDC must ensure that its members are granted the right to participate in the development of their treatment plans and that it has a policy in place that addresses the members' ability to freely exercise their rights without it adversely affecting the way they are treated.		
DCO Action Plan	**Individual(s) Responsible**	**Proposed Completion Date**
CDC will update its policies, including the member handbook to explain how members exercise the right to participate in the development of their treatment plans and exercise their rights without it adversely affecting them. CDC received final approval for 2021 Member Handbook on 7/2/2021. Updated Member Handbook is on CDC's website. Updated policies available for submission.	• Sarah Bell • Victor Kintz	8/31/2021

Standard VII—Member Rights and Protections		
HSAG Assessment of Plan	11/19/21: Please submit policies addressing member rights to participate in the development of their treatment plans and to freely exercise their rights without it adversely affecting the way they are treated. Please identify the page number in the member handbook that addresses members' ability to freely exercise their rights without it affecting the way they are treated. This finding remains **unresolved**.	
DCO Status Update	3/31/22: 2022 Member Handbook pages 23, 41-43.	
Documents submitted as evidence of implementation	2020-14_CDC-2022-MemberHandbook	
HSAG Assessment of Resolution	CDC did not submit its revised policies addressing the requirements in the element. In addition, the pages identified in the member handbook did not appear to include the member rights outlined in the standard. HSAG requested policies addressing requirements and received CDC's *Member Rights and Responsibilities* policy, member handbook, and a treatment plan example. Member rights were explained in the member handbook and an example of informed consent was provided in the sample treatment plan. The *Member Rights and Responsibilities* policy did not include the provision for the DCO to ensure members can exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCE, its staff, subcontractors, participating providers, or OHA, treat the member. The policy also did not include the responsibility of the DCO to not discriminate in any way against members when those members exercise their rights under the OHP. CDC must revise its policy to align with the requirements outlined in the standard. This finding remains **unresolved**.	
Status Update		
Documentation Submitted as Evidence		
Assessment of Resolution		☐ Resolved ☐ Resolved, with recommendations ☐ Not Resolved

Standard X—Grievance and Appeal System		
CMR Year	**Finding #**	**Element**
2020	10	The MCE allows for: a. A member to file a grievance with the MCE at any time, either orally or in writing. b. A provider or an authorized representative to file a grievance at any time either orally or in writing, on behalf of a member if there is written consent from the member. c. Grievances can be submitted to the state or the MCE. *42 CFR §438.402(c)(2)(i), (c)(3)(i)* *Contract: Exhibit I (1)* *OAR 410-141-3880 (1)*
Finding		
Documentation provided by CDC was inconsistent in providing complete information to members. CDC's member handbook; website; Grievance, Appeal, and Administrative Hearing policy; and provider manual did not include information about the ability of a provider or other party to file a grievance on a member's behalf, so long as they have the member's written consent to do so. Neither the DCO's website nor its policy included the option for members to file a grievance directly with the State. The DCO's website did not provide information about how to file a complaint with OHA.		
Required Action		
CDC must update its member handbook; website; provider manual; and Grievance, Appeal, and Administrative Hearing policy to include the allowability of a provider or other party to file a grievance on behalf of a member, with the member's written consent. CDC must also update its website and policy to include the member's option to file a grievance directly with the State and provide instructions on how to do so.		
DCO Action Plan	**Individual(s) Responsible**	**Proposed Completion Date**
CDC received final approval for 2021 Member Handbook on 7/2/2021. Updated Member Handbook is on CDC's website. Other documents updated and available for submission including Grievance, Appeal and Hearing policy.	• Sarah Bell • Victor Kintz	8/31/2021
HSAG Assessment of Plan	11/19/21: The member handbook on the website was updated to include the ability of a representative to file a complaint on the member's behalf (with written consent) and it stated that the member can file a complaint directly with the State, it did not provide instructions on how to file a complaint with OHA (i.e., a phone number and/or address). Please submit the updated member handbook, provider manual; a screenshot of the website; and the *Grievance, Appeal, and Administrative Hearing* policy for review. This finding remains **unresolved**.	
DCO Status Update	3/31/22: Updated Member Handbook, Provider Manual, Screenshot of website, and Grievance, Appeal, and Administrative Hearing policy attached.	

Standard X—Grievance and Appeal System		
Documents submitted as evidence of implementation	2020-14_CDC-2022-MemberHandbook 2020-14_Provider-Manual-CDC-2022.03.10 2020-14_CDC Website Screenshot Complaint 2020-14_Grievance, Appeal, and Hearing Policy 2021.06	
HSAG Assessment of Resolution	CDC submitted its revised member handbook, provider manual, and policy as well as a screenshot of its website. The member handbook was revised to inform the member that a representative or provider may file a grievance on the member's behalf with written consent. However, the member handbook that was submitted informed the member that they may file a grievance with the Department of Human Services Client Services Unit or the Authority's Ombudsperson if the member was unhappy with how the DCO handled the grievance. This did not fully comply with the State provision to allow members to also file a grievance directly with the State without the need to first file with the DCO. The screenshot of the website also did not comply with the requirement to allow members to file a complaint or grievance directly with the State. The website informed members that they "may file a complaint with CDC in writing or by telephone." The *Grievance, Appeal, and Administrative Hearing* policy required written consent for providers filing on behalf of members; however, it did not require written consent for a member's representative as required in the standard. Whereas the provider manual did not include the need for written consent for the provider to file on behalf of the member. The policy also did not include the provision for the member to file a grievance directly with the State. CDC must revise the *Grievance, Appeal, and Administrative Hearing* policy, provider manual, and DCO website to comply with the grievance filing requirements listed in the standard. However, due to the DCO contract ending December 2022, OHA will not require CDC to revise the member handbook. This finding remains **unresolved.**	
Status Update		
Documentation Submitted as Evidence		
Assessment of Resolution		☐ Resolved ☐ Resolved, with recommendations ☐ Not Resolved

2022 Improvement Plan for Capitol Dental Care, Inc.

2021 Findings

Standard I—Availability of Services		
CMR Year	**Finding #**	**Element**
2021	15	The DCO ensures that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities. *42 CFR §438.206(c)(3)* *Contract: Exhibit B Part 4 (2)(h)* *OAR 410-141-3515 (8),(12)*

Finding
Although the DCO had a policy that addressed accessibility for "patients who are blind, deaf-blind, or visually impaired," its scope did not include members with limited mobility. Additionally, CDC's Site Visit policy did not provide detailed assessment standards for ADA accessibility.

Required Action
CDC must provide evidence that it ensures network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities (e.g., a policy which addresses physical accessibility and completed, detailed evaluations of provider/clinic sites conducted by the DCO).

DCO Action Plan	**Individual(s) Responsible**	**Proposed Completion Date**
CDC to provide a policy which addresses physical accessibility and completed, detailed evaluations of provider/clinic sites conducted by the DCO.	• Sarah Bell • Victor Kintz	9/30/2021

HSAG Assessment of Plan	This action is likely to resolve the finding if there are established standards for assessing disability access. Please submit the updated policy and a sample assessment of physical access.
DCO Status Update	3/31/22: ADA Policy Healthcare Facilities policy and Facility Audit Policy and Facility Site Visit and Evaluation tool attached.
Documents submitted as evidence of implementation	2021-1_ADA Policy Healthcare Facilities 2022.02 2021-1_CDC Facility Site Visit and Evaluation 03.18.21 2021-1_Facility Audit Policy 2021.10

2022 Improvement Plan for Capitol Dental Care, Inc.

Standard I—Availability of Services		
HSAG Assessment of Resolution	CDC submitted its revised *ADA-Healthcare Facilities* , CDC Facility Site Visit and Evaluation, and *Facility Audit* policies. The *ADA-Healthcare Facilities* policy was not updated to include members with physical and mental disabilities beyond blind, deaf, or visually impaired. The CDC *Facility Site Visit and Evaluation* policy appeared to be in draft form as there were comments within the document. The CDC Facility Site Visit and Evaluation form included one element to assess for ADA accessibility. CDC must include members with physical and mental disabilities in its *ADA-Healthcare Facilities* policy. In addition, HSAG recommends CDC revise its Facility Site Visit and Evaluation form to include specific assessment areas related to handicap accessibility, including entry, parking, ramps, elevators, doors, etc. This finding remains **unresolved.**	
Status Update		
Documentation Submitted as Evidence		
Assessment of Resolution		☐ Resolved ☐ Resolved, with recommendations ☐ Not Resolved

Standard V—Provider Selection		
CMR Year	**Finding #**	**Element**
2021	16	The DCO ensures that all participating providers providing coordinated care services to members are credentialed upon initial contract with the DCO and recredentialed no less frequently than every three (3) years. *42 CFR §438.214(a)* *Contract: Exhibit B Part 4 (4)* *OAR 410-141-3510 (1)(a)*

Finding
The DCO submitted its Credentialing policy, which addressed the requirement to recredential providers every three years; however, during the record review, DCO staff members reported that the DCO was following the temporary guidance of NCQA allowing for a two-month extension on recredentialing, but the State had not granted an extension on recredentialing.

Required Action
CDC must recredential its providers no less than every three years pursuant to OAR 410-141-3510 and in accordance with the DCO's policy.

DCO Action Plan	**Individual(s) Responsible**	**Proposed Completion Date**
CDC to provide an updated Credentialing policy and recent evidence showing providers are re-credentialed no less than every three years and is no longer using the temporary guidance of NCQA.	• Sarah Bell • Victor Kintz	8/31/2021

HSAG Assessment of Plan	This action is likely to resolve the finding. Please submit the updated policy and evidence of tracking recredentialing dates in accordance with the three-year requirement.
DCO Status Update	3/31/22: Updated Credentialing policy attached + evidence of tracking in Active Provider database.
Documents submitted as evidence of implementation	2021-2_Credentialing Dates Tracking 2021-2_Credentialing Policy 2021.10
HSAG Assessment of Resolution	CDC submitted its revised *Credentialing* policy; however, revisions made to the document were unclear. Section I of the policy indicated CDC recredentialed providers "every three years," based on criteria patterned after NCQA accreditation requirements, and section VI reflected a time frame of "36 months." NCQA's recredentialing time frame is 36 months and allows the full 36th month for completion of recredentialing activities; however, the OAR 410-141-3510 (1)(a) requires

Standard V—Provider Selection		
	recredentialing to occur no less frequently than every three years. OHA confirmed the requirement was three years to the day, not by the end of the 36th month. The credentialing tracking screenshot included the initial credentialing date, the last credentialing date, and the next credentialing date; however, it did not provide sufficient information to determine compliance with the three-year requirement if the initial credentialing date was greater than three years prior to the last credentialing date. HSAG requested tracking documentation that was reflective of both CDC and MDCO providers and that demonstrated compliance with credentialing every three years during the virtual "onsite" review. The document submitted included initial, effective, last, and next credentialing dates; however, it was not clear whether the time frames longer than three years between the effective and last credentialing dates were out of compliance or a missing date field. CDC must revise its policy to reflect consistent language throughout the policy regarding the state-established time frame requirement of three years and provide the tracking document for providers recredentialed since the implementation of this improvement plan. The tracking document must include the last two credentialing dates as evidence of recredentialing providers no less than every three years. This finding remains **unresolved**.	
Status Update		
Documentation Submitted as Evidence		
Assessment of Resolution		☐ Resolved ☐ Resolved, with recommendations ☐ Not Resolved

Standard VI— Subcontractual Relationships and Delegation		
CMR Year	**Finding #**	**Element**
2021	19	The DCO's contract or written agreement with the subcontractor must provide for the following **corrective actions**: a. Termination of the subcontract, the right to take remedial action, and impose other sanctions such that the DCO's rights substantively align with OHA's rights, if the subcontractor's performance is inadequate to meet the requirements of the DCO's contract with the State. b. Revocation of the delegation of activities or obligations or specify other remedies in instances where the State or DCO determine that the subcontractor has not performed satisfactorily. *42 CFR §438.230(c)(1)(iii)* *Contract: Exhibit B Part 4 (9)(b)(1)(a-b)* *OAR 410-141-3505 (2)*

Finding
While the DCO's contract addressed the ability to terminate the agreement for unsatisfactory subcontractor performance, it did not allow the option for any remedial action other than termination of the agreement.

Required Action
CDC must update its contract to allow for remedial action such as revocation of the delegation of activities or obligations or other remedies in instances where the State or DCO determine that the subcontractor has not performed satisfactorily.

DCO Action Plan	**Individual(s) Responsible**	**Proposed Completion Date**
CDC to discuss with subcontractor PhTech at upcoming Account Management meeting on 9/16/2021 and have contract language updated to include allowing for remedial action such as revocation of the delegation of activities or obligations or other remedies in instances where the State or DCO determine that the subcontractor has not performed satisfactorily.	• Sarah Bell • Victor Kintz	9/30/2021

HSAG Assessment of Plan	This action is likely to resolve the finding. Please submit the updated contract for review once it has been revised.
DCO Status Update	3/31/22: CDC-PhTech contract updated. Attached page 3 with termination language.
Documents submitted as	2021-5_ 20220401 CapitolDental ASA_PH-Page 3

Standard VI— Subcontractual Relationships and Delegation		
evidence of implementation		
HSAG Assessment of Resolution	CDC submitted page 3 of its revised contract with PH TECH; however, part of the section under review was cut off at the end of the page. HSAG requested and received CDC's entire contract with PH TECH; however, the contract was not revised to meet the requirements outlined in the standard. CDC must align its subcontractor agreements with the specific corrective actions outlined in the requirement. This finding remains **unresolved**.	
Status Update		
Documentation Submitted as Evidence		
Assessment of Resolution		☐ Resolved ☐ Resolved, with recommendations ☐ Not Resolved

2022 Improvement Plan for Capitol Dental Care, Inc.

Standard VI— Subcontractual Relationships and Delegation		
CMR Year	**Finding #**	**Element**
2021	20	The DCO monitors the subcontractor's performance on an ongoing basis and performs, at least once a year, a formal review of compliance of all subcontracted obligations and other responsibilities, performance, deficiencies, and areas for improvement. Such review is documented in an Annual Subcontractor Performance Report, which is completed within 60 days after the annual anniversary of the effective date of the subcontract. *42 CFR §438.230* *Contract: Exhibit B Part 4 (9)(a)(12)* *OAR 410-141-3505 (1)(b)*

Finding
The DCO submitted its Delegation Oversight policy, its Delegated Work Report filed with the State, and a meeting summary detailing a review of its subcontractor's delegated functions. Although CDC reported that it holds quarterly oversight meetings, the DCO provided no evidence of this ongoing monitoring.

Required Action
CDC must provide evidence of ongoing subcontractor monitoring for delegated functions.

DCO Action Plan	**Individual(s) Responsible**	**Proposed Completion Date**
CDC to discuss with subcontractor PhTech at upcoming Account Management meeting on 9/16/2021 ways to better document and provide better evidence of ongoing monitoring.	• Sarah Bell • Victor Kintz	9/30/2021

HSAG Assessment of Plan	CDC must submit documentation of its ongoing oversight of subcontractors. For example, this can be done via meeting minutes or quarterly reports.
DCO Status Update	3/31/22: Evidence of monitoring subcontractor PhTech attached. Recent desk audit completed. No findings were identified during the desk review.
Documents submitted as evidence of implementation	2021-6_CDC-PHTech Oversight Audit
HSAG Assessment of Resolution	CDC submitted its PH TECH Oversight Audit; however, the documentation included a memo that the subcontractor responded to by listing the requested documentation. CDC did not submit documentation of monitoring the subcontractor on an ongoing basis or results of a formal compliance review of the subcontractor, including an assessment of performance,

Standard VI— Subcontractual Relationships and Delegation		
	deficiencies, and/or areas for improvement as contractually required. CDC must submit evidence of ongoing monitoring of its subcontractor and results of an annual compliance review that meets the requirements in the DCO contract. In addition, compliance monitoring review activities must be specific to the DCO-specific member population. This finding remains **unresolved**.	
Status Update		
Documentation Submitted as Evidence		
Assessment of Resolution		☐ Resolved ☐ Resolved, with recommendations ☐ Not Resolved

2022 Improvement Plan for Capitol Dental Care, Inc.

Standard XI—Practice Guidelines		
CMR Year	**Finding #**	**Element**
2021	22	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: Exhibit B Part 4(8*

Finding
The DCO reported meticulous clinical review and explained how practice guidelines are considered in decision making for coverage and utilization; however, no evidence of infrastructure or implementation was submitted to demonstrate compliance.

Required Action
CDC must have a process for ensuring its practice guidelines are considered when making coverage and utilization decisions and provide evidence of their implementation.

DCO Action Plan	**Individual(s) Responsible**	**Proposed Completion Date**
CDC to review Clinical Practice Guidelines policy and processes at upcoming QI Committee meeting on 8/18/2021 and discuss process for ensuring its practice guidelines are considered when making coverage and utilization decisions and provide evidence of their implementation.	• Sarah Bell • Victor Kintz	9/30/2021

HSAG Assessment of Plan	This action is likely to resolve the finding. Please submit evidence that CDC considers its practice guidelines when making coverage and utilization decisions.
DCO Status Update	3/31/22: Clinical Practice Guideline Policy + Policy Attestation attached. In addition clinical reviewers reference clinical practice guidelines when making coverage and utilization decisions. Not sure how to show evidence of this.
Documents submitted as evidence of implementation	2021-8_Clinical Practice Guidelines 2022.02 2021-8_La Lande, Philip DMD - 2020 Attestation
HSAG Assessment of Resolution	CDC submitted its *Clinical Practice Guidelines* policy and policy attestation as an example of dissemination of practice guidelines to a provider. CDC did not submit a documented process for ensuring decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply were consistent with the guidelines as required in the improvement plan. CDC's IP response indicated CDC was unsure how to provide evidence of ensuring its practice guidelines are considered when making coverage decisions. CDC must submit its policies and procedures for

Standard XI—Practice Guidelines		
	applying applicable clinical practice guidelines to utilization management, member education, and coverage decisions. This finding remains **unresolved.**	
Status Update		
Documentation Submitted as Evidence		
Assessment of Resolution		☐ Resolved ☐ Resolved, with recommendations ☐ Not Resolved

2022 Findings

Standard VIII—Confidentiality	
Element #3	The DCO and subcontractors adopt and employ reasonable administrative safeguards consistent with the security rules in 45 CFR Part 164 to ensure member information is used or disclosed in a manner consistent with applicable State and federal laws and the terms and conditions in the DCO contract. *42 CFR §438.224* *DCO Contract Exhibit E (6)(b)*

Finding: CDC's *Confidentiality* policy asserted that CDC is to employ reasonable administrative safeguards to protect the confidentiality of member information including the following:

- *Provider contracts and clinic agreements required providers and staff to protect the confidentiality of the member.*
- *The provider handbook further advised and educated providers and staff of the need to protect confidentiality.*
- *The employee handbook advised and educated employees of the need to protect confidentiality.*
- *The CDC QIC advised each new committee member of the need to protect confidentiality. Each new committee member was required to acknowledge and agree to that policy as a condition of participation.*
- *Through the CDC website, as well as hard copy distribution, CDC's provider and member newsletters advised providers and members of any changes or new additions regarding confidentiality standards and practices.*
- *All CDC providers and staff were required to complete HIPAA training upon employment and annually thereafter. The CDC compliance officer also encouraged additional trainings as issues and trends developed in this area.*

CDC demonstrated employing the following administrative safeguards:

- HIPAA training was provided.
- Education of providers through the provider manual.
- Business associate agreements ensured subcontractors agreed to follow policies and procedures for maintaining the privacy and security of records and authorizing the use and disclosure of records.
- Use of appropriate Notice of Privacy Practices.
- Advisement of confidentiality practices posted on the website.

CDC demonstrated employing the following physical safeguards:

Standard VIII—Confidentiality

• Facility site visit forms ensured a secure and confidential filing system and assessed whether dental charts/records were maintained in accordance with HIPAA regulations, including protection from public view.
• Interdent building workplace security measures.
 	
CDC demonstrated employing the following technical safeguards:
 	
• IT policies asserting the following:
  – Encryption
  – Passwords and logon controls
  – Identification and authentication requirements
  – User logon IDs
  – Termination of user accounts
  – Firewalls and malicious code
  – Information system review activities and audit controls
 	
CDC provided evidence of the appropriate policies and reasonable safeguards in place to ensure member information would be used or disclosed in a manner consistent with applicable State and federal laws and the terms and conditions in the DCO contract. CDC's subcontractor, PH TECH, was delegated to perform administrative services for CDC and was required by the contract to maintain HIPAA confidentiality. PH TECH's policies demonstrated the appropriate safeguards. During the virtual "onsite" review, CDC asserted that PH TECH would require its staff to undergo HIPAA Security training as well. However, CDC was unable to provide documentation that confirmed the subcontractor staff completed the required trainings. CDC also provided its *Site Visits* policy, which asserted that the DCO is to complete site visits for any provider entering into a contract with the DCO; however, the DCO provided a statement that site visits were not completed in 2021 due to the public health emergency. This requirement was *Partially Met*.

Required Action: CDC must ensure that its subcontractors employ the appropriate safeguards and adhere to their policies and procedures. CDC must demonstrate evidence that the subcontractors adhered to their policies, including providing confidentiality/HIPAA training to PH TECH staff.

2022 Improvement Plan for Capitol Dental Care, Inc.

Standard VIII—Confidentiality			
DCO Improvement Plan			
DCO Action Plan/Interventions		**Individual(s) Responsible**	**Completion Date**
		•	
Documentation Submitted as Evidence			
Assessment of Resolution		☐ Resolved ☐ Resolved, with recommendations ☐ Not Resolved	

Standard IX— Enrollment and Disenrollment	
Element #1	The DCO accepts individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by CMS), up to the limits set under the contract. *42 CFR §438.3(d)(1)* *OAR 410-141-3805(15)(b)* *DCO Contract Exhibit B Part 3(8)(b)*
Finding: CDC delegated all enrollment and disenrollment functions to its subcontractor and submitted PH TECH's *Oregon Medicaid Enrollment and Disenrollment* policy, which addressed enrollment and disenrollment processes and activities. While the document provided an overview of PH TECH's policy for managing enrollment through receipt of daily 834 transaction files from OHA, the policy did not state that members were enrolled in the order in which they applied without restriction (unless authorized by CMS) up to the limits set under the contract. Further, the policy did not outline the steps necessary to ensure the processing of member enrollment in the order received. However, CDC was able to confirm these processes during the virtual "onsite" review and later during a separate information systems session with PH TECH staff. During the virtual "onsite" review, CDC also asserted that eligibility for enrollment would be determined by OHA, although the policy described manual enrollment procedures that occurred only when a member needed access to services immediately. Additionally, although this policy was submitted to support DCO enrollment processes, PH TECH's policy only referenced CCOs. The *Monthly 834 Reconciliation Audit* policy specified the process for reconciling the enrollment report from OHA against the Community Integration Manager (CIM) system to identify discrepancies between the OHA eligibility Medicaid Management Information System (MMIS) and CIM. CDC provided a sample list of import error codes used to identify errors in eligibility identified by the CIM system. CDC described its process which relied on staff who worked the errors identified during the import process to reconcile the members identified on the 834 file provided by OHA. CDC demonstrated that the appropriate reconciliation reports were completed. This requirement was *Partially Met.*	
Required Action: CDC must ensure its subcontractor's policy, *Oregon Medicaid Enrollment and Disenrollment,* aligns with the federal requirement to accept individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by CMS), up to the limits set under the contract. Additionally, the policy should be updated to reflect applicability to CDC, as a DCO, in addition to the CCOs	

DCO Improvement Plan		
DCO Action Plan/Interventions	**Individual(s) Responsible**	**Completion Date**
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2022 Improvement Plan for Capitol Dental Care, Inc.

Standard IX— Enrollment and Disenrollment		
Documentation Submitted as Evidence		
Assessment of Resolution		☐ Resolved ☐ Resolved, with recommendations ☐ Not Resolved

2022 Improvement Plan for Capitol Dental Care, Inc.

Standard IX— Enrollment and Disenrollment	
Element #2	The DCO does not discriminate against individuals eligible to enroll and will not use any policy or practice that has the effect of discriminating on the basis of health status or need for health care services, race, color, or national origin, religion, sex, sexual orientation, marital status, age, gender identity, or disability. *42 CFR §438.3(d)(3-4)* *DCO Contract Exhibit B Part 3(8)(c)*

Finding: During the virtual "onsite" review, CDC asserted that eligibility would be determined by OHA, the DCO would accept members as they were assigned, and that CDC would not discriminate. CDC also provided its *Nondiscrimination* policy which stated that CDC would not exclude, deny benefits to, or otherwise discriminate against any person on the basis of sex, sexual orientation, marital status, race, color, national origin, disability, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by CDC directly or through its network of providers or any other entity which arranged to carry out its programs and activities. The policy did not include the requirement to not discriminate on the basis of health status or need for health care services or gender identity.

CDC also provided a screen shot of The Right to Receive Services without Discrimination section on the Member Rights page of its website and asserted during the virtual "onsite" review that this section was directed to individuals eligible to enroll; however, the statement on the website only mentioned members and did not address individuals who were eligible to enroll. CDC also provided examples of reconciliation reports which demonstrated that discrepancies for enrollment did not include the aforementioned reasons. This requirement was *Partially Met.*

Required Action: CDC must update its *Nondiscrimination* policy to include the requirement of the DCO to not discriminate on the basis of health status or need for health care services or gender identity. CDC must also update the discrimination section on the Member Rights page of its website to include a statement that its non-discrimination is inclusive of members as well as individuals eligible to enroll. If CDC contracts with a CCO to provide dental services to Medicaid enrollees after its DCO contract ends, CDC must also align its non-discrimination policies with the CCO's non-discrimination policies.

DCO Improvement Plan

DCO Action Plan/Interventions	Individual(s) Responsible	Completion Date
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Standard IX— Enrollment and Disenrollment		
Documentation Submitted as Evidence		
Assessment of Resolution		☐ Resolved ☐ Resolved, with recommendations ☐ Not Resolved

2022 Improvement Plan for Capitol Dental Care, Inc.

Standard IX—Enrollment and Disenrollment	
Element #3	The DCO may only request disenrollment of members for one or more of the following reasons: • Is uncooperative or disruptive, except where this is a result of the member's special needs or disability • Commits fraudulent or illegal acts • Makes credible threats of or commits acts of violence *42 CFR §438.56(b)(1)* *OAR 410-141-3810* *DCO Contract Exhibit B Part 3(9)*
Finding: The *Oregon Medicaid Enrollment & Disenrollment* policy asserted that members are to be disenrolled from the plan for "various" reasons such as the member is no longer eligible or the member moved from the plan's service area. However, the policy does not discuss the aforementioned reasons in which CDC can request disenrollment of members. This requirement was *Partially Met*.	
Required Action: CDC must ensure the *Oregon Medicaid Enrollment and Disenrollment* policy aligns with state-established reasons that DCOs may request disenrollment of a member.	

DCO Improvement Plan			
DCO Action Plan/Interventions		**Individual(s) Responsible**	**Completion Date**
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Documentation Submitted as Evidence			
Assessment of Resolution		☐ Resolved ☐ Resolved, with recommendations ☐ Not Resolved	

2022 Improvement Plan for Capitol Dental Care, Inc.

Standard IX—Enrollment and Disenrollment	
Element #4	The DCO may **not** request disenrollment of a member because of an adverse change in the member's health status or because of the member's: a. Utilization of health services. b. Physical, intellectual, developmental, or mental disability. c. Uncooperative or disruptive behavior resulting from the member's special needs, disability or any condition that is a result of their disability. d. Being in the custody of DHS/Child Welfare. e. Prior to receiving any services, including, without limitation, anticipated placement in or referral to a psychiatric residential treatment facility. f. A member's decision regarding their own medical care with which the contractor disagrees. g. Filing a grievance or exercising any appeal or contested case hearing rights. *42 CFR §438.56(b)(2)* *OAR 410-141-3810(4)(c)* *DCO Contract Exhibit B Part 3(9)(d)*
Finding: The *Oregon Medicaid Enrollment & Disenrollment* policy did not address the inability to request disenrollment for the aforementioned reasons. In addition, CDC lacked evidence of monitoring disenrollment requests to ensure compliance with the regulatory requirements. This requirement was *Partially Met*.	
Required Action: CDC must ensure the *Oregon Medicaid Enrollment and Disenrollment* policy aligns with state-established reasons that DCOs may not request disenrollment of a member.	

DCO Improvement Plan

DCO Action Plan/Interventions	Individual(s) Responsible	Completion Date
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Standard IX—Enrollment and Disenrollment		
Documentation Submitted as Evidence		
Assessment of Resolution		☐ Resolved ☐ Resolved, with recommendations ☐ Not Resolved

Standard IX— Enrollment and Disenrollment	
Element #5	The DCO has a process that allows members to disenroll **without cause** for any of the following reasons: a. OHP clients auto-enrolled or manual-enrolled in error may change plans, if another plan is available, within thirty (30) days of the member's enrollment. b. Newly eligible members may change plans, if another plan is available within ninety (90) days of their initial plan enrollment. c. A member may request to change plans, after six (6) months of their initial plan enrollment. d. A member may request disenrollment during "OHP eligibility renewal," which is typically twelve (12) months. e. Full benefit dual eligible members and members who are American Indian/Alaska Native beneficiaries may change plans or disenroll to Fee-for-Service at any time. f. Upon automatic re-enrollment (e.g., a recipient who is automatically re-enrolled after being disenrolled, solely because such recipient loses Medicaid eligibility for a period of two (2) months or less), if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity. g. Whenever the member's eligibility is re-determined by OHA. h. When OHA has imposed sanctions on the DCO, including the suspension of all new enrollment (consistent with 42 CFR 438.702(a)(4). i. Members have one additional opportunity to request a plan change during the eligibility period if none of the above options can be applied. *42 CFR §438.56(c)(2) and (g)* *OAR 410-141-3810(1)(b)(A* *DCO Contract Exhibit B Part 3(9)(c)(1)(a)*

Finding: CDC's *Oregon Medicaid Enrollment & Disenrollment* policy asserted that members may request disenrollment from the DCO without cause (30 days from enrollment or reenrollment, after six months of enrollment, or by member choice); however, the policy did not specify all reasons members may request disenrollment without cause.

The 2021 member handbook informed members they may request disenrollment from the DCO for the following without cause reasons:

- *You are new to OHP, and it is within the first 90 days.*
- *You are returning to OHP, and it is within the first 30 days.*
- *You are renewing your OHP coverage (usually once per year).*
- *You have been enrolled already for 6 months.*
- *You have another reason (up to one time per year).*

Standard IX— Enrollment and Disenrollment
However, the 2021 member handbook did not inform members that they may request disenrollment without cause for the following reasons: • OHP clients auto-enrolled or manual-enrolled in error may change plans, if another plan is available, within 30 days of the member's enrollment. • Full benefit dual eligible members and members who are American Indian/Alaska Native beneficiaries may change plans or disenroll to FFS at any time. • Upon automatic reenrollment (e.g., a recipient who is automatically reenrolled after being disenrolled, solely because such recipient loses Medicaid eligibility for a period of two months or less), if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity. • When OHA has imposed sanctions on the DCO, including the suspension of all new enrollment (consistent with 42 CFR §438.702(a)(4). CDC submitted its revised 2022 member handbook, which included the following reasons members may request disenrollment without cause: • *Members may request to change their DCO enrollment within 30 calendar days of the Authority's automatic or manual enrollment error. If approved the change would happen during the next weekly enrollment cycle.* • *Members may request to change their DCO enrollment within 90 calendar days of the initial DCO enrollment or during the 90 days following the date OHA sends the member notice of that enrollment, whichever is later if another plan is available in the member's service area. If approved, the change would happen during the next weekly enrollment cycle.* • *At least once every 12 months thereafter.* • *Members may request to change their DCO enrollment after they have been enrolled with that DCO for at least six months. If approved, the change would happen at the end of the month.* • *A member may request to change their DCO enrollment at their OHP eligibility renewal, usually once per year.* • *Full benefit dual eligible members and members who are American Indian/Alaska Native beneficiaries may change plans or disenroll to FFS at any time.* However, the 2022 member handbook did not include: • When OHA has imposed sanctions on the DCO, including the suspension of all new enrollment (consistent with 42 CFR §438.702(a)(4). • Members have one additional opportunity to request a plan change during the eligibility period if none of the above options can be applied. This requirement was *Partially Met*.

2022 Improvement Plan for Capitol Dental Care, Inc.

Standard IX— Enrollment and Disenrollment			
Required Action: CDC must ensure *the Oregon Medicaid Enrollment and Disenrollment* policy aligns with state-established reasons that members may request disenrollment without cause. Although the member handbook was also out of compliance for the current review period, due to the DCO program ending in December 2022, OHA will not require corrective action for the member handbook.			
DCO Improvement Plan			
DCO Action Plan/Interventions		**Individual(s) Responsible**	**Completion Date**
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Documentation Submitted as Evidence			
Assessment of Resolution		☐ Resolved ☐ Resolved, with recommendations ☐ Not Resolved	

Standard IX— Enrollment and Disenrollment	
Element #6	The DCO has a process to allow members to disenroll **with cause** for any of the following reasons: a. The member moves out of the DCO's service area; b. The DCO does not, because of moral or religious objections, cover the service the member seeks; c. The member needs related services to be performed at the same time, not all related services are available from the DCO's plan, and the member's primary care dentist (or another provider) determines that receiving the services separately would subject the member to unnecessary risk; d. Other reasons, including poor quality of care or lack of access to services covered under the contract or providers experienced with dealing with the member's specific needs. Examples include: • Services not provided in the member's preferred language; • Services not provided in a culturally appropriate manner; • It would be detrimental to the member's health to continue enrollment; • For continuity of care. *42 CFR §438.56(c)* *OAR 410-141-3810(1)(b)(B)* *DCO Contract Exhibit B Part 3(9)(c)(1)(b)*

Finding: The *Oregon Medicaid Enrollment & Disenrollment* policy asserted that members may request disenrollment from the DCO with cause (quality of care and/or access issues, the member is Native American or Alaskan Native); however, it did not specify all reasons that members may request disenrollment with cause.

The 2021 member handbook informed members that they may request disenrollment for the DCO for one with cause reason:

- *You move somewhere that Capitol Dental Care doesn't serve.*

However, the 2021 member handbook did not inform members that they may request disenrollment with cause for the following:

- The DCO does not, because of moral or religious objections, cover the service the member seeks.
- The member needs related services to be performed at the same time, not all related services are available from the DCO's plan, and the member's primary care dentist (or another provider) determines that receiving the services separately would subject the member to unnecessary risk.

Standard IX— Enrollment and Disenrollment
• Other reasons, including poor quality of care or lack of access to services covered under the contract or providers experienced with dealing with the member's specific needs. Examples include: – Services not provided in the member's preferred language. – Services not provided in a culturally appropriate manner. – It would be detrimental to the member's health to continue enrollment. – For continuity of care. In 2022 CDC updated the member handbook to include the following reasons members may request disenrollment with cause: • *The member moves out of Capitol Dental Care's service area; or* • *Due to moral or religious objections the DCO does not cover the service the member seeks;* • *When the member needs related services to be performed at the same time and:* – *Not all related services are available within the provider network.* – *Your PCD or another provider determines that receiving the services separately would subject the member to unnecessary risk.* • *Other reasons including poor quality of care, lack of access to covered services, or lack of access to participating providers who are experienced in dealing with the specific member's health care needs.* – *Examples of sufficient cause include:* o *The member moves out of the service area;* o *Services are not provided in the member's preferred language;* o *Services are not provided in a culturally appropriate manner;* o *It would be detrimental to the member's health to continue enrollment; or* o *For purposes of continuity of care.* This requirement was *Partially Met*.
Required Action: CDC must ensure the *Oregon Medicaid Enrollment and Disenrollment* policy aligns with state-established reasons that members may request disenrollment with cause. Although the member handbook was also out of compliance for the current review period, due to the DCO program ending in December 2022, OHA will not require corrective action for the member handbook.

2022 Improvement Plan for Capitol Dental Care, Inc.

Standard IX— Enrollment and Disenrollment			
DCO Improvement Plan			
DCO Action Plan/Interventions		**Individual(s) Responsible**	**Completion Date**
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Documentation Submitted as Evidence			
Assessment of Resolution		☐ Resolved ☐ Resolved, with recommendations ☐ Not Resolved	

2022 Improvement Plan for Capitol Dental Care, Inc.

Standard XII—Quality Assessment and Performance Improvement	
Element #3	The DCO's QAPI program includes annually collecting and submitting (to the State): • Performance measure data using standard measures identified by the State; • Data, specified by the State, which enables the State to calculate the DCO's performance using the standard measures identified by the State; or • A combination of the above activities. *42 CFR §438.330(b)(2) and (c)(2)(i-iii)* *CCO Contract Exhibit B Part 10(3)*
Finding: CDC provided a report that demonstrated the collection of performance metric data within the QI Dashboard and the Metric Utilization report. However, neither the *Quality Improvement Committee* policy nor the QI workplan described the DCO's process for annually collecting performance measures or data or identified the performance measures used. This requirement was *Partially Met*.	
Required Action: CDC must demonstrate that the QAPI program includes annually collecting performance measure data within the program description or workplan.	

DCO Improvement Plan

DCO Action Plan/Interventions	Individual(s) Responsible	Completion Date
	•	

Documentation Submitted as Evidence	
Assessment of Resolution	☐ Resolved ☐ Resolved, with recommendations ☐ Not Resolved

2022 Improvement Plan for Capitol Dental Care, Inc.

Standard XII—Quality Assessment and Performance Improvement	
Element #6	The DCO conducts and submits to OHA an annual written evaluation of the QAPI program and member care as measured against the written procedures and protocols of member care. The QAPI and member care evaluation includes the following: • Assessment of annual activities conducted, including background and rationale • Plan of ongoing improvement activities to address gaps, which will ensure quality of care for members and overall effectiveness of the QAPI program *42 CFR §438.330(e)(2)* *OAR 410-141-3525(11)(c)*
Finding: CDC submitted its written evaluation of the 2021 QAPI program. The evaluation included an assessment of the activities conducted in 2021. However, the evaluation did not include an assessment for gaps or a plan of ongoing improvement activities to address any gaps to ensure quality of care for members and overall effectiveness of the QAPI program. This requirement was *Partially Met*.	
Required Action: CDC must address gaps within its QAPI program and include a plan of ongoing improvement activities to address gaps to ensure quality of care for members and overall effectiveness of the QAPI program.	

DCO Improvement Plan

DCO Action Plan/Interventions	Individual(s) Responsible	Completion Date
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Documentation Submitted as Evidence		
Assessment of Resolution		☐ Resolved ☐ Resolved, with recommendations ☐ Not Resolved