



Iowa Medicaid
Iowa HHS

**Calendar Year 2026 Readiness Review
Report**

for

DentaQuest USA Insurance Company, Inc.

July 2026



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Background

The State of Iowa, Department of Health and Human Services (HHS) administers and oversees the Iowa Medicaid managed care program, which provides Medicaid and Children’s Health Insurance Program (CHIP, also referred to in Iowa as Healthy and Well Kids in Iowa [Hawki]) dental benefits to members. HHS implemented a unified dental managed care program for all adult populations on July 1, 2017, known as the Dental Wellness Program (DWP), which provides dental services to adults 19 years of age and older. Effective July 1, 2021, HHS transitioned coverage of children’s Medicaid dental benefits from fee-for-service to coverage through the DWP managed care program. The DWP program covers diagnostic and preventive dental services, fillings for cavities, surgical and nonsurgical gum treatment, root canals, dentures and crowns, and extractions. Hawki has been in effect since March 1, 2010, and provides dental services to children 18 years of age and younger, with full access to routine dental benefits.

In February 2025, HHS released a request for proposal (RFP) to solicit responses from prepaid ambulatory health plans (PAHPs) qualified to provide managed care dental services designed in support of the Title XIX (Medicaid) and Title XXI (CHIP) programs. Through the RFP process, HHS selected two PAHPs to administer the covered services under the Iowa Medicaid managed care dental program effective July 1, 2026. Although one of the selected entities (Delta Dental of Iowa) is an existing PAHP, one PAHP (**DentaQuest USA Insurance Company, Inc.**) was newly selected for the Iowa Medicaid managed care dental program.

In accordance with 42 Code of Federal Regulations (CFR) §438.66(d)(1), a state must assess the readiness of each PAHP with which it contracts when the specific PAHP has not previously contracted with the State. As such, HHS contracted with Health Services Advisory Group, Inc. (HSAG), to conduct a readiness review of **DentaQuest USA Insurance Company, Inc.**, on behalf of HHS. Table 1-1 displays the naming conventions for the newly contracted PAHP.

Table 1-1—PAHP Information

PAHP Long Name	DentaQuest USA Insurance Company, Inc.
PAHP Short Name	DentaQuest

Readiness Review Process

The readiness review for **DentaQuest** included an assessment of all key program areas noted in 42 CFR §438.66(d)(4), which are presented in Table 1-2. The key program areas were divided into three readiness review components—Operational,¹ Information Systems Management, and Financial Management—and each component was assessed using a variety of tools, staff interviews, information system demonstrations, testing scenarios, and/or requested data submissions. Please refer to Section 2 for a detailed methodology of the readiness review activity.

Table 1-2—Federal Readiness Review Areas

Federal Readiness Review Areas	
Operations/Administration	
Administrative Staffing and Resources	
Delegation and Oversight	
Member and Provider Communications	
Grievance and Appeals	
Member Services and Outreach	
Provider Network Management	
Program Integrity/Compliance	
Service Delivery	
Case Management/Care Coordination	
Quality Improvement	
Utilization Review	
Financial Management	
Financial Reporting and Monitoring	
Financial Solvency	
Systems Management	
Claims Management	
Encounter Data Management	
Enrollment Information Management	

HSAG’s readiness review for **DentaQuest** included a review of the documentation submitted by the PAHP that was available at the time of the readiness review. HSAG reviewed **DentaQuest**’s documentation and capabilities (e.g., policies, procedures, networks, member- and provider-facing materials, systems) to comply with and implement the requirements mandated by federal rule and outlined in the Contract between HHS and the PAHP. While HSAG will continue to collaborate with HHS to support program readiness through

¹ The Operational component of the readiness review includes Operations/Administration and Service Delivery.

the implementation effective date of July 1, 2026, and ongoing, HHS maintains ultimate responsibility in determining **DentaQuest**'s final readiness status.

Summary of Results

In accordance with 42 CFR §438.66(d)(3), the readiness review included a desk review of documents related to operational, information systems, and financial management areas, and an initially scheduled three-day virtual site review. Based on the interview sessions and the documentation submitted, HSAG, in collaboration with HHS, scheduled four additional virtual site review dates to interview **DentaQuest** staff members and leadership managing key operational areas and supporting functions. Throughout the virtual site review sessions, HSAG also observed system demonstrations of multiple information systems used by **DentaQuest** to support activities in applicable program areas and the outcomes associated with HSAG-developed claims testing scenarios. Further, **DentaQuest** is required to review and implement all recommendations provided by HSAG to ensure compliance. Please refer to Appendix I for more information related to the implementation of HSAG's recommendations.

As **DentaQuest** is expected to have membership by July 1, 2026, HSAG and HHS required **DentaQuest** to complete the following prior to the effective date of the Iowa Medicaid managed care dental program:

- Finalize all policies and procedures.
- Finalize Iowa-specific training materials and ensure all staff members that support the Iowa Medicaid managed care dental program are trained.
- Finalize all member and provider materials (e.g., member handbook, member notices, provider manual, provider contracts, provider directory).
- Finalize all information systems, including but not limited to, enrollment, claims, encounters, care management, utilization management (UM), and grievance and appeal systems.
- Finalize the member and provider portals, and the website with Iowa-specific information.
- Close any provider network gaps that may impact access to care.
- Finalize transition-of-care processes (e.g., sharing of authorizations, assessments, service plans, and any historical member data).
- Configure benefits to ensure coverage criteria and claims payment processing aligns with the scope of benefits, limitations, and payment processing requirements established by HHS.
- Implement tracking and reporting mechanisms as necessary within all program areas to monitor timeliness requirements.

DentaQuest must also continue to test claims scenarios internally following all required guidance and information issued through Contract and by HHS. This final testing approach will allow for a comprehensive evaluation of **DentaQuest**'s ability to process dental claims in accordance with HHS program requirements.

Summary of Results for Operational Readiness Review

The Operational component of the readiness review included an assessment of **DentaQuest**'s responses to the PAHP Readiness Review Questionnaire, which provided HSAG with pertinent information about the PAHP's organization, staffing and resources, systems, and contingency plans. The Operational component also included a review of federal and state-specific requirements separated into 14² program areas, called standards, as displayed in Table 1-3. These standards and the elements they contained were further supported by evidence obtained through the following:

- Fourteen checklist reviews (i.e., Member Rights, Member Handbook, Provider Directory, New Member Communications, Member Services Help Line, Marketing, Appointment Times, Network Adequacy, Care Coordination, Clinical Records, Provider Contract, Provider Manual, Staff Training, and Staffing)
- Three file reviews (i.e., Practitioner Credentialing, Organizational Credentialing, and Delegation)
- Information system demonstrations, such as the following:
 - Customer Service/Call Center
 - Enrollment
 - Case Management/Care Coordination
 - Utilization Management (service authorizations)
 - Credentialing
 - Grievances and Appeals
 - Claims/Encounters (storage and processing)
 - Provider Network Management (fee schedule maintenance, provider directory)
 - Program Integrity (Health Insurance Portability and Accountability Act [HIPAA] violations and fraud/abuse tracking applications)

² While the Operational standards consist of 15 program areas, the Health Information Systems Standard was reviewed as a component of the Information Systems Readiness Review.

Table 1-3 presents the summary of results of the Operational readiness review assessment performed by HSAG for **DentaQuest**. The table lists the standards reviewed and the total number of elements (requirements) reviewed within each of the readiness review program areas (standards), the number of elements *Met* and *Not Met*, percentage of elements with a score of *Met*, and the overall *Met* and *Not Met* percentages as of April 24, 2026.

Table 1-3—Summary of Results for the Operational Readiness Review

Standard		Elements/Requirements Assessed			
		Number of Elements	Number <i>Met</i>	Number <i>Not Met</i>	Percent <i>Met</i>
I	Disenrollment: Requirements and Limitations	6	6	0	100%
II	Member Rights and Member Information	33	21	12	64%
III	Emergency and Poststabilization Services	15	9	6	60%
IV	Availability of Services	16	12	4	75%
V	Assurances of Adequate Capacity and Services	9	7	2	78%
VI	Coordination and Continuity of Care	11	7	4	64%
VII	Coverage and Authorization of Services	33	15	18	45%
VIII	Provider Selection	19	17	2	89%
IX	Confidentiality	23	23	0	100%
X	Grievance and Appeal Systems	42	25	17	60%
XI	Subcontractual Relationships and Delegation	12	10	2	83%
XII	Practice Guidelines	6	3	3	50%
XIII	Health Information Systems	This program area was assessed through the Information Systems Readiness Review.			
XIV	Quality Assessment and Performance Improvement Program	32	29	3	91%
XV	Program Integrity	19	16	3	84%
Total		276	200	76	72%
Overall Percent <i>Met</i> (No Action Required)			72%		
Overall Percent <i>Not Met</i> (Action Required)			28%		

Number of Elements = The total number of applicable requirements included as part of each standard that were reviewed for readiness.

Number *Met* = The total number of elements within each standard that supported readiness.

Number *Not Met* = The total number of elements within each standard that did not support readiness.

DentaQuest demonstrated readiness in 200 of 276 elements, with an overall completion status of *Met* in the Standard I—Disenrollment: Requirements and Limitations and Standard IX—Confidentiality standards, indicating the necessary policies, procedures, and initiatives are in place to effectively support **DentaQuest**'s readiness in these two program areas. However, 76 elements were determined as *Not*

Met, indicating **DentaQuest** has significant opportunities for improvement to operationalize the related requirements in accordance with federal and State regulations under the remaining 12 program areas.

In addition to ensuring that **DentaQuest** has remediated all deficiencies identified through the readiness review process, **DentaQuest** must attest to HSAG and/or HHS prior to July 1, 2026, that all policies and procedures, member and provider materials, and the systems that will be used to support the Iowa Medicaid managed care dental program are final and in production to ensure **DentaQuest**'s ability and capacity to manage the assigned membership. Additionally, **DentaQuest** will be expected to demonstrate implementation of its policies, procedures, and plans in future compliance activities.

Detailed findings, including recommendations for program enhancements, are documented in Appendix A.

Remediation Plan

DentaQuest was required to submit a remediation plan on May 11, 2026, for Operational readiness review elements determined to be *Not Accepted*. **DentaQuest** subsequently had to provide an updated remediation plan that was due on May 26, 2026. All *Not Accepted* elements are required to be successfully remediated prior to the program effective date of July 1, 2026. **DentaQuest**'s Operational remediation plans are located in Appendix B.

Table 1-4 presents the summary of results of the Operational readiness review assessment for **DentaQuest** upon completion of its remediation plans and supporting documents submitted as of May 26, 2026. Table 1-4 also lists the standards reviewed, the total number of elements (requirements) reviewed within each of the readiness review program areas (standards) that required remediation, the total number of elements *Accepted* and *Not Accepted* for each standard, and the overall number of elements with a score of *Accepted* and *Not Accepted*.

Table 1-4—Summary of Results for the Operational Readiness Review as of May 26, 2026

Standard		Elements/Requirements Assessed		
		Number of Elements	Accepted	Not Accepted
II	Member Rights and Member Information	12	12	0
III	Emergency and Poststabilization Services	6	6	0
IV	Availability of Services	4	3	1
V	Assurances of Adequate Capacity and Services	2	1	1
VI	Coordination and Continuity of Care	4	4	0
VII	Coverage and Authorization of Services	18	18	0
VIII	Provider Selection	2	2	0
X	Grievance and Appeal Systems	17	17	0
XI	Subcontractual Relationships and Delegation	2	2	0
XII	Practice Guidelines	3	3	0

Standard		Elements/Requirements Assessed		
		Number of Elements	Accepted	Not Accepted
XIII	Health Information Systems	This program area was assessed through the Information Systems Readiness Review.		
XIV	Quality Assessment and Performance Improvement Program	3	3	0
XV	Program Integrity	3	3	0
Total		76	74	2

Number of Elements = The total number of requirements included as part of each standard that were reviewed for readiness.

Accepted = The total number of elements within each standard that supported readiness.

Not Accepted = The total number of elements within each standard that did not support readiness.

HSAG reviewed **DentaQuest**'s remediation plan and supporting documentation and determined that **DentaQuest** demonstrated sufficient operations; however, **DentaQuest** has not successfully demonstrated a sufficient network as of May 29, 2026, to meet Iowa-specific network adequacy standards. Although **DentaQuest**'s network does not presently meet Iowa-specific network adequacy standards, it has a contingency plan, including strategies for use of single case agreements and a process for authorizing services and paying claims from non-network providers for a minimum of 90 days. Further, once the PAHP executes its pending contracts with the Federally Qualified Health Centers (FQHCs) and the University of Iowa Dental School, it will positively impact its network capacity. Therefore, HSAG recommends that HHS continue to closely monitor **DentaQuest**'s progress on closing network adequacy gaps to ensure member access to care.

DentaQuest's completed remediation plan and HSAG's acceptance of the remediation plan, including readiness status and recommendations for continued program enhancements, are documented in Appendix B.

Summary of Results for Information Systems Readiness Review

The Information Systems component of the readiness review assessed the PAHP's ability to manage and adjudicate a set of test claims, and to subsequently prepare encounters based on the adjudicated test cases. The Information Systems component also included an assessment of **DentaQuest**'s systems and processes in place to process and manage enrollment data, and to support performance measure reporting for the Iowa Medicaid and Iowa Hawki populations. As part of these assessments, HSAG reviewed **DentaQuest**'s responses within the completed Information Systems Capabilities Assessment Tool (ISCAT); documentation provided to support federal and state-specific requirements delineated within three Information Systems evaluation tools, called standards, as displayed in Table 1-5; and the outcomes observed through test claim scenarios.

Table 1-5 also presents the summary of results of the Information Systems readiness review assessment performed by HSAG for **DentaQuest** and lists the Information Systems standards reviewed, the total number of requirements reviewed within each of the systems-related program areas (standards), the

percentage of *Met* and *Not Met* elements for each individual program area, and the overall *Met* and *Not Met* percentages.

Table 1-5—Summary of Results for the Information Systems Readiness Review

Standard		Elements/Requirements Assessed			
		Number of Elements	Number <i>Met</i>	Number <i>Not Met</i>	Percent <i>Met</i>
I	Enrollment Systems	5	3	2	60%
II	Claims and Encounter Systems	4	1	3	25%
XIII	Health Information Systems	15	7	8	47%
Total		24	11	13	46%
Overall Percent <i>Met</i> (No Action Required)				46%	
Overall Percent <i>Not Met</i> (Action Required)				54%	

Number of Elements = The total number of requirements included as part of each standard that were reviewed for readiness.

Number *Met* = The total number of elements within each standard that supported readiness.

Number *Not Met* = The total number of elements within each standard that did not support readiness.

DentaQuest demonstrated readiness in 11 of 24 elements, and did not have an overall completion status of *Met* in any of the information systems standards, indicating that either the systems and/or documentation was not in place to effectively support **DentaQuest**'s readiness in these program areas. Twelve elements were determined as *Not Met*, indicating that **DentaQuest** had significant opportunities to improve its documentation and systems to adequately demonstrate system readiness. Detailed findings, including recommendations for system enhancements, are documented in Appendix C. Appendix D provides the test claim scenarios that were demonstrated by **DentaQuest** to support readiness in accepting and maintaining member enrollment data from HHS and to confirm system readiness to support accurate claims payment and complete encounter submissions.

Remediation Plan

DentaQuest was required to submit a remediation plan to remedy all Information Systems readiness review requirements determined to be *Not Met* prior to the program implementation effective date of July 1, 2026. **DentaQuest**'s Information Systems remediation plan is located in Appendix E.

Table 1-6 presents the summary of results of the Information Systems readiness review assessment upon completion of **DentaQuest**'s remediation plan, supporting documents, and system demonstrations reviewed as of May 29, 2026. Table 1-6 lists the Information Systems standards reviewed, the total number of elements (requirements) reviewed within each of the systems-related program areas (standards) that required remediation, the total number of elements *Accepted* and *Not Accepted* for each standard, and the overall number of elements with a score of *Accepted* and *Not Accepted*.

Table 1-6—Summary of Results for the Information Systems Readiness Review as of May 29, 2026

Standard		Elements/Requirements Assessed		
		Number of Elements	Accepted	Not Accepted*
I	Enrollment Systems	2	2	0
II	Claims and Encounter Systems	3	2	1
XIII	Health Information Systems	8	8	0
Total		13	12	1

* *Not Accepted* system-related elements must be remedied prior to enrolling members.

Number of Elements = The total number of requirements included as part of each standard that were reviewed for readiness.

Accepted = The total number of elements within each standard that supported readiness.

Not Accepted = The total number of elements within each standard that did not support readiness.

DentaQuest has one requirement that was *Not Accepted* in the Claims and Encounter Systems program areas; however, HHS and HSAG are meeting with **DentaQuest** on June 15, 2026, to confirm **DentaQuest's** claims-processing system is fully configured to meet Iowa Medicaid program requirements and that it has sufficient monitoring efforts in place to ensure manual process risks are mitigated.

Due to the significant degree of follow-up required for **DentaQuest** to articulate an understanding of HHS' requirements as well as the amount of attempts by **DentaQuest** to correctly process test claims in alignment with Iowa-specific guidance, HSAG recommends that **DentaQuest** assign a high degree of oversight specific to claims accuracy in accordance with HHS' expectations. **DentaQuest** should focus especially on providing this increased level of oversight during the first six months post-implementation to ensure any issues can be immediately addressed. The increased oversight should be further prioritized during any time period when adjustments are made in **DentaQuest's** claims processing system that impact claims payment, such as when prior authorization (PA) edits are implemented in production or when the provider network has significant increases.

DentaQuest's completed remediation plan and HSAG's acceptance of the remediation plan, including readiness status and recommendations for continued program enhancements, are documented in Appendix E.

Summary of Results for Financial Management Readiness Review

The Financial Management component of the readiness review assessed **DentaQuest's** readiness against a variety of standards including those established by the National Association of Insurance Commissioners (NAIC) in addition to an evaluation of readiness to meet the financial management requirements established by HHS and within the applicable subparts of Title 42 CFR. Table 1-7 presents the summary of results of the Financial Management readiness review assessment performed by HSAG for **DentaQuest** and lists the Financial Management standards reviewed, the total number of

requirements reviewed within each of the standards, the percentage of *Met* and *Not Met* elements for each individual standard and the overall *Met* and *Not Met* percentages.

Table 1-7—Summary of Results for the Financial Management Readiness Review

Standard		Elements/Requirements Assessed			
		Number of Elements	Number <i>Met</i>	Number <i>Not Met</i>	Percent <i>Met</i>
1	Financial Monitoring and Reporting	7	7	0	100%
2	Financial Solvency	5	5	0	100%
Total		12	12	0	100%
Overall Percent <i>Met</i> (No Action Required)				100%	
Overall Percent <i>Not Met</i> (Action Required)				0%	

Number of Elements = The total number of requirements included as part of each standard that were reviewed for readiness.

Number *Met* = The total number of elements within each standard that supported readiness.

Number *Not Met* = The total number of elements within each standard that did not support readiness.

DentaQuest demonstrated readiness in all elements, with an overall completion status of *Met* in the *Financial Monitoring and Reporting* and *Financial Solvency* standards, indicating the ability to meet its financial obligations and manage operations required under the Iowa Medicaid managed care dental program and its Contract with HHS.

Remediation Plan

DentaQuest was required to submit a remediation plan to remedy all Financial Management readiness review requirements determined to be *Not Met* prior to the program implementation effective date of July 1, 2026; however, as **DentaQuest** received *Met* scores across all standards and elements, a remediation plan was not required as noted in Appendix G.

2. Methodology

Readiness Review Process

The readiness review included an assessment of key program areas noted in 42 CFR §438.66(d)(4), which are presented in Table 2-1. The federal readiness review key program areas (i.e., Operations/Administration, Service Delivery, Financial Management, and Systems Management) and related requirements are delineated between three separate HSAG readiness review components—Operational, Information Systems, and Financial Management—which were evaluated simultaneously.

Table 2-1—Federal Readiness Review Areas

Federal Readiness Review Areas	
Operations/Administration	
Administrative Staffing and Resources	
Delegation and Oversight	
Member and Provider Communications	
Grievance and Appeals	
Member Services and Outreach	
Provider Network Management	
Program Integrity/Compliance	
Service Delivery	
Case Management/Care Coordination/Service Planning	
Quality Improvement	
Utilization Review	
Financial Management	
Financial Reporting and Monitoring	
Financial Solvency	
Systems Management	
Claims Management	
Encounter Data Management	
Enrollment Information Management	

HSAG will also assess the PAHP’s level of compliance with State and federal requirements, and its ability to provide the requested services to the State as set forth in the MEDIOMC27001 Contract with the PAHP. To accomplish this assessment, HSAG will evaluate the PAHP in all applicable program areas identified within Section 1.3.1.4 Readiness Review Key Deliverables and Content from the MED-22-003 External Quality Review Services Contract between HHS and HSAG through a comprehensive desk review and virtual site review process.

Table 2-2 provides a crosswalk that compares the federal readiness review requirements, State contract requirements, and federal standards applicable for compliance reviews under 42 CFR §438.358(b)(1)(iii) to the HSAG readiness review standards and tools.

Table 2-2—Readiness Review Requirements and Standards Crosswalk

438.66(d)(4) State Monitoring Requirements—Readiness Review Standards	Federal Standards Applicable for Compliance Reviews Under 438.358(b)(1)(iii)	HHS/PAHP Contract	HSAG Readiness Review Standards and Tools
Operations/Administration			
A. Administrative staffing and resources	Not applicable	- Written policies and procedures - Organizational structures (key personnel requirements) - Implementation plan	- Standard XIV—Quality Assessment and Performance Improvement Program - Staffing Checklist (Standard XIV) - Staff Training Checklist (Standard XIV)
B. Delegation and oversight of PAHP responsibilities	438.230 Subcontractual relationships and delegation	- Written policies and procedures - Subcontractor requirements	- Standard XI—Subcontractual Relationships and Delegation - Delegation File Review Tool (Standard XI)
C. Enrollee and provider communications	438.10 Information requirements - Subpart C—Enrollee Rights and Protections 438.100 Enrollee rights 438.102 Provider-enrollee communications 438.104 Marketing activities 438.106 Liability for payment 438.114 Emergency and poststabilization services	- Written policies and procedures - Member rights, materials, and services - Marketing materials and activities - Member handbook	- Standard II—Member Rights and Member Information - Standard VII—Coverage and Authorization of Services - Standard VIII—Provider Selection - Provider Manual Checklist (Standard VIII) - Member Handbook Checklist (Standard II) - Marketing Checklist (Standard II) - New Member Communications Checklist (Standard II)

438.66(d)(4) State Monitoring Requirements—Readiness Review Standards	Federal Standards Applicable for Compliance Reviews Under 438.358(b)(1)(iii)	HHS/PAHP Contract	HSAG Readiness Review Standards and Tools
			• Provider Directory Checklist (Standard II) • Member Rights Checklist (Standard II)
D. Grievance and appeals	• Subpart F—Grievance and Appeal System – 438.400 Definitions – 438.402 General requirements – 438.404 Timely and adequate notice of adverse benefit determination – 438.406 Handling of grievances and appeals – 438.408 Resolution and notification: Grievances and appeals – 438.410 Expedited resolution of appeals – 438.414 Information about the grievance and appeal system to providers and subcontractors – 438.416 Recordkeeping requirements – 438.420 Continuation of benefits while appeal and the State fair hearing are pending – 438.424 Effectuation of reversed appeal resolutions	• Written policies and procedures • Maintenance of records • Grievances, appeals, and State fair hearings	• Standard VII—Coverage and Authorization of Services • Standard X—Grievance and Appeal Systems

438.66(d)(4) State Monitoring Requirements—Readiness Review Standards	Federal Standards Applicable for Compliance Reviews Under 438.358(b)(1)(iii)	HHS/PAHP Contract	HSAG Readiness Review Standards and Tools
E. Member services and outreach	438.10 Information requirements 438.56 Disenrollment: Requirements and limitations	- Written policies and procedures - Enrollment discrimination - Member disenrollment - Marketing - Member communications - Member services hotline - Electronic communications - Member website - Member rights - Redetermination assistance - Implementation support	- Standard II—Member Rights and Member Information - Standard I—Disenrollment Requirements and Limitations - Member Handbook Checklist (Standard II) - Member Services Helpline Checklist (Standard II) - Marketing Checklist (Standard II) - New Member Communications Checklist (Standard II) - Provider Directory Checklist (Standard II)
F. Provider network management	438.12 Provider discrimination prohibited 438.206 Availability of services 438.207 Assurances of adequate capacity and services 438.214 Provider selection	- Written policies and procedures - Covered benefits - Network development and adequacy - Requirements by provider type - Provider network reports and performance targets	- Standard IV—Availability of Services - Standard V—Assurances of Adequate Capacity and Services - Standard VIII—Provider Selection - Provider Contract Checklist (Standard VIII) - Provider Manual Checklist (Standard VIII) - Credentialing File Review Tool (Standard VIII) - Provider Directory Checklist (Standard II) - Appointment Times Checklist - Network Adequacy Checklist

438.66(d)(4) State Monitoring Requirements—Readiness Review Standards	Federal Standards Applicable for Compliance Reviews Under 438.358(b)(1)(iii)	HHS/PAHP Contract	HSAG Readiness Review Standards and Tools
G. Program integrity/compliance	• 438.224 Confidentiality • 438.608 Program integrity requirements • 438.610 Prohibited affiliations	• Written policies and procedures • Maintenance of records • Disclosures • Confidentiality of member medical records and other information, including HIPAA compliance • General requirements and authorities • Program integrity plan (compliance program) • Required fraud and abuse activities • Reporting fraud and abuse • Coordination and program integrity efforts • Verification of services provided • Obligation to suspend payments to providers • Required provider ownership and control disclosures • Contractor reporting obligations for adverse actions taken on provider • Applications for program integrity reasons • Enforcement of Iowa Medicaid managed care program rules	• Standard IX—Confidentiality • Standard XV—Program Integrity

438.66(d)(4) State Monitoring Requirements—Readiness Review Standards	Federal Standards Applicable for Compliance Reviews Under 438.358(b)(1)(iii)	HHS/PAHP Contract	HSAG Readiness Review Standards and Tools
Service Delivery			
A. Case management/care coordination/service planning	438.208 Coordination and continuity of care 438.224 Confidentiality	- Written policies and procedures - Maintenance of records - Continuity of care - Care coordination	- Standard VI—Coordination and Continuity of Care - Standard XII—Practice Guidelines - Care Coordination Checklist (Standard VI) - Clinical Records Checklist (Standard VI)
B. Quality improvement	438.330 Quality assessment and performance improvement program	- Written policies and procedures - Contractor quality management/quality improvement (QM/QI) program - Population health - Provider preventable conditions - Quality management reports and performance targets	Standard XIV—Quality Assessment and Performance Improvement Program
C. Utilization review	438.114 Emergency and poststabilization services 438.210 Coverage and authorization of services 438.236 Practice guidelines	- Written policies and procedures - Maintenance of records - Utilization management program - Prior authorization (PA) - Utilization reports and performance targets	- Standard VII—Coverage and Authorization of Services - Standard XII—Practice Guidelines
Financial Management			
A. Financial reporting and monitoring	438.116 Solvency Standards	Financial reports and performance targets	DentaQuest Financial Management Readiness Review Tool
B. Financial solvency			

438.66(d)(4) State Monitoring Requirements—Readiness Review Standards	Federal Standards Applicable for Compliance Reviews Under 438.358(b)(1)(iii)	HHS/PAHP Contract	HSAG Readiness Review Standards and Tools
Systems Management			
A. Claims management	438.242 Health information systems	- Information system services - Contingency and continuity planning - Data exchange - Claims processing - Encounter claims submission - Third party liability processing - Health information technology - Claims reports and performance targets	- Standard XIII—Health Information Systems - Information Systems Standards I and II—Enrollment Systems and Claims and Encounter Systems - ISCAT - Claims scenarios testing
B. Encounter data and enrollment information management			

Table 2-3 provides the timeline and key dates for **DentaQuest**’s readiness review, which included a desk review and a virtual site review.

Table 2-3—Key Readiness Review Dates

Key Readiness Review Dates	
Task Description	Date
HSAG provides Readiness Review information packet to PAHP (Submissions Requirements Checklist; Questionnaire; Operational, Information Systems, and Financial Management tools; Post Site Review Documentation Tracker; and Agenda)	1/16/2026
HSAG hosts webinar with PAHP	1/20/2026
PAHP uploads universe files for credentialing and delegation file reviews to HSAG’s Secure Access File Exchange (SAFE) site	1/23/2026
HSAG uploads sample selections for credentialing and delegation file reviews to SAFE for PAHP retrieval	1/26/2026
PAHP uploads completed tools, questionnaire, supporting documents (including provider network adequacy status), and case file review documentation for credentialing and delegation file reviews to SAFE	2/27/2026
HSAG conducts virtual site reviews with PAHP	3/17/2026–3/19/2026; 3/23/2026; 4/20/2026; 5/28/2026; 6/15/2026

Key Readiness Review Dates	
Task Description	Date
PAHP conducts ongoing remediation of noted deficiencies and submits periodic updated provider network adequacy status/supporting evidence to HSAG/HHS.	3/25/2026— Implementation

Please refer to Appendix J for the complete timeline of readiness review activities and agenda items for each virtual site review.

Methods for Data Collection

To support the readiness review process, HSAG developed multiple data collection tools to document findings from the desk review and virtual site review. To obtain comprehensive information about **DentaQuest**, HSAG developed the PAHP Readiness Review Questionnaire that **DentaQuest** completed with information about its overall organization structure and processes, including:

- Full name and physical address of the Iowa PAHP.
- Key contact information.
- Primary staff members accountable for each program area under review.
- Evidence that the PAHP is licensed and in good standing in the State of Iowa as a health maintenance organization (HMO) in accordance with Iowa Administrative Code (IAC) Chapter 191-40 and Contract A.02.
- The PAHP's implementation plan for the Iowa Medicaid managed care dental program.
- Provider network onboarding plan.
- High-level organizational chart depicting the names, credentials, and positions of the key staff responsible for the Contract with HHS.
- Description of **DentaQuest**'s training program and the process for training staff members responsible for managing Iowa Medicaid and Iowa Hawki populations.

The PAHP Readiness Review Questionnaire also required **DentaQuest** to provide the following information for each program area under review:

- Organizational chart and key staff members, including the number of full-time equivalents assigned to the Iowa Medicaid managed care dental program.
- Delineation of responsibilities between corporate staff and state-level staff.
- Process for assessing the need for additional staffing and resources to accommodate the Iowa Medicaid and Iowa Hawki populations.
- Recruitment strategies for additional staffing and resources, including the name and number of new positions and how many of those positions had been filled versus those that were still vacant.
- Process for evaluating the sufficiency of staffing and resources after program implementation on July 1, 2026.

- The PAHP's contingency plan for unfilled positions.
- System(s) used to maintain data (e.g., enrollment and disenrollment information, grievances, appeals, service authorization denials).
- High-level overview of the program area's processes.
- List of subcontractors/delegated entities responsible for managed care contract requirements, and the functions or activities being delegated.

The completed PAHP Readiness Review Questionnaire is located in Appendix H.

HSAG also developed a set of data collection tools that included all Medicaid managed care standards required under 42 CFR §438.358 (b)(1)(iii) and the requirements related to operations/administration, service delivery, information systems, and financial management areas delineated under 42 CFR §438.66 (d)(4). These tools included 17 standard tools (14 Operational and three Information Systems), 14 checklist reviews, three case file review tools that supported readiness with the elements under review in the Operational standards, an ISCAT and test claims scenarios worksheet to document system readiness, and one Financial Management tool with two standards and a *Requested Files* table. Each completed standard tool is located in appendices A, C, and F.

The PAHP Readiness Review Questionnaire, located in Appendix H, was provided to **DentaQuest** for completion, which provided HSAG with pertinent information about the PAHP's organization, staffing and resources, systems, and contingency plans.

A Submission Requirements Checklist was also provided to **DentaQuest** that described the readiness review activities and timeline; logistical requirements; data submission requirements; and an overview of each tool used to document readiness review findings, including the expectations for **DentaQuest** to provide supporting evidence to confirm readiness in each program area under review. A technical assistance webinar with **DentaQuest** was conducted to walk through the readiness review expectations and data collections tools, and to provide the PAHP the opportunity to ask questions.

Description of Data Obtained

To assess **DentaQuest**'s ability and capacity to perform managed care activities consistent with federal regulations, HSAG obtained information from a wide range of written documents completed or produced by **DentaQuest**, including, but not limited to, the following:

- Organizational questionnaire
- Staffing structure and staffing/hiring plan
- Training plan and training agendas
- ISCAT
- Program area-specific policies, procedures, processes, descriptions, and workflows
- Provider materials, including the provider manual and contract templates

- Member materials, including the member handbook, notice templates, and provider directory
- Sample reports across a broad range of performance and content areas
- Network adequacy data and information, including contracting/credentialing status
- Financial reports and attestations

HSAG obtained additional information for the readiness review through interactive discussions and interviews with **DentaQuest** key staff members and system demonstrations of key program areas such as the following:

- Customer service/call center
- Enrollment
- Case management
- Utilization management (service authorizations)
- Credentialing
- Grievances and appeals
- Claims/encounters (storage and processing)
- Provider network management (fee schedule maintenance, provider directory)
- Program integrity (HIPAA violations and fraud/abuse tracking applications)

The findings from the desk review and the virtual site reviews were documented within the data collection tools.

Readiness Review Activities

To complete the readiness review, HSAG conducted pre-site review, virtual site review, and post-site review activities.

Pre-site review activities included:

- Developing the questionnaire, data requests, and readiness review data collection tools.
- Preparing and forwarding to the PAHP an introduction and submission requirements document with instructions for submitting requested documentation to HSAG for its desk review.
- Scheduling the virtual site reviews.
- Conducting a readiness review preparation webinar.
- Conducting a desk review of documents. HSAG conducted a desk review of the information obtained from the PAHP. The desk review enabled HSAG reviewers to increase their knowledge and understanding of the PAHP's operations, identify areas needing clarification, and begin compiling information before each virtual site review.
- Developing an agenda for the initial three-day virtual site review.

Virtual site review activities included:

- Facilitating an opening conference, with introductions and a review of the agenda and logistics for HSAG's virtual site review activities.
- Interviewing PAHP key administrative and program staff members. HSAG and PAHP staff members participating in the interview sessions were required to be on camera to facilitate face-to-face interactive discussions.
- Reviewing the PAHP's data systems used in its operations.
- Reviewing the PAHP's test claims scenarios to observe the outcomes.
- After the initial three-day virtual site review, adding a subsequent one-day virtual site review and providing an updated agenda to the PAHP.
- After the subsequent one-day virtual site review, adding three additional one-day virtual site reviews and providing agendas to the PAHP.
- Facilitating a closing conference during which HSAG reviewers summarized their preliminary findings.

Post-site review activities: HSAG reviewers aggregated findings to produce this readiness review report. In addition, HSAG created remediation plan templates for the PAHP to detail its plans to remedy the deficiencies noted. The readiness review data collection tools contained the findings and recommendations for each requirement found to be *Not Met* during the readiness review. The PAHP was required to use the HSAG-developed remediation plan templates to submit its plans to HSAG and HHS to remediate all requirements scored *Not Met*. The criteria used in evaluating the sufficiency of the remediation plan were:

- The completeness of the remediation plan in addressing each required action and assigning a responsible individual, a timeline/completion date, and specific actions/interventions that the organization has taken or will take.
- The degree to which the planned activities/interventions met the intent of the requirement.
- The appropriateness of the timeline for correcting the deficiency.

Although HSAG evaluated the PAHP's remediation plans and provided recommendations to the PAHP and HHS, HHS maintains ultimate authority for determining the PAHP's readiness to provide services to Iowa Medicaid members effective July 1, 2026.

Data Aggregation and Analysis

From a review of documents, observations, and interviews with key staff during the readiness review, HSAG reviewers assigned a score for each requirement within a program area as *Met* or *Not Met* (Operational and Information Systems components only).

HSAG's scoring included the following:

- **Met** indicates full compliance defined as *all* of the following:
 - All documentation was present.
 - The documentation (whether it was a policy, procedure, diagram, or some other form of communication) contained sufficient information to ascertain how the PAHP met this requirement.
 - The documentation included appropriate identification that signified the functional area(s) or organization(s) responsible for carrying out the specifics outlined in the document.
 - Staff members provided responses consistent with the policies and/or processes described in documentation.
- **Not Met** indicates noncompliance defined as *one or more* of the following:
 - A portion of the documentation was unclear or contained conflicting information that did not address the regulatory requirements.
 - The documentation (whether it was a policy, procedure, diagram, or some other form of communication) did not contain the information needed to ascertain how the PAHP met this requirement.
 - The documentation did not have the appropriate identification that signified the functional area(s) or organization(s) responsible for carrying out the specifics outlined in the document.
 - Staff members had little or no knowledge of processes or issues addressed by the regulatory and/or contractual provisions.
 - For those provisions with multiple components, key components of the provision could not be identified and any *Not Met* findings would result in an overall finding of *Not Met*, regardless of the findings noted for the remaining components.

The overall readiness review findings for each program area and systems reviewed were subsequently documented within this Iowa CY 2026 PAHP Readiness Review Report for submission to the Centers for Medicare & Medicaid Services (CMS) to support the State's obligations under 42 CFR §438.66(d)(2)(iii) and 42 CFR §438.3(a).

Appendix A. Operational Readiness Review Standards

Standards

Standard I—Disenrollment: Requirements and Limitations

Standard I—Disenrollment: Requirements and Limitations		
Requirement	Supporting Documentation	Score
Disenrollment Requested by the PAHP		
1. The PAHP may request disenrollment of a member when the member's continued enrollment seriously impairs the PAHP's ability to furnish services to the enrolled member or other enrolled members. 42 CFR §438.56(b)(1) 42 CFR §457.1212 Contract B.5.01 Contract B.5.02(d)	HSAG Required Evidence: • Policies and procedures • Member materials, such as the member handbook • Staff training materials Evidence as Submitted by the PAHP: • SI_COM-FED-01-INS-Disenrollment Requirements and Limitations <Page 1 Policy I.b> • SI_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft_2.27.26 • SI_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26	☒ Met ☐ Not Met
PAHP Description of Process: The member handbook is currently in development and is projected to be completed by the IA HHS due date of 3/16/26. DentaQuest will ensure member disenrollment information is referenced in the Member Handbook by date requested by HHS. Staff Training materials are currently under development. They will be submitted by May 1st.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: While not specific to this element but the entire standard, HSAG strongly recommends that the PAHP incorporate Iowa-specific disenrollment requirements within its staff training materials to ensure staff awareness.		
Required Actions: None.		

Standard I—Disenrollment: Requirements and Limitations		
Requirement	Supporting Documentation	Score
2. The PAHP does not request disenrollment because of: a. An adverse change in the member’s health status. b. The member’s utilization of medical [dental] services. c. The member’s diminished mental capacity. d. Uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the PAHP seriously impairs the PAHP’s ability to furnish services to either this particular member or other members). 42 CFR §438.56(b)(2) 42 CFR §457.1212 Contract B.5.02	HSAG Required Evidence: • Policies and procedures • Staff training materials	☒ Met ☐ Not Met
	Evidence as Submitted by the PAHP: • SI_COM-FED-01-INS-Disenrollment Requirements and Limitations <Page 1 Policy I.a.>	
PAHP Description of Process: Staff Training materials are currently under development. They will be submitted by May 1st.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
3. The PAHP assures HHS that it does not request disenrollment for reasons other than those permitted under the contract. <i>At minimum:</i> a. <i>The PAHP’s request documents that reasonable steps were taken to educate the member regarding proper behavior and the member refused to comply.</i> b. <i>The PAHP has methods by which HHS is assured that disenrollment is not requested for another reason.</i> c. <i>HHS retains sole authority for determining if this condition has been met and whether disenrollment will be approved.</i> 42 CFR §438.56(b)(3)	HSAG Required Evidence: • Policies and procedures • Workflow delineating HHS and PAHP responsibilities for PAHP-initiated disenrollment requests • Staff training materials	☒ Met ☐ Not Met
	Evidence as Submitted by the PAHP: • SI_NET13-INS-Involuntary Disenrollment <Procedure A. 1,2,3>	

Standard I—Disenrollment: Requirements and Limitations		
Requirement	Supporting Documentation	Score
42 CFR §457.1212 Contract B.5.03		
PAHP Description of Process: Staff Training materials are currently under development. Member education will be included in the final product. They will be submitted by May 1st.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
Disenrollment Requested by the Member		
4. The member may request disenrollment from the PAHP as follows: a. For cause, at any time. b. Without cause, at the following times: i. During the 90 days following the date of the member’s initial enrollment into the PAHP, or during the 90 days following the date HHS sends the member notice of that enrollment, whichever is later. ii. At least once every 12 months thereafter. iii. Upon automatic enrollment under 42 CFR § 438.56(g), if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity. iv. When HHS imposes the intermediate sanction specified in § 438.702(a)(4)—suspension of all new enrollment, including default enrollment, after the date the Secretary or HHS notifies the PAHP of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Act. 42 CFR §438.56(c) 42 CFR§438.56(g) 42 CFR §438.702(a)(4)	HSAG Required Evidence: • Policies and procedures • Member materials, such as the member handbook • Staff training materials Evidence as Submitted by the PAHP: • SI_COM-FED-01-INS- Disenrollment Requirements and Limitations<Page 1 Policy II a,> • SI_COM-FED-01-INS- Disenrollment Requirements and Limitations<Page 1 Policy II b> • SI_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft_2.27.26 • SI_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26	☒ Met ☐ Not Met

Standard I—Disenrollment: Requirements and Limitations		
Requirement	Supporting Documentation	Score
42 CFR §457.1212 Contract B.5.05		
PAHP Description of Process: The member handbook is currently in development and is projected completion by the IA HHS due date of 3/16/26.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Recommendations: While the DWP Adults, DWP Kids, and Hawki member handbooks included the reasons a member may request disenrollment, disenrollment is referred to as “end of care,” which may be confusing to members. HSAG strongly recommends that the PAHP consider alternative language to describe the disenrollment process other than “end of care.”		
Required Actions: None.		
Procedures for Disenrollment		
5. The following are causes for disenrollment: - The member moves out of the PAHP’s service area. - The plan does not, because of moral or religious objections, cover the service the member seeks. - The member needs related services be performed at the same time; not all related services are available within the provider network; and the member’s primary care provider (PCP) or another provider determines that receiving the services separately would subject the member to unnecessary risk. - For other reasons, including poor quality of care, lack of access to services covered under the Contract, or lack of access to providers experienced in dealing with the member’s care needs. 42 CFR §438.56(d)(2) 42 CFR §457.1212 Contract B.5.07–B.5.10	HSAG Required Evidence: - Policies and procedures - Member materials, such as the member handbook - Staff training materials Evidence as Submitted by the PAHP: - SI_COM-FED-01-INS-Disenrollment Requirements and Limitations<Pages 1,2 Policy III b> - SI_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft_2.27.26 - SI_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26	☒ Met ☐ Not Met
PAHP Description of Process: The member handbook is currently in development and is projected completion by the IA HHS due date of 3/16/26.		

Standard I—Disenrollment: Requirements and Limitations		
Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
6. The member (<i>or his or her representative</i>) must request disenrollment by submitting an oral or written request. a. <i>The member must seek redress through the PAHP's grievance process before a determination will be made on a disenrollment request.</i> b. <i>If the member remains dissatisfied with the result of the grievance process, the PAHP directs the member to contact HHS and request disenrollment from the PAHP.</i> c. <i>HHS will make the final disenrollment determination following completion of the PAHP's grievance process.</i> Note: If HHS fails to make a disenrollment determination within the specified timeframes (i.e., the first day of the second month following the month in which the member requests disenrollment or the PAHP refers the request to HHS), the disenrollment is considered approved for the effective date that would have been established had HHS made a determination in the specified timeframe. 42 CFR §438.56(d)(1) 42 CFR §457.1212 Contract B.6.01–B.6.04	HSAG Required Evidence: • Policies and procedures • Member materials, such as the member handbook • Workflow delineating HHS and PAHP responsibilities for member-initiated disenrollment requests • Grievance resolution notice template for member disenrollment requests • Staff training materials Evidence as Submitted by the PAHP: • SI_COM-FED-01-INS-Disenrollment Requirements and Limitations<Pages 1,2 Policy III d and III e.> • SI_NET13-INS-Involuntary Disenrollment <Full Document> • SI_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft_2.27.26 • SI_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26	☒ Met ☐ Not Met
PAHP Description of Process: The member handbook is currently in development and is projected completion by the IA HHS due date of 3/16/26.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		

Standard I—Disenrollment: Requirements and Limitations						
Met	=	6	X	1	=	6
Not Met	=	0	X	0	=	0
Total	=	6	Total Score		=	6
Total Score ÷ Total					=	100%

Standard II—Member Rights and Member Information

Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
General Rule		
1. The PAHP has written policies regarding member rights. 42 CFR §438.100(a)(1) 42 CFR §457.1220 Contract F.16.01–F.16.08	HSAG Required Evidence: - Member rights policy Evidence as Submitted by the PAHP: - SII_COM-FED-02-Enrollee Rights <full document> - SII_DQ3197 IA_Medicaid Adult (7.26) HBEN - SII_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 - SII_MKT01-INS-Marketing Safeguards-FINAL	☒ Met ☐ Not Met
PAHP Description of Process: HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: HSAG recommends that the PAHP incorporate all member rights into the PAHP's <i>COM-FED-02-Enrollee Rights</i> policy.		
Required Actions: None.		
2. The PAHP complies with any applicable Federal and State laws that pertain to member rights and ensures that its employees and contracted providers observe and protect those rights. 42 CFR §438.100(a)(2) 42 CFR §457.1220 Contract J.2.02	HSAG Required Evidence: - Policies and Procedures - Provider materials, such as the provider manual, provider contract, and provider training materials - Employee training materials - Auditing/oversight mechanisms - Grievance log Evidence as Submitted by the PAHP: - SII_COM-FED-02-Enrollee Rights <full document> - SII_Provider Reference Manual <Pg 2 Bill of rights> - SII_DQ3197 IA_Medicaid Adult (7.26) HBEN - SII_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26	☒ Met ☐ Not Met

Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
PAHP Description of Process: HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: HSAG recommends that the PAHP ensure it is training its employees and contracted providers on members rights, including state-specific member rights. Additionally, HSAG recommends that the PAHP place all its members’ rights, including state-specific member rights, in one location within the <i>COM-FED-02-Enrollee Rights</i> policy.		
Required Actions: None.		
Specific Rights		
3. The PAHP complies with the requirements listed in the Member Rights Checklist. 42 CFR §438.100(b-d) 42 CFR §457.1220 Contract C.2.12- C.2.13 Contract F.16	HSAG Required Evidence: • Policies and Procedures • Member materials, such as the member handbook • Section 1557 Language Access Provisions • HSAG will use the results of the Member Rights Checklist Evidence as Submitted by the PAHP: • SII_DQ3197 IA_Medicaid Adult (7.26) HBEN • SII_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26	☐ Met ☒ Not Met
PAHP Description of Process: HSAG Findings: The PAHP’s <i>Marketing Safeguards</i> policy included information related to members’ right to “privacy and to be treated with respect and recognition of their dignity when receiving dental care,” and its member handbooks (i.e., DWP Adults, DWP Kids, and Hawki) informed members they have the right to be treated with respect and have their information kept private; however, the PAHP’s policies and member handbooks did not specify that the PAHP will not in any way restrict the member’s right to fully participate in the community and to work, live, and learn to the fullest extent possible. Recommendations: Although the PAHP’s policy included information on member rights related to receiving information on available treatment options, HSAG recommends that the PAHP update its <i>Marketing Safeguards</i> policy and its member handbooks to specify that members also have the right to receive information on alternatives. Following the site review, the PAHP provided its member handbooks and cited information related to members obtaining rides to their dental appointments; however, it was unclear to HSAG how these sections were related to this recommendation. Additionally, HSAG recommends that the PAHP clarify in its policies and member handbooks that members have the right to receive a copy of his or her <i>dental</i> records, rather than “medical records.” Further, HSAG strongly recommends that the PAHP ensure that all applicable member rights are consolidated in its “Rights		

Standard II—Member Rights and Member Information

Requirement	Supporting Documentation	Score
and Responsibilities” section of its member handbooks as HSAG noted information related to member rights throughout several sections of the member handbooks. Lastly, although the PAHP included language in its member handbook related to ensuring its members have the right to be furnished healthcare services in accordance with 42 CFR §438.206 through §438.210, HSAG recommends that the PAHP expand upon this member right in the PAHP’s member handbook, as well as in any applicable policies, procedures, or provider contracts. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Add Requirement #10 of HSAG’s <i>Member Rights Checklist</i> to policies and procedures.		
Information Requirements		
4. The PAHP provides all required information referenced in 42 CFR §438.10 to members and potential members in a manner and format that may be easily understood and is readily accessible by members and potential members. “Readily accessible” means electronic information and services which comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C’s Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions. 42 CFR §438.10(c)(1) 42 CFR §457.1207 Contract C.1.01	HSAG Required Evidence: - Policies and Procedures - Member materials, such as the member handbook, provider directory, member notices, etc. - Mechanism to assess reading level of member materials and supporting evidence (e.g., screenshots of reading level of member materials) - Proof of website accessibility (e.g., assessment or testing of accessibility features of website and confirmation of Section 508 compliance) Evidence as Submitted by the PAHP: - SII_MKT04-Health Literacy <Pg 2-3 Procedure B 1> - SII_DQ3197 IA_Medicaid Adult (7.26) HBEN - SII_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 - SII_Reading Level_Iowa CHIP_Welcome Letter_2-26-26 - SII_Reading Level_Iowa Medicaid_Welcome Letter_2-26-26	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		

Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
5. The PAHP uses the definitions for managed care terminology developed by HHS including: a. Appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. 42 CFR §438.10(c)(4)(i) 42 CFR §457.1207 Contract C.8.07-C.8.08 Contract Exhibit B	HSAG Required Evidence: • Policies and procedures • Member materials, such as the member handbook	☐ Met ☒ Not Met
	Evidence as Submitted by the PAHP: • SII_DQ3197 IA_Medicaid Adult (7.26) HBEN • SII_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26	
PAHP Description of Process: This is a stand-alone dental plan.		
HSAG Findings: HSAG could not find all the required definitions for managed care terminology as required by 42 CFR §438.10(c)(4)(i) and HHS’ <i>Exhibit B: Glossary of Terms/Definitions</i> . During the review, the PAHP indicated it would update the draft versions of the <i>DQ3197 IA_Medicaid Adult (7.26) HBEN</i> and <i>DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26</i> member handbooks. Following the review, the PAHP provided the DWP Adults, DWP Kids, and Hawki member handbooks; however, the updated member handbooks did not include all the required definitions for managed care terminology. Recommendations: HSAG strongly recommends that the PAHP include the list of required definitions for managed care terminology as required by 42 CFR §438.10(c)(4)(i) and HHS’ <i>Exhibit B: Glossary of Terms/Definitions</i> in its policies and procedures.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: • Include all required definitions for managed care terminology as required by 42 CFR §438.10(c)(4)(i) and HHS.		

Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
6. The PAHP uses HHS-developed model member handbooks and member notices, <i>if applicable</i>. 42 CFR §438.10(c)(4)(ii) 42 CFR §457.1207 Contract C.2.01 Contract C.8.11	HSAG Required Evidence: • Policies and Procedures • Member materials, such as the member handbook • Member notice templates, such as adverse benefit determination (ABD) notices, grievance and appeal letter templates Evidence as Submitted by the PAHP: • SII_DQ3197 IA_Medicaid Adult (7.26) HBEN • SII_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
Language and Format		
7. The PAHP makes its written materials that are critical to obtaining services, including at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in its service areas. a. Written materials that are critical to obtaining services are also made available in alternative formats upon request of the member or potential member at no cost. b. Written materials that are critical to obtaining services include 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. <i>Taglines also include</i>	HSAG Required Evidence: • Policies and procedures • Provider directory in English, including taglines • Provider directory in prevalent non-English languages, including taglines • Member handbook in English, including taglines • Member handbook in prevalent non-English languages, including taglines • Examples of member notices in English, including taglines (i.e., appeal, grievances, and ABD notices) • Examples of member notices in prevalent non-English languages (i.e., appeal, grievances, and ABD notices), including taglines	☐ Met ☒ Not Met

Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
<i>teletypewriter telephone/text Telephone (TTY/TDY) telephone number of the PAHP’s member/customer service unit.</i> c. Written materials that are critical to obtaining services include information on how to request auxiliary aids and services. d. Written materials that are critical to obtaining services include the toll-free and TTY/TDY telephone number of the PAHP’s member/customer services unit. e. Auxiliary aids and services must be made available upon request of the member or potential member at no cost. “Prevalent languages” means English and Spanish, and any language spoken by at least five percent of the general population in the PAHP’s service area. 42 CFR §438.10(d)(3) 42 CFR §457.1207 Contract C.1.19-C.1.22 Contract C.1.24(c) Contract C.1.27(b)	- Definition of conspicuously visible font - Mechanisms to ensure taglines are included as part of all critical member materials Evidence as Submitted by the PAHP: - SII_DQ3197 IA_Medicaid Adult (7.26) HBEN - SII_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 - SII_Reading Level_Iowa CHIP_Welcome Letter_2-26-26 - SII_Reading Level_Iowa Medicaid_Welcome Letter_2-26-26 - SII_Checklist_MKT03-INS-COMM-Member Communications Distribution	
PAHP Description of Process: The Member handbook is in development and is projected to be completed by the IA HHS due date of March 16, 2026. The ABD notices are still being developed and drafts are currently unavailable. DentaQuest will be able to provide drafts as a follow-up from the Virtual Review.		
HSAG Findings: HSAG’s review identified the findings below: - HSAG could not confirm the font size of the taglines within the <i>DQ3197 IA_Medicaid Adult (7.26) HBEN</i> and <i>DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26</i> member handbooks as the taglines were in a picture format; however, the taglines did appear to be in a small font size. The PAHP provided the <i>IA Medicaid MLI</i> document that was different than what was included in the member handbooks. - During the review, the PAHP confirmed the definition of conspicuously visible font was “...as well as large print of no less than 18-pt font size,” that was referenced on page 10 of the <i>MKT04-Health Literacy</i> policy and procedure. Following the review, the PAHP provided the DWP Adults, DWP Kids, and Hawki member handbooks; however, in the updated member handbooks, the taglines and customer service telephone number were in 12-point font size. These taglines did not align with the <i>IA Medicaid MLI</i> document that was provided as follow-up that had the taglines in 18-point font size and the customer service number in 14-point font size.		

Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
The PAHP provided the <i>CORR06-INS Letter Template Translation and Alternate Format</i> policy and procedure, which indicated “MLI contains statements for how the member can request the document translated into a non-English language or alternate format, and includes the phone number to call to make the request. i. Content in the MLI is also included in a conspicuously visible font size.” This did not provide clarity on the definition of conspicuously visible font and could potentially cause confusion for staff members as the <i>MKT04-Health Literacy</i> policy and procedure indicates an 18-point font and staff members may not be aware to go to both policies to identify the PAHP’s definition of conspicuously visible font.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Provide evidence, including updated member handbooks, to support that its written materials critical to obtaining services include taglines in accordance with 42 CFR §438.10(d)(3) and the requirements of this element. - Provide updated policies and procedures that demonstrate alignment of the definition of conspicuously visible font.		
8. The PAHP makes interpretation services available to each member free of charge. a. This includes oral interpretation and the use of auxiliary aids such as TTY/TDY and American Sign Language (ASL). b. Oral interpretation requirements apply to all non-English languages, not just those that HHS identifies as prevalent. 42 CFR §438.10(d)(4) 42 CFR §457.1207 Contract C.1.23	HSAG Required Evidence: - Policies and procedures - Executed interpretation services (oral and written) contract(s) - Workflow for obtaining oral interpretation services	☒ Met ☐ Not Met
	Evidence as Submitted by the PAHP: - SII_DQ3197 IA_Medicaid Adult (7.26) HBEN - SII_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 - SII_Reading Level_Iowa CHIP_Welcome Letter_2-26-26 - SII_Reading Level_Iowa Medicaid_Welcome Letter_2-26-26	
PAHP Description of Process: The Member handbook is in development and is projected to be completed by the IA HHS due date of March 16, 2026		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
9. The PAHP notifies members: a. That oral interpretation is available for any language and written translation is available in prevalent languages; b. That auxiliary aids and services are available upon request and at no cost for members with disabilities; and	HSAG Required Evidence: - Policies and procedures - Member materials, such as the member handbook	☒ Met ☐ Not Met
	Evidence as Submitted by the PAHP:	

Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
c. How to access these services. 42 CFR §438.10(d)(5) 42 CFR §457.1207 Contract C.1.24	- SII_DQ3197 IA_Medicaid Adult (7.26) HBEN - SII_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 - SII_Reading Level_Iowa CHIP_Welcome Letter_2-26-26 - SII_Reading Level_Iowa Medicaid_Welcome Letter_2-26-26	
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
10. The PAHP provides all written materials for potential members and members consistent with the following: a. Use easily understood language and format. b. Use a font size no smaller than 12 point. c. Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of members or potential members with disabilities or limited English proficiency. “Limited English proficient (LEP)” means potential members and members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter. 42 CFR §438.10(d)(6) 42 CFR §457.1207 Contract C.1.25 Contract C.1.27	HSAG Required Evidence: - Policies and procedures - Member handbook - Provider directory - Member notices (in Microsoft Word), including an ABD notice, grievance resolution notice, and appeal resolution notice - Mechanisms to assess reading grade level of member materials and supporting evidence (e.g., screenshots of reading grade level of member materials) - Tracking or reporting mechanism on use of interpretation services and auxiliary aids and services Evidence as Submitted by the PAHP: - SII_MKT04-Health Literacy - SII_DQ3197 IA_Medicaid Adult (7.26) HBEN - SII_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 - SII_Reading Level_Iowa CHIP_Welcome Letter_2-26-26 - SII_Reading Level_Iowa Medicaid_Welcome Letter_2-26-26	☒ Met ☐ Not Met

Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
	SII_DQ3181 IA State Medicaid_Welcome Letter-ID Card_DH_EN_SP (2.26)_DRAFT_2-6-26	
PAHP Description of Process: The ABD and member notices are still being developed and drafts are currently unavailable. DentaQuest will be able to provide drafts as follow-up from the Virtual Review.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: While not critical to program implementation, the <i>Breach Notification Letter Template</i> was not in 12-point font. Therefore, HSAG strongly recommends that the PAHP updates the <i>Breach Notification Letter Template</i> prior to July 1, 2026, and also confirm prior to finalizing all member materials that they are in at least the 12-point font size requirement.		
Required Actions: None.		
11. <i>HHS provides the PAHP with the primary language of each member. The PAHP uses this information to ensure communication materials are distributed in the appropriate language.</i> Contract C.1.26	HSAG Required Evidence: - Policies and procedures - Mechanism for tracking members' primary language (e.g., screenshot of system) - Workflow for translating written member materials in a member's primary language - Workflow for providing member materials in primary language	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		

Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
Information for Members		
12. The PAHP makes a good faith effort to give written notice of termination of a contracted provider to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. Notice to the member must be provided by the later of: a. Thirty calendar days prior to the effective date of the termination; or b. Fifteen calendar days after receipt or issuance of the termination notice. 42 CFR §438.10(f)(1) 42 CFR §457.1207 Contract C.6.01	HSAG Required Evidence: • Policies and procedures • Workflow of provider termination process • Template of written notice to members of provider termination • Tracking or reporting mechanism that demonstrates timeliness Evidence as Submitted by the PAHP: • SII_CORR01-INS-Member Notifications of Provider Terminations <Pg 1 Procedure A> • SII_Provider Reference Manual <Pg. 39 Section 12.01>	☐ Met ☒ Not Met
PAHP Description of Process: The ABD and member notices are still being developed and drafts are currently unavailable. DentaQuest will be able to provide drafts as follow-up from the Virtual Review.		
HSAG Findings: While the PAHP’s <i>CORR01-INS-Member Notifications of Provider Terminations</i> policy included language that indicates a “good faith effort to provide written notice to a member of the termination or departure of a network provider are within fifteen calendar days after receipt or issuance of the termination notice or departure,” the policy did not include language to satisfy sub-element (a) for this element.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: • Provide an updated policy to include all language required by 42 CFR §438.10(f)(1).		
13. The PAHP makes available upon request, any physician incentive plans in place as set forth in 42 CFR §438.3(i). 42 CFR §438.3(i) 42 CFR §438.10(f)(3) 42 CFR §457.1207 Contract C.6.02	HSAG Required Evidence: • Policies and procedures • List of physician incentive plans • Process for dissemination of physician incentive plans when requested by a member Evidence as Submitted by the PAHP: • SII_VBC02-INS-Provider Incentive Policy <full document>	☒ Met ☐ Not Met

Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
PAHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
Member Handbook		
14. The member handbook is provided to the member <i>and their authorized representative</i> within <i>seven days after receiving notice of the member's enrollment</i>. The member handbook is considered provided if the PAHP: - Mails a printed copy of the information to the member's mailing address <i>and their authorized representative's address</i>; - Provides the information by email after obtaining the member's agreement to receive the information by email; - Posts the information on the PAHP's website and advises the member <i>and their authorized representative</i> in paper or electronic form that the information is available on the internet and includes the applicable internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or - Provides the information by any other method that can reasonably be expected to result in the member <i>and authorized representative</i> receiving that information. 42 CFR §438.10(g)(1) 42 CFR §438.10(g)(3) 42 CFR §457.1207 Contract C.2.02 Contract C.3.01	HSAG Required Evidence: - Policies and procedures - Member materials, such as member welcome packet - Mechanism for disseminating the member handbook (e.g., mailing of printed copy, mailing of welcome packet with link to member handbook on website, etc.) - Tracking mechanism for mailings of the member handbook or welcome notice Evidence as Submitted by the PAHP: - SII_DQ3197 IA_Medicaid Adult (7.26) HBEN - SII_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 - SII_DQ3181 IA State Medicaid_Welcome Letter-ID Card_DH_EN_SP (2.26)_DRAFT_2-6-26 <full document> - SII_Checklist_MKT03-INS-COMM-Member Communications Distribution <page 2, B. Campaign Distribution>	☒ Met ☐ Not Met

Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
PAHP Description of Process: The Member handbook is in development and is projected to be completed by the IA HHS due date of March 16, 202		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: HSAG strongly recommends that the PAHP update the language in its <i>DQ3181 IA State Medicaid_Welcome Letter-ID Card_DRAFT</i> to indicate, “Call your Dental Home and schedule an appointment,” instead of “Call your child’s Dental Home and schedule an appointment” to ensure that the welcome letter is inclusive to both adult and child members.		
Required Actions: None.		
15. The member handbook includes all requirements listed in the Member Handbook Checklist. 42 CFR §438.10(g)(2) 42 CFR §457.1207 Contract C.2	HSAG Required Evidence: - Searchable (Word/PDF) version of member handbook (version that would be provided to member if paper copy requested) - Link to member handbook on PAHP’s website - HSAG will also use the results of the Member Handbook Checklist Evidence as Submitted by the PAHP: - SII_DQ3197 IA_Medicaid Adult (7.26) HBEN - SII_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 - SII_Checklist_MKT03-INS-COMM-Member Communications Distribution	☐ Met ☒ Not Met
PAHP Description of Process: The website is still in development. Once the configuration is complete, a link to the member handbook can be provided.		
HSAG Findings: Although the PAHP’s member handbooks contained information on member rights, they did not contain all required member rights and responsibilities as specified in 42 CFR §438.100. The PAHP’s member handbooks included information on the members’ right to be treated with respect and to have their information kept private; however, they did not specify the member right to dignity. Additionally, the PAHP’s member handbooks also did not include the following member rights as specified in 42 CFR §438.100: - Receive information on available treatment options and alternatives, presented in a manner appropriate to the member’s condition and ability to understand; - Exercise his or her rights, and that the exercise of those rights does not adversely affect the way the PAHP and its network providers or HHS treat the member; and,		

Standard II—Member Rights and Member Information

Requirement	Supporting Documentation	Score
- In recognizing each member’s dignity and privacy, the PAHP does not in any way restrict the member’s right to fully participate in the community and to work, live, and learn to the fullest extent possible. Lastly, the PAHP’s member handbooks included language stating that “[i]f we plan to stop or reduce a service you already get, you may keep the service while we review your appeal if you ask within 10 days of the letter date (or before your current approval ends). If the final decision is not in your favor, you may have to pay for care you got during the appeal.” However, the member handbooks did not clearly indicate the requirements pertaining to continuation of benefits during the state fair hearing (SFH) or that members are required to pay for the cost of continued services provided during an SFH. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Update its member handbooks to include Requirements #15 and #21 in the <i>Member Handbook Checklist</i>.		
16. The PAHP gives each member notice of any change to the member handbook that HHS defines as significant in the information specified in the member handbook, at least 30 days before the intended effective date of the change. <i>Significant changes include any change that may impact member accessibility to services and benefits in:</i> <i>Restrictions on the member’s freedom of choice among network providers;</i> <i>Member rights and protections;</i> <i>Grievance and fair hearing procedures;</i> <i>Amount, duration, and scope of benefits available;</i> <i>Procedures for obtaining benefits, including authorization requirements;</i> <i>The extent to which, and how, members may obtain benefits from out-of-network providers;</i> <i>The extent to which, and how, after-hours and emergency coverage are provided;</i> <i>Policy on referrals for specialty care and for other benefits not furnished by the member’s primary care provider (PCP);</i> <i>or</i> <i>Cost sharing.</i>	HSAG Required Evidence: - Policies and procedures - Workflow for member handbook changes - Tracking mechanism for timely member notifications of significant changes that demonstrate the effective date of the significant change and the date members were notified Evidence as Submitted by the PAHP: - SII_DQ3197 IA_Medicaid Adult (7.26) HBEN - SII_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 - SII_Checklist_MKT03-INS-COMM-Member Communications Distribution < page 4, C. Communication of Benefit Changes to Members> - SII_Checklist_MKT03-INS-COMM-Member Communications Distribution < page 7, D. Communicate changes to Enrollee>	☐ Met ☒ Not Met

Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
42 CFR §438.10(g)(4) 42 CFR §457.1207 Contract C.2.19–C.2.20		
PAHP Description of Process: N/A		
HSAG Findings: The PAHP provided the <i>COMM-Member Communications Distribution</i> policy, which did not specify that notification of significant changes to the member handbook must be made “...at least 30 days before the intended effective date of the change...” After the review, the PAHP provided the <i>COMM-Member Communications Distribution</i> policy, with a comment of “Standard II – Element 16” on page seven; however, the specific time frame of “at least 30 days...” was not documented on this page or in this policy.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Provide updated policies and procedures that include the time frame for notifying members of significant changes as required by 42 CFR §438.10(g)(4).		
Provider Directory		
17. The PAHP makes the provider directory available in paper form upon request and electronic form. The provider directory must include the information from the Provider Directory Checklist. 42 CFR §438.10(h)(1-2) 42 CFR §457.1207 Contract C.4.01	HSAG Required Evidence: - Policies and procedures - Process for generating a paper copy of the provider directory (e.g. bulk printing, print on demand) - Copy of the member-facing provider directory in Word or PDF format (excerpts are acceptable) - Link to the online provider directory - HSAG will also use the results of the Provider Directory Checklist Evidence as Submitted by the PAHP: - SII_Checklist_MKT03-INS-COMM-Member Communications Distribution <page 6, A. Enrollee materials available in paper form> - SII_MKT11-INS-FAD Online Directory <full document> Dental Providers DentaQuest	☐ Met ☒ Not Met
PAHP Description of Process: N/A		

Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
HSAG Findings: The PAHP was unable to demonstrate that it would make its provider directory available in paper form, upon request, and electronic form that will include all information required federally and in Contract as included in the <i>Provider Directory Checklist</i>. - The PAHP’s website contained provider directories for other states in which the PAHP conducts business, and the PAHP was unable to provide evidence (e.g., test environment of a provider directory specific to Iowa) that it was collecting and would be able to display all required provider information. - The PAHP provided a template for a paper provider directory. However, the template did not include all required fields, such as whether the provider’s office/facility has accommodations for people with physical disabilities, (offices, exam room[s], equipment, including but not limited to wide entries, wheelchair access, accessible exam tables and rooms, lifts, scales, bathrooms, grab bars, or other equipment). The paper provider directory template only listed “handicap accessible.” - Following the review, the PAHP indicated on the <i>Post-Site Review Tracker</i>, “DentaQuest is still working on adding providers to our directory for IA. As soon as we have a provider added, we will provide the screen shot.” Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Provide a completed version of the Iowa paper provider directory, including all required provider data elements. - A link for the PAHP’s online provider directory, including all required provider data elements.		
18. Information included in the PAHP’s paper provider directory is updated at least: a. Monthly, if the PAHP does not have a mobile-enabled electronic provider directory; or b. Quarterly, if the PAHP has a mobile-enabled electronic provider directory. 42 CFR §438.10(h)(3)(i) 42 CFR §457.1207 Contract C.4.02(a)	HSAG Required Evidence: - Policies and procedures - Verification of a mobile-enabled electronic provider directory - Workflow for updating paper provider directories Evidence as Submitted by the PAHP: - SII_Provider Update Example_2.20.2026 - SII_Fulfillment Process Workflow 8.18.25	☒ Met ☐ Not Met
PAHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		

Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
19. Information included in the PAHP’s electronic provider directory is updated no later than 30 calendar days after the PAHP receives updated provider information. 42 CFR §438.10(h)(3)(ii) 42 CFR §457.1207 Contract C.4.02(b)	HSAG Required Evidence: • Policies and procedures • Workflow for updating the electronic provider directory • Three consecutive provider directory update examples Evidence as Submitted by the PAHP: • SII_MKT11-INS-FAD Online Directory <full document>	☒ Met ☐ Not Met
PAHP Description of Process: DentaQuest has ongoing recruitment strategies in effect. Currently there is no network to pull a provider directory as this plan does not go live until 7/1.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
20. The PAHP’s provider directory is made available on the PAHP’s website in a machine-readable file and format as specified by the Secretary. 42 CFR §438.10(h)(4) 42 CFR §457.1207 Contract C.4.03	HSAG Required Evidence: • Policies and procedures • Confirmation of machine-readable provider directory (e.g., JavaScript Object Notation [JSON] format) • Link to the publicly available machine-readable provider directory on the PAHP’s website Evidence as Submitted by the PAHP: • https://www.dentaquest.com/en/find-a-dentist	☒ Met ☐ Not Met
PAHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Of note, while the PAHP demonstrated its ability to create and post a machine-readable provider directory, the PAHP was unable to demonstrate the machine-readable provider directory for the Iowa Medicaid managed care program. As such, the PAHP will be required to conduct a system demonstration of this capability during the follow-up sessions that will occur with HSAG prior to July 1, 2026. Any failure to demonstrate a sufficient machine-readable provide directory in a conspicuous location may result in a <i>Not Ready</i> status in the member information program area.		

Standard II—Member Rights and Member Information

Requirement	Supporting Documentation	Score
Recommendations: The PAHP demonstrated its ability to create and post a machine-readable provider directory for another Medicaid managed care plan (MCP), therefore, this element was scored as <i>Met</i> . However, HSAG recommends that the PAHP ensure that the machine-readable provider directory for Iowa is posted to a conspicuous location on the Members tab of the website prior to July 1, 2026.		
Required Actions: None.		
Electronic Materials and Communications		
21. Member information required in 42 CFR §438.10 may not be provided electronically unless the PAHP meets all of the following: - The format is readily accessible. - The information is placed in a location on the PAHP’s website that is prominent and readily accessible. - The information is provided in an electronic form which can be electronically retained and printed. - The information is consistent with the content and language requirements of 42 CFR §438.10. - The member is informed that the information is available in paper form without charge upon request and provides it upon request within five business days. 42 CFR §438.10(c)(6) 42 CFR §457.1207 Contract C.8.01	HSAG Required Evidence: - Policies and Procedures - Workflow for disseminating member materials - List of all materials that are only provided electronically - Link to the PAHP’s homepage of its website - Tracking mechanisms related to requests for information in paper form that includes the date of the member’s request and the date it was provided to the member (e.g., mailed) - Evidence for how members are informed that paper copies of information are available upon request and without charge Evidence as Submitted by the PAHP: - SII_Fulfillment Process Workflow 8.18.25 <full document> - SII_COM15-ENT-Nondiscrimination Compliance Program - DQ3197 IA_Medicaid Adult (7.26) HBEN - SII_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 - DQ3181 IA State Medicaid_Welcome Letter-ID Card_DH_EN_SP (2.26)_DRAFT_2-6-26	☒ Met ☐ Not Met
PAHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: HSAG recommends that the PAHP update the language from “Mailing frequency depends on client contract requirements. Frequency/turnaround time examples: 5 – 10 business day turnaround timeframe,” to “five-business-day turnaround time frame” in its <i>Fulfillment Process Work 8.18.25</i> document as the five business days apply to all Medicaid lines of business.		

Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
Required Actions: None.		
22. <i>The PAHP leverages technology to promote timely, effective, and secure communications with members.</i> a. <i>Once a member selects a communication pathway, the PAHP confirms that choice through regular mail with instructions on how to change the selection if desired.</i> b. <i>The PAHP maintains the means to receive communication from members electronically, including via mail and website.</i> c. <i>The PAHP responds to electronic inquiries within one business day.</i> d. <i>The PAHP is encouraged to utilize mobile technology, such as electronic delivery of medication and appointment reminders.</i> Contract C.8.02	HSAG Required Evidence: • Policies and procedures • Member materials with information on the modes by which members can communicate with the PAHP • Mechanism for tracking members' preferred communication pathway (e.g., screenshot of system) • Screenshot of the messaging option on the member website • Mobile application workflows (e.g., text message reminders) Evidence as Submitted by the PAHP: • SII_DQ3197 IA_Medicaid Adult (7.26) HBEN_Draft_2.27.26 • SII_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 • SII_CS05-INS-DENT-SOP-CS Call Handling-Dental-FINAL	☒ Met ☐ Not Met
PAHP Description of Process: The member website is still being configured. Once configuration is complete, a screenshot can be provided.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: Based on the PAHP's policies and procedures confirming it will implement processes to leverage technology to communicate with members, including through telephone, email, and text messaging, the PAHP received a <i>Met</i> score for this element. However, HSAG recommends that the PAHP ensure that members are provided with information on the modes by which they can communicate with the PAHP within the member-facing materials and be able to demonstrate where members' preferred communication pathways are maintained. Additionally, HSAG recommends that the PAHP ensure that its system has the capability to track and monitor compliance with the one-business-day turnaround time frame for responding to electronic inquiries.		
Required Actions: None.		

Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
Member Website and Mobile Applications		
23. <i>The PAHP maintains member websites and mobile applications available in English and Spanish that are accessible via cell phone.</i> a. <i>The website must include at a minimum all information made available for new members.</i> b. <i>The provider network information available via the member website must be searchable and updated, at minimum, every two weeks.</i> c. <i>All website materials are submitted to HHS for review and approval prior to posting.</i> Contract C.8.03	HSAG Required Evidence: • Policies and procedures • Link to member website • Confirmation member website is available via English and Spanish • Confirmation of a mobile application of the member website • Link to provider network information available via the member website • Workflow for updating provider directory/network information Evidence as Submitted by the PAHP: • https://www.dentaquest.com/en/find-a-dentist	☒ Met ☐ Not Met
PAHP Description of Process: The member website is still being configured. Once configuration is complete, a screenshot can be provided.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
New Member Communications		
24. <i>In addition to information set forth in Contract sections C.1.01 and C.1.02, the enrollment materials include all information on the New Member Communications Checklist.</i> Contract C.1.03	HSAG Required Evidence: • Policies and procedures • Member materials, such as the member handbook and welcome packet • HSAG will also use the results of the New Member Communications Checklist Evidence as Submitted by the PAHP: • SII_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft 2.27.26	☐ Met ☒ Not Met

Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
	SII_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26	
PAHP Description of Process: N/A		
HSAG Findings: The PAHP was unable to confirm that it will distribute all enrollment materials to all members and their authorized representatives with all required information. During the review, the PAHP confirmed that its enrollment materials will be distributed to members through its member handbooks. However, the PAHP’s member handbooks did not contain the following information required to be in its enrollment materials: - Contact information specifying where members can ask questions regarding their cost-sharing obligations. - Procedures for changing PAHPs and circumstances under which this is possible as described in Contract. Further, although the PAHP’s member handbooks contained a Post Office (P.O.) Box mailing address in Wisconsin, following the review, the State confirmed that, “Pursuant to DentaQuest’s RFP Response, incorporated by reference into their contract with Iowa Medicaid, DentaQuest is required to have an Iowa mailing address including but not limited to the purpose of meeting Member and Provider requirements in the Contract and managed care regulations.” As such, the PAHP must include an Iowa address in its enrollment materials for its members. Recommendation: Although the PAHP’s member handbooks included a description of how to complete an oral health risk assessment, the instructions included a quick response (QR) code that did not work. During the review, PAHP staff members stated this was because the website was not yet live. HSAG strongly recommends that the PAHP proceed with launching its member website and all applicable website links.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Provide updated enrollment materials that include: - Contact information where members can ask questions regarding their cost-sharing obligations. - Procedures for changing PAHPs and circumstances under which this is possible as described in Contract. - An Iowa-specific mailing address.		
Health Education and Initiatives		
25. <i>The PAHP’s communication initiatives include information on programs, to include the I-Smile dental home initiative and contact information, and how members can participate in activities to enhance the general health and well-being of members.</i> a. The PAHP develops a strategy to participate in and interface with the Healthiest State Initiative.	HSAG Required Evidence: - Policies and procedures - List and description of planned initiatives and programs - Informational materials related to I-Smile dental home initiative - Plan(s) to disseminate information on program initiatives to members - Strategy supporting the Healthiest State Initiative	☒ Met ☐ Not Met

Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
Contract C.1.04	Evidence as Submitted by the PAHP: SII_2024 Iowa Outreach Plan_Draft_std VII <full document>	
PAHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
Cost and Quality Information		
26. <i>The PAHP implements and adheres to innovative strategies to provide price and quality transparency to members.</i> a. <i>The PAHP makes cost and quality information available to members in order to facilitate more responsible use of health care services and inform health care decision-making.</i> Contract C.1.05	HSAG Required Evidence: - Policies and procedures - Member informational materials on cost and quality information Evidence as Submitted by the PAHP: - SII_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft_2.27.26 <pages 9-10, Yearly Spending Limit on Dental Care> - SII_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <page 11, Annual Benefit Maximum>	☒ Met ☐ Not Met
PAHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
Implementation Support		
27. <i>The PAHP publicizes methods for members to obtain support and ask questions during program implementation, including information on how to contact the Ombudsman and the PAHP via the member services hotline.</i>	HSAG Required Evidence: - Policies and procedures - Member informational materials Evidence as Submitted by the PAHP:	☒ Met ☐ Not Met

Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
Contract C.1.09	- SII_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft_2.27.26 <page 27, Ombudsman Assistance> - SII_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <page 35-36, Ombudsman Assistance>	
PAHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
Member Services Helpline		
28. <i>The PAHP maintains a member services helpline that complies with the Member Services Helpline Checklist.</i> Contract C.1.10–C.1.16	HSAG Required Evidence: - Policies and procedures - Member informational materials - Member Services Helpline communication workflows - Member Services Helpline staff training program/topics - Member Services Helpline monitoring plan for call center performance metrics - Member Services Helpline back-up plan - Member Services Helpline testing plan/results - Member Services Helpline call scripts - Staff training materials - HSAG will also use the results of the Member Services Helpline Checklist	☐ Met ☒ Not Met
	Evidence as Submitted by the PAHP: - SII_CS02-INS-Customer Service Standards-FINAL <page 1> - SII_CS06-INS-Customer Service Monitoring Outcomes-FINAL <page 1>	

Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
	- SII_CS08-INS-DENT-Customer Service-Call Metric Reporting-Dental-FINAL <page 1> - SII_CS10-INS-CS Call Scripts-FINAL	
PAHP Description of Process: Staff Training materials are currently being developed. They will be submitted by May 1, 2026. HSAG Findings: Although the PAHP provided a report and policy that included information related to Contract A.27, the PAHP did not provide evidence it had a process to ensure all requirements of Contract A.27 would be met, including evidence that PAHP staff members: - Respond to all urgent requests within four hours if received prior to 1:00 p.m., and by 11:00 a.m. the next business day if received after 1:00 p.m. - Issue responses to enrolled member billing inquiries within 20 business days after the initial inquiry. - Ensure that 100 percent of provider billing inquiries will be responded to by phone or in writing within three business days. Additionally, although the PAHP provided policies related to training, the PAHP did not provide evidence that its member services helpline staff are trained on all concerns or issues as required by Contract (i.e., how to access dental healthcare services and dentists accepting new members who provide those services; identification or explanation of covered services; procedures for submitting a grievance or appeal; reporting fraud or abuse; locating a provider; dental health crises; balance billing issues; cost-sharing; primary care provider (PCP) change and/or initial attribution; or incentive programs). Further, although the PAHP submitted the <i>Customer Service-Call Handling-Claims/Authorization Related Inquiries</i> document, the processes within this document were not specific and did not adequately describe how the PAHP will ensure that there is a backup system capable of operating the telephone system, at full capacity, with no interruption of data collections. Instead, this document only indicated the following: “If a complete service outage lasts 2 hours messaging will be placed on incoming phone lines alerting callers to the outage; If the outage is intermittent, messaging will be placed on the incoming phone lines after 4 hours; Messaging will be of a general nature as to allow for appropriateness for all service areas; Customized messages will only be considered if there is a specific client requirement.” However, these processes do not ensure that the telephone system will operate without disruption for its Iowa population and does not include Iowa-specific reporting requirements. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Develop a process and tracking mechanism to demonstrate that all urgent requests are responded to within four hours if received prior to 1:00 p.m., and by 11:00 a.m. the next business day if received after 1:00 p.m. - Develop a process and tracking mechanism to demonstrate that enrolled member billing inquiries are resolved and that notices are sent within 20 business days after the initial inquiry. - Develop a process and tracking mechanism to demonstrate that 100 percent of provider billing inquiries are responded to by phone or in writing within three business days. - Develop a detailed backup plan that ensures that the telephone system can be operated at full capacity with no interruption of data collection and also ensures requests can be continued to be processed if the system is down.		

Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
Develop a notification plan specific to Iowa that details the procedures for notifying HHS when the phone system is inoperative or when a backup system is being used.		
Dental Call Line		
29. The PAHP operates a toll-free Dental Call Line which provides nurse triage telephone services for members to receive dental advice 24 hours a day/seven days a week from trained dental professionals. a. The Dental Call Line is well publicized and designed as a resource to members to help discourage inappropriate emergency room use. b. The Dental Call Line has a system in place to communicate all issues with the member's health care providers, as applicable. c. The PAHP has a written protocol specifying when a dentist must be consulted in response to a call received. d. Calls requiring a dental decision are forwarded to the on-call dentist, and a response to each call which requires a dental decision is provided by the dentist within 30 minutes. Contract C.1.17	HSAG Required Evidence: - Policies and procedures - Member informational materials - Dental Call Line communication workflows - Dental Call Line and on-call dentist schedule - Tracking mechanism for monitoring timely responses to dental decisions - Staff training materials Evidence as Submitted by the PAHP: - SII_Teledentistry.com Flyer - SII_Teledentistry Outreach -MESH Flyer - SII_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft_2.27.26 <page 7> - SII_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <page 7>	☐ Met ☒ Not Met
PAHP Description of Process: Staff Training materials are currently being developed. They will be submitted by May 1, 2026.		
HSAG Findings: HSAG's review identified the findings below: - The PAHP provided a <i>Teledentistry.com Flyer</i>, which included information regarding to "24/7 access to a dentist 365 days a year through the convenience of your telephone or video conference on your smartphone or computer." Additionally, the PAHP provided the <i>DQ3197 IA_Medicaid Adult (7.26) HBEN Draft_2.27.26</i> and the <i>DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26</i> member handbooks which included, "After Hours Care 24/7 Emergency Care Available via Teledentistry bit.ly/IA-teledentistry 866-302-0905. For more information, see Teledentistry Page 16," and "When to Use TeleDentistry.com Use teledentistry when: - You have a dental emergency and don't have a regular dentist		

Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
– You need help after hours and your dentist is closed – You cannot get to a dentist’s office right away Want to make a teledentistry appointment? Visit our website for more information: [website].” However, the Teledentistry platform appears to be an actual billed service for members and not a nurse triage telephone service for members to receive dental advice 24 hours a day/seven days a week from trained dental professionals. During the review, HSAG asked for clarification if Teledentistry would be utilized as the toll-free dental call line, which the PAHP confirmed. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: • Distinguish its use of the term “teledentistry” for the dental call line from its use of teledentistry as a covered service offered by a network provider requiring an encounter and claim. • Provide the dental call line that members can contact for dental advice from a trained dental professional that will not result in an encounter and claim and provide confirmation that the line is active.		
Redetermination Process		
30. <i>In providing redetermination assistance, all questions and calls are referred to the HHS Enrollment Broker. The PAHP does not engage in any of the following activities:</i> a. <i>Discriminate against members, including particularly high-cost members or members that have indicated a desire to change PAHPs.</i> b. <i>Talk to members about changing PAHPs.</i> c. <i>Provide any indication as to whether the member will be eligible, as this decision is at the sole discretion of HHS.</i> d. <i>Engage in or support fraudulent activity in association with helping the member complete the redetermination process.</i> e. <i>Sign the member’s redetermination form.</i> f. <i>Complete or send redetermination materials to HHS on behalf of the member.</i> Contract C.1.18	HSAG Required Evidence: • Policies and procedures • Redetermination reminder notice templates • Staff training materials Evidence as Submitted by the PAHP: • SII_COM15-ENT-Nondiscrimination Compliance Program <full document>	☒ Met ☐ Not Met

Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
PAHP Description of Process: All member communication and templates are currently under development. Staff training is currently being developed.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: HSAG recommends that the PAHP ensure all its member communication and templates are developed and approved prior to July 1, 2026.		
Required Actions: None.		
Marketing		
31. The PAHP complies with the requirements listed in the Marketing Checklist. 42 CFR §438.104 Contract C.7	HSAG Required Evidence: • Policies and Procedures • Marketing program/plan for Iowa • Examples of current and planned marketing materials • Staff training materials • HSAG will also use the results of the Marketing Checklist Evidence as Submitted by the PAHP: • SII_MKT01-INS-Marketing Safeguards-FINAL<Full Document> • SII_Checklist_MKT02-INS-COM-Member Communications Development-FINAL <full document>	☐ Met ☒ Not Met
PAHP Description of Process: Staff training is currently being developed.		
HSAG Findings: The PAHP was unable to demonstrate it had a process to obtain approval from HHS for all marketing materials timely. The PAHP’s <i>Member Communications Development</i> policy contained general information on obtaining approval from the State prior to distributing it to members. However, this policy did not contain specific steps on how the PAHP would obtain approval from HHS for all marketing materials at least 30 days or within the time frame requested by HHS prior to distribution. During the review, PAHP staff members stated they would send member marketing materials to HHS at least 30 days prior to distribution. HSAG requested evidence for how the PAHP will adhere to this time frame requirement (e.g., a policy with Iowa-specific information on marketing workflows, training materials, reporting/tracking mechanism); however, no supporting evidence was provided by the PAHP following the review.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must:		

Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
Develop and provide an Iowa-specific policy that outlines the procedures for obtaining HHS’ approval for all marketing materials within at least 30 days or within the time frame requested by HHS prior to distribution.		
Stakeholder Education		
32. <i>The PAHP has a formal process for ongoing education of stakeholders prior to, during, and after implementation of the Contract.</i> a. <i>Stakeholders include, but are not limited to, providers, advocates, members, and their families or caregivers.</i> b. <i>This includes publicizing methods by which members can ask questions regarding the program.</i> c. <i>The PAHP submits a Stakeholder Education Plan to HHS for review and approval in the timeframe and manner determined by HHS.</i> Contract A.23	HSAG Required Evidence: - Policies and procedures - Stakeholder education plan Evidence as Submitted by the PAHP: - SII_Stakeholder Education Plan 2026 <Full Document>	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
Billings and Collections		
33. <i>The PAHP imposes copayments, if required by HHS, for Iowa Dental Wellness Plan participants in accordance with the State’s 1115 waiver and Hawki members in accordance with the State’s CHIP State Plan. If HHS requires the PAHP to impose copayments, the PAHP ensures compliance with the requirements outlined in the Contract.</i>	HSAG Required Evidence: - Policies and procedures - Member materials, such as the member handbook - List of copayments imposed by the PAHP - Notification to HHS of imposed State Plan cost sharing - Staff training materials	☐ Met ☒ Not Met

Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
Contract F.8.06	Evidence as Submitted by the PAHP: - SII_Member Handbook Prev Implementation DRAFT <full document> - SII_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft_2.27.26 - SII_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26	
PAHP Description of Process: There are no member copayments under this plan at this time. Staff Training materials are currently being developed. They will be submitted by May 1, 2026.		
HSAG Findings: Although the PAHP indicated “[t]here are no member copayments under this plan at this time...,” no documentation was provided that demonstrated that the PAHP had evaluated the State’s 1115 waiver and Hawki members in accordance with the State’s CHIP State Plan and stipulated in written documentation of the circumstances for when members are and are not subjected to copays.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Develop a procedure document and update member materials that stipulate the circumstances for when members are and are not subjected to copays.		

Standard II—Member Rights and Member Information						
Met	=	21	X	1	=	21
Not Met	=	12	X	0	=	0
Total	=	33	Total Score		=	21
Total Score ÷ Total					=	64%

Standard III—Emergency and Poststabilization Services

Standard III—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
Definitions		
1. The PAHP defines “emergency medical [dental] condition” as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical/dental attention to result in the following: a. Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. b. Serious impairment to bodily functions. c. Serious dysfunction of any bodily organ or part. 42 CFR §438.114(a) 42 CFR §457.1228 Contract Exhibit B: Glossary of Terms/Definitions	HSAG Required Evidence: • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Staff training materials Evidence as Submitted by the PAHP: • SIII_UM08-INS-Authorization Review, Pg 2 • Member materials: ○ SIII_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft_2.27.26 – Pages 15-17 ○ SIII_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 – Pages 18-20 • SIII_Provider Reference Manual <Pg 18 Section 4.03 Emergency Services and Post Stabilization Care (All Plans) > • Staff training materials pending review	☒ Met ☐ Not Met
PAHP Description of Process: DentaQuest is currently reviewing HHS feedback on our Office Reference Manual. Some updates are pending DentaQuest Legal and Compliance review before changes can be made. The Member handbook is in development and is projected to be completed by the IA HHS due date of March 16, 2026.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
2. The PAHP defines “emergency services” as covered inpatient and outpatient services that are as follows: a. Furnished by a provider that is qualified to furnish these services under Title 42.	HSAG Required Evidence: • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual	☒ Met ☐ Not Met

Standard III—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
b. Needed to evaluate or stabilize an emergency medical [dental] condition. 42 CFR §438.114(a) 42 CFR §457.1228 Contract Exhibit B: Glossary of Terms/Definitions	- Staff training materials Evidence as Submitted by the PAHP: - SII_UM08-INS-Authorization Review, Definitions Section Page 2 - Member materials: - SIID_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft 2.27.26 – Pages 2 and 4 - SIID_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft 2.26.26 – Pages 2 and 4 - SII_Provider Reference Manual <Pg 13 Section 2.00 “Emergency Service”> - Staff training materials pending	
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
3. The PAHP defines “poststabilization care services” as covered services, related to an emergency medical [dental] condition that are provided after a member is stabilized to maintain the stabilized condition, or, under the circumstances described in 42 CFR §438.114(e), to improve or resolve the member’s condition. 42 CFR §438.114(a) 42 CFR §438.114(e) 42 CFR §457.1228 Contract Exhibit B: Glossary of Terms/Definitions	HSAG Required Evidence: - Policies and procedures - Member materials, such as the member handbook - Provider materials, such as the provider manual - Staff training materials Evidence as Submitted by the PAHP: - SII_Utilization Management Program Description Page 11 Post-Stabilization of Care and Dental Services Section - Member materials: - SIID_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft 2.27.26 – Pages 15-17, 33	☒ Met ☐ Not Met

Standard III—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
	○ SIII_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 – Pages 18-20, 36 • SIII_Provider Reference Manual <Pg 14 Section 2.00 Post Stabilization Care Services> • Staff training materials pending review	
PAHP Description of Process: DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
Coverage and Payment		
4. The PAHP covers and pays for emergency services regardless of whether the provider that furnishes the services is Iowa Medicaid enrolled or has a contract with the PAHP. a. The PAHP must provide emergency services without requiring prior authorization (PA) or PCP referral, regardless of whether these services are provided by a contract or non-contracted provider. 42 CFR §438.114(c)(1)(i) 42 CFR §457.1228 Contract F.1.05(a) Contract F.1.08	HSAG Required Evidence: • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual, education on how to submit a claim for emergency dental services • Claim payment algorithm for emergency dental services • Mechanism(s) (e.g., edits, flags) to identify claims for emergency dental services • Staff training materials • HSAG will use results from the mock claims demonstration (i.e., mock adjudicated claims for emergency services) Evidence as Submitted by the PAHP: • Policies and Procedures: ○ SIII_UM08-INS-Authorization Review – Page 4 Numbers 7 and 8 ○ SIII_UM15-INS-Access to Services Out of Network <Full Document>	☐ Met ☒ Not Met

Standard III—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
	- Member materials: - SIID_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft 2.27.26 – Page 16 - SIID_DQ4080 IA_Medicaid Child (7.26) HBEN Draft 2.26.26 – Page 19 - SIID_CL02-INS-Claims Payment <Pg 3 Procedure B. 2> - SIID_Provider Reference Manual <Pg 19 Section 4.03 Payment of Emergency Services> - Staff training materials under review	
PAHP Description of Process: Claim payment algorithm for emergency dental services will be reviewed in the claims demonstration. DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made.		
HSAG Findings: HSAG’s review identified the following: - The <i>List of Emergency Key Words</i> document submitted after the review explained how providers can identify claims pertaining to emergency services and the process for the PAHP to adjudicate claims pertaining to emergency services. Of note, this document pertained to emergency claims and pre-service requests; however, the requirements of this element only pertain to emergency claims (i.e., post-service) and not PAs (i.e., pre-service). Further, the screenshot of a claim included in the document identified the “Claim Type” as a “Prior Auth” which is not applicable to this element, and while a provider may submit an expedited PA (i.e., pre-service), this is not same as a claim (i.e., post-service) for emergency services and a PA cannot be required for emergency services. - The two claims scenarios for emergency dental services for out-of-network (OON) providers did not align with the PAHP’s procedures for processing claims related to emergency dental services. The claim screenshots included in the <i>List of Emergency Key Words</i> document indicated that claims for emergency services are identified by the “Claim Priority” as “Emergency” and the “Emergency Claim” field as “Y.” However, both OON claims scenarios had “Regular Claim” as the “Claim Type” and “N” as the “Emergency Claim.”		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Submit two mock OON claims for emergency services, including the completed American Dental Association (ADA) claim form and adjudicated claim.		
5. The PAHP pays non-contracted and/or non-Iowa Medicaid enrolled providers for emergency services at the amount that would have been paid if the service had been provided under HHS’ fee-for-service Medicaid program.	HSAG Required Evidence: - Policies and procedures - Member materials, such as the member handbook - Provider materials, such as the provider manual	☐ Met ☒ Not Met

Standard III—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
Contract F.1.04	- Claim payment algorithm for emergency dental services - Staff training materials - Examples of emergency dental services (i.e., current dental terminology [CDT code] and corresponding fee schedule) - HSAG will use results from the mock claims demonstration (i.e., mock adjudicated claims for emergency services)	
	Evidence as Submitted by the PAHP: - SIII_UM15-INS-Access to Services-Out of Network Page 1 letter C. - Member materials: - SIII_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft_2.27.26 – Page 15 - SIII_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 – Page 19 - SIII_Provider Reference Manual <Pg 19 Section 4.03> - Staff training materials pending review	
PAHP Description of Process: DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made.		
HSAG Findings: The <i>UM15-INS-Access to Services-Out of Network</i> policy confirmed that compensation for OON providers is limited to the applicable State Medicare, Medicaid, or designated health plan fee schedule or reimbursement rate; and the <i>Provider Reference Manual</i> confirmed that both enrolled and non-enrolled providers will be paid at HHS’ fee schedule. However, during the claims scenario demonstrations, while the demonstrations were in the PAHP’s testing environment, PAHP staff members were unable to verbalize the linkage of the paid amount to the OON provider to any associated fee schedule.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Submit two mock OON claims for emergency services, including the charged amount, allowed amount, paid amount, and configuration to the PAHP’s associated fee schedule.		

Standard III—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
6. The PAHP does not deny payment for treatment obtained under either of the following circumstances: a. A member had an emergency dental condition, including cases in which the absence of immediate medical/dental attention would not have had the outcomes as specified in the definition of “emergency dental condition.” b. A representative of the PAHP instructs the member to seek emergency services. 42 CFR §438.114(c)(1)(ii) 42 CFR §457.1228 Contract F.1.05(b-c)	HSAG Required Evidence: • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claim algorithm for emergency dental services • Staff training materials • HSAG will use results from the mock claims demonstration (i.e., mock adjudicated claims for emergency services) Evidence as Submitted by the PAHP: • SIII_UM08-INS-Authorization Review page 4 number 7 and 8 • Member materials: ○ SIII_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft_2.27.26 – Page 16 ○ SIII_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 – Page 19 • SIII_Provider Reference Manual <Pg 19 Section 4.03> • Staff training materials pending review	☒ Met ☐ Not Met
PAHP Description of Process: DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
7. While the PAHP is required to reimburse providers for the screening examination, the PAHP is not required to reimburse providers for non-emergency services rendered in an emergency room for treatment of conditions that do not meet the prudent layperson standard.	HSAG Required Evidence: • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claim algorithm for emergency dental services	☐ Met ☒ Not Met

Standard III—Emergency and Poststabilization Services

Requirement	Supporting Documentation	Score
a. The PAHP does not deny or pay less than the allowed amount for the CDT code on the claim without a clinical record review to determine if the prudent layperson standard was met. b. The PAHP bases coverage decisions for emergency services on the severity of the symptoms at the time of presentation and shall cover emergency services where the presenting symptoms are of sufficient severity to constitute an emergency dental condition in the judgment of a prudent layperson, even if the condition turned out to be non-emergency in nature. c. The prudent layperson review is conducted by a PAHP staff member who does not have dental training. d. The PAHP does not impose restrictions on coverage of emergency services more restrictive than those permitted by the prudent layperson standard. e. In addition to using the prudent layperson standard, the PAHP endeavors to incorporate emergency dental condition as defined by the American Dental Association Emergency Dental Condition Guidelines in their review of emergency claims. Contract F.1.02	- Staff training materials - Examples of emergency dental services (i.e., CDT code and corresponding fee schedule) - Workflow for conducting a prudent layperson review - Department/staff members responsible for conducting a prudent layperson review - Mechanism(s) to identify claims requiring a prudent layperson review - Mechanism(s) to document the outcome of a prudent layperson review - One mock example of a prudent layperson review Evidence as Submitted by the PAHP: - SIII_UM08-INS-Authorization Review page 4 number 8 and 11 - Member materials: - SIII_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft_2.27.26 – Pages 15-17 - SIII_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 – Pages 18-19 - SIII_Provider Reference Manual <Pg 19 Section 4.03> - Staff Training materials pending review	
PAHP Description of Process: DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made.		
HSAG Findings: The PAHP’s policies, claims scenario demonstrations, and discussion with PAHP staff members confirmed that the PAHP’s claim payment review process for emergency dental treatment included a clinical and/or Dental Consultant review. The PAHP provided no documentation confirming that a “prudent layperson review” is conducted by a PAHP staff member who does not have dental training. After the review, the PAHP provided the following statement, “Our Clinical Review Specialist teams determine whether services meet the definition of emergency care by applying the prudent layperson standard. Specifically, reviews are based on symptoms that a layperson could reasonably identify at the time of presentation, such as pain, swelling, or signs of infection, rather than relying on predefined lists of diagnoses or outcomes. This ensures that determinations are grounded in the severity of presenting symptoms, consistent with the intent of the standard.” However, the PAHP’s contract with HHS requires that the prudent layperson		

Standard III—Emergency and Poststabilization Services

Requirement	Supporting Documentation	Score
review be conducted by a PAHP staff member who does not have dental training. The PAHP’s qualifications for Clinical Review Specialists included dental assisting experience or a degree in a dental field; therefore, the PAHP would not be able to have a staff member who does not have dental training conduct a prudent layperson review. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: • Submit a policy outlining the PAHP’s procedures for implementing HHS’ requirement that a prudent layperson review is conducted by a PAHP staff member who does not have dental training. • Submit evidence (e.g., system screenshots) for how the prudent layperson review by a PAHP staff member will be documented. • Submit staff training materials related to the prudent layperson review.		
Additional Rules for Emergency Services		
8. The PAHP does not: - Limit what constitutes an emergency dental condition on the basis of lists of diagnoses or symptoms. - Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member’s PCP, the PAHP, or HHS of the member’s screening and treatment within 10 calendar days of presentation for emergency services. 42 CFR §438.114(d)(1) 42 CFR §457.1228 Contract F.1.06	HSAG Required Evidence: • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claim payment algorithm for emergency dental services • Staff training materials • Notification requirements when a member presents for emergency dental services • HSAG will use results from the mock claims demonstration (i.e., mock adjudicated claims for emergency services) Evidence as Submitted by the PAHP: • SIII_UM08-INS-Authorization Review page 4 numbers 7 and 8 • Member materials: ○ SIII_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft_2.27.26 – Page 15-17 ○ SIII_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 – Page 18-20 • SIII_Provider Reference Manual <Pg 19 Section 4.03>	☒ Met ☐ Not Met

Standard III—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
	Staff training materials pending review	
PAHP Description of Process: DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
9. A member who has an emergency medical [dental] condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member. 42 CFR §438.114(d)(2) 42 CFR §457.1228 Contract F.1.03 Contract F.1.07	HSAG Required Evidence: - Policies and procedures - Member materials, such as the member handbook - Provider materials, such as the provider manual - Staff training materials - Claim payment algorithm for emergency dental services - HSAG will use results from the mock claims demonstration (i.e., mock adjudicated claims for emergency services) Evidence as Submitted by the PAHP: - SII Utilization Management Program Description Page 11 Post-Stabilization of Care and Dental Services Section - Member materials: - SIII_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft 2.27.26 – Page 4, 33 - SIII_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft 2.26.26 – Page 4, 36 - SIII Provider Reference Manual <Pg 19 Section 4.03> - Staff training materials pending review	☐ Met ☒ Not Met
PAHP Description of Process: DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made.		

Standard III—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
HSAG Findings: While the claims scenario demonstrations for emergency dental treatment included no member financial liability, the two OON scenarios were for a non-emergency PA and not post-service claims for emergency dental treatment; therefore, they are unable to be accepted as confirmation of member financial liability or lack thereof.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Submit two mock OON claims for emergency services, including member financial liability.		
10. The attending emergency provider, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the PAHP. 42 CFR §438.114(d)(3) 42 CFR §457.1228 Contract F.1.09	HSAG Required Evidence: - Policies and procedures - Provider materials, such as the provider manual - Staff training materials Evidence as Submitted by the PAHP: - SII_Utilization Management Program Description Page 11 Post-Stabilization of Care and Dental Services Section - SIII_Provider Reference Manual <Pg 19 Section 4.03> - Staff training materials pending review	☒ Met ☐ Not Met
PAHP Description of Process: DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
Coverage and Payment of Poststabilization Care Services		
11. The PAHP is financially responsible for post-stabilization care services obtained within or outside the PAHP that are pre-approved by a plan provider or other PAHP representative. 42 CFR §422.113(e)(2)(i) 42 CFR §438.114(e) 42 CFR §457.1228 Contract F.1.10(a)(1)	HSAG Required Evidence: - Policies and procedures - Provider materials, such as the provider manual - Workflow for claims processing for poststabilization care services - Staff training materials - PA requirements for poststabilization care services	☐ Met ☒ Not Met

Standard III—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
	Evidence as Submitted by the PAHP: - SII_Utilization Management Program Description Page 11 Post-Stabilization of Care and Dental Services Section - SIII_Provider Reference Manual <Pg 19 Section 4.03> - Staff training materials pending review	
PAHP Description of Process: DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made.		
HSAG Findings: HSAG’s review identified the findings below: - As poststabilization care services may be obtained within the PAHP’s network or outside the PAHP’s network that are pre-approved by the PAHP, HSAG requested clarification on the PAHP’s process should the member seek OON emergency dental treatment and, subsequently, the OON provider submitted a PA request for continued treatment needed after initially addressing the emergency dental condition. HSAG also asked if coverage of OON poststabilization care services would be considered for continuity of care and for members who may reside in geographical shortage areas or in service areas where a member may not have access to an in-network provider within HHS’ network adequacy standards. After the review, the PAHP did not submit additional documentation and explained that it is still developing its policy for reviewing poststabilization care services for OON providers. - The <i>Provider Reference Manual</i> included the following statements: “DentaQuest is financially responsible for eligible member’s post-stabilization of care, regardless of location, when a plan is pre-approved by an enrolled provider. No preauthorization is required for poststabilization services.” Based on this language, the PAHP appears to misunderstand the federal provision. These statements conflict with one another and it is unclear if the PAHP is indicating that poststabilization care services require or do not require pre-approval/PA. Further, an enrolled provider would not “pre-approve” a “plan,” rather, the PAHP (as the dental plan) would authorize or preapprove services requested by a provider. Recommendations: The <i>Utilization Management Program Description</i> indicated that “[i]n the dental context, the concept of ‘post-stabilization of care’ generally does not apply in the same way for Medicaid, Medicare Advantage, or commercial dental plans. Dental services do not fall under the medical emergency framework, and dental benefit programs typically do not use ‘stabilization’ as a coverage category. Instead: 1. Dental benefits-regardless of payer type- are adjudicated based on CDT codes submitted by the treating provider. 2. Coverage and payment determinations are tied to the specific procedure performed, not to a poststabilization status. 3. Dental claims are evaluated according to the members’ benefit plan, clinical policies, documentation guidelines, and fee schedules.” While HSAG agrees that poststabilization care dental services may align with standard dental treatment and with HHS’ associated dental benefit package, HSAG is reminding the PAHP that the poststabilization care services provisions do apply to dental PAHPs. Therefore, HSAG recommends that the PAHP ensure that staff training materials include poststabilization care services, the applicability to the PAHP, and processes for how the PAHP implements the poststabilization care services requirements.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Submit its policy for covering poststabilization care services for OON providers (when pre-approved by the PAHP), when finalized by the PAHP.		

Standard III—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
- Update the <i>Provider Reference Manual</i> to align the process for providers, including OON, to request PA of poststabilization care services once the PAHP finalizes its process. - Review the <i>Provider Reference Manual</i> and revise any confusing/incorrect information (refer to the second bullet above in <i>HSAG Findings</i>).		
12. The PAHP is financially responsible for poststabilization care services obtained within or outside the PAHP that are not pre-approved by a plan provider or other PAHP representative, but administered to maintain the member’s stabilized condition within one hour of a request to the PAHP for pre-approval of further poststabilization care services. 42 CFR §422.113(c)(2)(ii) 42 CFR §438.114(e) 42 CFR §457.1228 Contract F.1.10(a)(2)	HSAG Required Evidence: - Policies and procedures - Provider materials, such as the provider manual - Workflow for claims processing for poststabilization care services - PA requirements for poststabilization care services - Staff training materials Evidence as Submitted by the PAHP: - SII Utilization Management Program Description Page 11 Post-Stabilization of Care and Dental Services Section - SIII Provider Reference Manual <Pg 19 Section 4.03> - Staff training materials under review	☒ Met ☐ Not Met
PAHP Description of Process: DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
13. The PAHP is financially responsible for poststabilization care services obtained within or outside the PAHP that are not pre-approved by a plan provider or PAHP representative, but administered to maintain, improve, or resolve the member’s stabilized condition <i>without PA</i> if:	HSAG Required Evidence: - Policies and procedures - Provider materials, such as the provider manual - Workflow for claims review process for poststabilization care services - Staff training materials	☐ Met ☒ Not Met

Standard III—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
a. The PAHP does not respond to a request for pre-approval within one hour. b. The PAHP cannot be contacted. c. The PAHP representative and the treating provider cannot reach an agreement concerning the member’s care and a plan provider is not available for consultation. In this situation, the PAHP must give the treating provider the opportunity to consult with a plan provider and the treating provider may continue with care of the patient until a plan provider is reached or one of the criteria in 42 CFR §422.113(c)(3) is met. 42 CFR §422.113(c)(2)(iii) 42 CFR §422.113(c)(3) 42 CFR §438.114(e) 42 CFR §457.1228 Contract F.1.10(b)	- Process to track requests for pre-approval of poststabilization care services and timeliness of the PAHP’s response Evidence as Submitted by the PAHP: - SII_Utilization Management Program Description Page 11 Post-Stabilization of Care and Dental Services Section - SIII_Provider Reference Manual <Pg 19 Section 4.03> - Staff training materials pending review	
PAHP Description of Process: DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made.		
HSAG Findings: While the requirements of this element were included in the <i>Provider Reference Manual</i>, PAHP staff members were unable to speak to the PAHP’s process for complying with the one-hour time frame for responding to requests for pre-approval of poststabilization care services. After the review, the PAHP again cited the <i>Provider Reference Manual</i>; however, it does not provide assurances of a process for implementation. As a reminder, should an in-network or OON provider contact the PAHP requesting a PA for poststabilization care services, the PAHP must respond to the requesting provider within one hour. If the provider is unable to contact the PAHP or the PAHP does not respond to the provider’s request within one hour, the provider can proceed with delivering services, and the PAHP is financially liable for those services.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Develop a procedure describing the PAHP’s process to implement the poststabilization care requirements, including how the PAHP will respond to requests for preapproval for poststabilization care services within one hour.		

Standard III—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
14. The PAHP limits charges to members for poststabilization care services to an amount no greater than what the PAHP would charge the member if he or she had obtained the services through the PAHP. 42 CFR §422.113(c)(2)(iv) 42 CFR §438.114(e) 42 CFR §457.1228 Contract F.1.12	HSAG Required Evidence: • Policies and procedures • Member materials, such as the member handbook • Member cost-sharing responsibility for poststabilization care services • Staff training materials Evidence as Submitted by the PAHP: • SII_Utilization Management Program Description Page 11 Post-Stabilization of Care and Dental Services Section • Member materials: ○ SIII_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft 2.27.26 – Page 14 ○ SIII_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft 2.26.26 – Page 17 • SIII_Provider Reference Manual <Pg 19 Section 4.03> • Staff training materials pending review	☒ Met ☐ Not Met
PAHP Description of Process: DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
End of the PAHP's Financial Responsibility		
15. The PAHP's financial responsibility for poststabilization care services it has not pre-approved ends when: a. A plan provider assumes responsibility for the member's care through transfer. b. A plan representative and the treating provider reach an agreement concerning the member's care.	HSAG Required Evidence: • Policies and procedures • Provider materials, such as the provider manual • Staff training materials Evidence as Submitted by the PAHP:	☒ Met ☐ Not Met

Standard III—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
c. The member is discharged. 42 CFR §422.113(c)(3) 42 CFR §438.114(e) 2 CFR §457.1228 Contract F.1.13	- SII_Utilization Management Program Description Page 11 Post-Stabilization of Care and Dental Services Section - SIII_Provider Reference Manual <Pg 19 Section 4.03> - Staff training materials pending review	
PAHP Description of Process: DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		

Standard III—Emergency and Poststabilization Services						
Met	=	9	X	1	=	9
Not Met	=	6	X	0	=	0
Total	=	15	Total Score	=		9
Total Score ÷ Total					=	60%

Standard IV—Availability of Services

Standard IV—Availability of Services		
Requirement	Supporting Documentation	Score
Delivery Network		
1. The PAHP maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical or mental disabilities. 42 CFR §438.206(b)(1) 42 CFR §457.1230(a) Contract E.1.05 Contract E.1.21	HSAG Required Evidence: • Policies and procedures • Provider materials, such as the provider manual • One example of each type of provider contract (individual dentist/group) • One example of each type of provider contract (Federally Qualified Health Center [FQHC] and screening center) • One example of each type of provider contract (maternal health center) • Provider Network Onboarding Plan (as requested in the PAHP Questionnaire) • Network adequacy analyses, such as GeoAccess mapping Evidence as Submitted by the PAHP: • SIV_NET05-INS-Provider Network Adequacy <Pg 2 Procedure D> • SIV_NET07-INS-Access to Dental Services for Members <Pg 2-3 Procedure B 1,2,5,6 and Pg 4 Procedure D> • SIV_Iowa Provider Office Reference Manual<Full Document> • SIV_230206 IA MA MC HIX Provider Agreement <Full Document> • SIV_2026.02.26 DRAFT Provider Agreement FQHC <Full document> • SIV_2026.02.04 Iowa Provider Education Plan <Full Document>	☐ Met ☒ Not Met

Standard IV—Availability of Services		
Requirement	Supporting Documentation	Score
	- SIV_NET01-INS-Network Development Maintenance and Use<Full Document> - SIV_Sample Network Analysis – GEO Report<Full Document>	
PAHP Description of Process: DentaQuest utilizes a single Provider Agreement for all contracted providers. Page 1 demonstrates the various types of contracts for which a Provider can credential. The appropriate box will be checked for an individual's contract. The GEO is a sample of what we provide, an Iowa version of the GEO will be available post go-live.		
HSAG Findings: The PAHP confirmed that its provider network consisted of 28 contracted providers at the time of the review, indicating that substantial gaps remain in the PAHP building an adequate provider network. While HSAG understands that it takes time for a new PAHP to build its provider network, and the PAHP indicated that it had a plan to outreach to recruit and contract with dental providers and build its network, concerns remain that the PAHP was not able to demonstrate that more progress had been made in building its provider network. Further, HSAG had requested that the PAHP submit a provider network onboarding plan that included all requirements outlined in question 10 of the <i>Readiness Review Questionnaire</i>; however, the PAHP's Provider Onboarding Plan did not include the number/mix of provider types by specialty expected to be contracted with the PAHP by July 1, 2026, and the number/mix of provider types by specialty currently contracted with the PAHP. Further, in the GeoAccess reports the PAHP submitted in follow-up, each type of specialty (i.e., oral surgery, orthodontia, prosthodontia, periodontia, endodontia, and pediatric specialties) was not included but rather reported as a whole, as "specialists." Without the specificity in the PAHP's network adequacy reports, it does not provide an accurate picture of whether the PAHP has an adequate network, where provider type gaps exist, and if the PAHP meets the required time and distance access standards.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Demonstrate that significant progress has been made toward achieving an adequate network with an appropriate range of providers to serve members assigned to the PAHP. - Submit the number/mix of provider types by specialty expected to be contracted with the PAHP by July 1, 2026, and the number/mix of provider types by specialty currently contracted with the PAHP for each county and urbanicity. - Submit network adequacy reports weekly that demonstrate significant progress toward establishing a sufficient provider network and include, at a minimum, provider counts by provider type and a time and distance analysis once the PAHP receives an enrollment file from HHS. - Submit provider listings for the Dental Wellness Plan (DWP) Adults, DWP Kids, and Hawki programs routinely that include the provider name, provider location, and program(s) served.		

Standard IV—Availability of Services		
Requirement	Supporting Documentation	Score
Recommendations: While not specific to this element but this entire standard, HSAG strongly recommends that the PAHP ensure it includes the specific procedures for how the PAHP implements the Iowa-specific contract requirements in its policies. These procedures can be included as an appendix to a policy, standard operating procedure (SOP), workflow, and/or other formal guidance document.		
2. The PAHP provides for a second opinion from a network provider, or arranges for the member to obtain one outside the network, at no cost to the member. 42 CFR §438.206(b)(3) 42 CFR §457.1230(a) Contract F.4.02	HSAG Required Evidence: • Policies and procedures • Member materials, such as the member handbook • Coverage/authorization guidelines Evidence as Submitted by the PAHP: • SIV_CGA04-INS-Monitoring complaints <Pg 2 Section A, 1, (b) (vi)> • SIV_CGA06-INS-Member Complaints <Pg 6 Section D> • SIV_Utilization Management Program Description <Pg 9 Second Opinions>	☐ Met ☒ Not Met
PAHP Description of Process: The member handbook is currently in development and is projected to be completed by the IA HHS due date of 3/16/26. DentaQuest will ensure second opinions are referenced in the Member Handbook by the date requested by HHS.		
HSAG Findings: Although the <i>CGA04-INS-Monitoring Complaints</i> policy and procedure included that the PAHP’s Complaints and Grievances Specialist would arrange for a second opinion consultation as a step for a complaint/grievance resolution, and the DWP Adults, DWP Kids, and Hawki member handbooks included in the “Rights and Responsibilities” section that a member has the right to a second opinion, none of these documents adequately included how members are informed of the process to obtain a second opinion.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: • Include detailed language in member-facing materials (e.g., member handbook) that informs member that a second opinion is available and the process to obtain a second opinion, either from a network provider or from an OON provider, at no cost to the member.		
3. If the provider network is unable to provide necessary services, covered under the contract, to a particular member, the PAHP adequately and timely covers these services out of network for the member, for as long as the PAHP provider network is unable to provide them.	HSAG Required Evidence: • Policies and procedures • Member materials, such as the member handbook • Network adequacy monitoring mechanisms • Provide Network Onboarding Plan (as requested in the PAHP Questionnaire), including provider network contingency plan	☒ Met ☐ Not Met

Standard IV—Availability of Services		
Requirement	Supporting Documentation	Score
42 CFR §438.206(b)(4) 42 CFR §457.1230(a) Contract E.1.25 Contract F.4.03	Evidence as Submitted by the PAHP: - SIV_NET05-INS-Provider Network Adequacy <Pg 2 Procedures A, D> - SIV_NET07-INS-Access to Dental Services for Members <Pg 2-3 Procedures A, C> - SIV_CS07-INS-DENT-Access2Care Team <Pg 2 Section B5>	
PAHP Description of Process: The member handbook is currently in development and is projected to be completed by the IA HHS due date of 3/16/26. DentaQuest will ensure details around OON services are referenced in the Member Handbook by the date requested by HHS.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
4. <i>During the first 90 days following the PAHP's entry into the Iowa Dental Wellness Plan and Hawki Dental program, the PAHP allows a member who is receiving covered benefits from a non-network provider at the time of PAHP enrollment to continue accessing that provider, even if the network has been closed due to the PAHP meeting the network access requirements.</i> <i>The PAHP is permitted to establish single case agreements with providers enrolled with Iowa Medicaid or otherwise authorize non-network care past the initial 90 days of the contract to provide continuity of care for members receiving out-of-network services.</i> <i>The PAHP makes commercially reasonable attempts to contract with providers from whom a member is receiving ongoing care.</i> <i>Out-of-network providers will be reimbursed a percentage of the network rate unless otherwise agreed upon through a single case agreement.</i>	HSAG Required Evidence: - Policies and procedures - Member materials, such as the member handbook and welcome packet - Single case agreement template - Continuity of care plan Evidence as Submitted by the PAHP: - SIV_NET07-INS-Access to Dental Services for Members <Pg 3 Procedure C> - SIV_Single Case Agreement Form <Full Document> - SIV_UM17-INS-GOV-Continuation of Care-FINAL <Full Document>	☒ Met ☐ Not Met

Standard IV—Availability of Services		
Requirement	Supporting Documentation	Score
Contract G.2.37		
PAHP Description of Process: The member handbook is currently in development and is projected to be completed by the IA HHS due date of 3/16/26. DentaQuest will ensure details around Coordination of Care are referenced in the Member Handbook by the date requested by HHS.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: Although the <i>UMI7-INS-GOV-Continuation of Care-FINAL, Exhibit M – Iowa</i> included the requirements of this element, HSAG recommends that the PAHP enhance the language to clearly identify the procedures to be taken, and tracking mechanisms that will be in place to ensure adherence to the requirements and associated time frames. Additionally, please refer to Standard VI—Coordination and Continuity of Care, Element 11 for findings related to continuity of care time frame requirements.		
Required Actions: None.		
5. <i>The PAHP will negotiate and execute single case agreements or arrangements with non-network providers, when medically necessary, to ensure access to covered services.</i> Contract F.4.04	HSAG Required Evidence: • Policies and procedures • Out-of-network contracting flow • Single case agreement template • Provide Network Onboarding Plan (as requested in the PAHP Questionnaire), including provider network contingency plan Evidence as Submitted by the PAHP: • SIV_NET07-INS-Access to Dental Services for Members <Pg 3 Procedure C> • SIV_NET07-INS-SOP-Member Placement Process <Full Document> • SIV_Single Case Agreement Form <Full Document>	☒ Met ☐ Not Met
PAHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		

Standard IV—Availability of Services		
Requirement	Supporting Documentation	Score
6. The PAHP requires out-of-network providers to coordinate with the PAHP for payment and ensures the cost to the member is no greater than it would be if the services were furnished within the network. 42 CFR §438.206(b)(5) 42 CFR §457.1230(a) Contract F.4.06	HSAG Required Evidence: • Policies and procedures • Claims processing guidelines • Provider materials, such as materials on the PAHP’s website (e.g., provider manual) • Single case agreement template Evidence as Submitted by the PAHP: • SIV_NET07-INS-SOP-Member Placement Process <Full Document> • SIV_NET07-INS-Access to Dental Services for Members <Pg 3 Procedure C> • SIV_CL01-INS-Claims Processing<Pg 3-4 Procedure B-7> • SIV_Single Case Agreement Form <Full Document>	☒ Met ☐ Not Met
PAHP Description of Process: DentaQuest does not distribute our Provider Manuals to OON providers.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
7. <i>With the exception of single case agreements and other arrangements established with out-of-network providers, the PAHP pays out-of-network providers no less than 80 percent of the rate of reimbursement to in-network providers.</i> Contract F.4.07	HSAG Required Evidence: • Policies and procedures • Claims processing and payment guidelines • Out of network fee schedule documentation Evidence as Submitted by the PAHP: • SIV_NET07-INS-Access to Dental Services for Members <Pg 3 Procedure C 1 b> • SIV_CL01-INS-Claims Processing<Pg 3-4 Procedure B-7> • SIV_CL02-INS-Claims Payment <Pgs 2-3 Procedure B 2, 3> • SIV_Single Case Agreement Form <Full Document>	☒ Met ☐ Not Met

Standard IV—Availability of Services		
Requirement	Supporting Documentation	Score
	SIV_Out of Network Fee Schedule	
PAHP Description of Process: For OON fee schedules, the screenshot shows the set up for required for our configuration team – noting 80% of our in-network provider fees.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
8. <i>The PAHP ensures that no provider bills a member for all or any part of the cost of treatment service, except as allowed for Title XIX cost sharing and client participation as described in Section F.8 of the contract.</i> Contract F.4.08	HSAG Required Evidence: - Policies and procedures - Provider contract template - Provider materials, such as the provider manual - Plan for provider monitoring of balance billing practices Evidence as Submitted by the PAHP: - SIV_2026.02.29 DRAFT Provider Agreement FQHC <Pg 10 Section 1.4 Hold Harmless> - SIV_230206 IA MA MC HIX Provider Agreement<Pg 10 Section 1.4 Hold Harmless> - SIV_Provider Reference Manual <Pg 11 Balance Billing definition> - SIV_CGA04-INS-Monitoring complaints <Pg 2 Procedure A>	☐ Met ☒ Not Met
PAHP Description of Process: Note: DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made.		
HSAG Findings: HSAG’s review identified the following findings: - Although the <i>DQ Provider ORM Draft Review v2</i> (provider manual) included information to inform providers of the prohibition of balance billing members for covered services, specifics related to Contract Section F.8 were not clearly identified (e.g., cost sharing, exempt populations, copayments for Iowa DWP members in accordance with Iowa Administrative Code-441 IAC §779.1[13]). - The provider agreement templates submitted had cited language that applied to Medicare Advantage members and not Medicaid members, and the Iowa Medicaid Addendum did not include the requirements of this element. The PAHP submitted its <i>CGA04-INS-Monitoring Complaints</i> policy; however, it		

Standard IV—Availability of Services		
Requirement	Supporting Documentation	Score
was not clear how the PAHP would confirm and subsequently monitor all providers to ensure provider adherence to cost-sharing and balance billing requirements through the PAHP’s complaints process. - In follow-up, the PAHP submitted its <i>NET32-INS Access and Availability Survey</i> policy and procedure; however, the exhibit included appointment standards and the PAHP’s availability of services survey process, and not the requirements of this element. Recommendations: HSAG strongly recommends that the PAHP establish monitoring mechanisms to ensure that providers do not balance bill members for all or part of any covered services except when allowed under Title XIX or through Contract. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Update its provider manual to include all applicable Contract requirements regarding cost sharing. - Update applicable policies and procedures to include the requirements of this element. - Include language within its provider agreements for the Iowa DWP Adult, DWP Kids, and Hawki programs that the provider is prohibited from billing a member for all or any part of the cost of treatment service, except as allowed for Title XIX cost-sharing and client participation as described in Section F.8 of the Contract.		
<i>42 CFR §438.206(b)(6) requires the PAHP to demonstrate that its network providers are credentialed as required by §438.214. This requirement is reviewed under Standard VIII: Provider Selection.</i>		
Timely Access		
9. The PAHP meets and requires its network providers to meet HHS standards for timely access to care and services, taking into account the urgency of the need for services. Refer to the Appointment Times Checklist. 42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) Contract E.5.01(a) Contract Exhibit C: General Access Standards	HSAG Required Evidence: - Policies and procedures - Provider materials, such as the provider manual and provider contract - Plan to monitor compliance with appointment time standards (e.g., surveys, (submit contract, if survey to be conducted by a delegate), time frames/schedule, notice of results template to providers, corrective action plan [CAP] process, etc.) - HSAG will also use the results of the Appointment Times Checklist Evidence as Submitted by the PAHP: - SIV_NET05-INS-Provider Network Adequacy <Pg. 2, Procedure: B.1 and Pg. 2, D.3 and D.6> - SIV_Provider Reference Manual <Pg 17 Section 4.01 ¶2>	☐ Met ☒ Not Met

Standard IV—Availability of Services		
Requirement	Supporting Documentation	Score
	- SIV_NET32-INS Access and Availability Survey <Full Document> - SIV_PEC05-INS-Provider Disciplinary Action CAP and Appeal Policy <Pg 3 Procedure B 1>	
PAHP Description of Process: Note: DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made.		
HSAG Findings: Although the PAHP’s provider manual included the contractually required appointment time access standards, the <i>NET32-INC Access and Availability Survey, Exhibit A</i> policy did not include the appointment standards for emergency and poststabilization services standards. Of note, the emergency and poststabilization services access standards were included in the <i>NET05-INC-Provider Network Adequacy FINAL</i> policy and procedure; however, it did not include the contractually required dentist and specialty care access standards, indicating inconsistencies between applicable policies exist and may be confusing to PAHP staff members.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Update applicable policies and procedures to include all contractually required appointment time access standards to ensure consistency in information provided to PAHP staff members.		
10. The PAHP ensures that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for service (FFS) if the provider serves only Medicaid <i>and/or CHIP</i> members. 42 CFR §438.206(c)(1)(ii) 42 CFR §457.1230(a) Contract E.5.01(b)	HSAG Required Evidence: - Policies and procedures - Provider materials, such as the provider manual and provider contract - Plan for provider monitoring of hours of operation Evidence as Submitted by the PAHP: - SIV_NET05-INS-Provider Network Adequacy <Pg 2 Procedure D> - SIV_2026.02.26 DRAFT Provider Agreement FQHC <Page 2, Section 3d – Non-discrimination> - SIV_230206 IA MA MC HIX Provider Agreement<Page 2, Section 3d – Non-discrimination> - SIV_2026.02.04 Iowa Provider Education Plan <Full Document>	☒ Met ☐ Not Met

Standard IV—Availability of Services		
Requirement	Supporting Documentation	Score
	SIV_NET32-INS Access and Availability Survey<Full Document>	
PAHP Description of Process: DentaQuest will continue to educate providers on appointment availability during webinars and through appointment availability surveys.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
11. The PAHP makes services included in the contract available 24 hours a day, seven days a week, when medically necessary. a. <i>Provide reasonable and adequate hours of operation, including 24 hour availability of information, referral, and treatment for dental-related emergency medical conditions.</i> 42 CFR §438.206(c)(1)(iii) 42 CFR §457.1230(a) Contract E.1.01(a) Contract E.5.01(c)	HSAG Required Evidence: - Policies and procedures - Provider materials, such as the provider manual and provider contract - Plan for provider monitoring of service availability Evidence as Submitted by the PAHP: - SIV_Provider Reference Manual<DWP and Hawki Benefit grid – D995/D9996> - SIV_2026.02.26 DRAFT Provider Agreement FQHC - SIV_230206 IA MA MC HIX Provider Agreement - SIV_Teledentistry.com flyer<Full Document>	☒ Met ☐ Not Met
PAHP Description of Process: DentaQuest uses Teledentistry.com; Teledentistry - we do not have a standard contract; we have one unique provider with a special deal. Note: DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		

Standard IV—Availability of Services		
Requirement	Supporting Documentation	Score
12. The PAHP establishes mechanisms to ensure compliance with timely access to care and services standards by network providers. a. The PAHP monitors network providers regularly to determine compliance. b. The PAHP takes corrective action if there is a failure to comply by a network provider. 42 CFR §438.206(c)(1)(iv-vi) 42 CFR §457.1230(a) Contract E.5.01(d-e)	HSAG Required Evidence: • Policies and procedures • Plan to monitor compliance with appointment time standards (e.g., surveys [submit contract, if survey to be conducted by a delegate], time frame/schedule, notice of results template to providers, CAP process, etc.) • CAP template Evidence as Submitted by the PAHP: • SIV_NET05-INS-Provider Network Adequacy <Pg 2 Procedure B and E> • SIV_NET32-INS Access and Availability Survey <Full Document> • SIV_PEC05-INS-Provider Disciplinary Action CAP and Appeal Policy <Pg 3 Procedure B 1> • SIV_PRC and Corrective Action Plan Letter Template <Full Document>	☒ Met ☐ Not Met
PAHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
13. <i>The PAHP shall maintain an emergency/contingency plan in the event that a large provider of services collapses or is otherwise unable to provide needed services.</i> Contract E.1.22	HSAG Required Evidence: • Policies, procedures, and workflows • Emergency/contingency plan template that identifies alternative providers Evidence as Submitted by the PAHP: • SIV_NET05-INS-Provider Network Adequacy <Pg 2 Procedure B and D>	☒ Met ☐ Not Met

Standard IV—Availability of Services		
Requirement	Supporting Documentation	Score
	- SIV_NET32-INS Access and Availability Survey <Full Document> - SIV_NET01-INS-Network Development Maintenance and Use<Procedure C 1-2>	
PAHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: HSAG strongly recommends that the PAHP enhance the language in its <i>NET05-INS-Provider Network Adequacy</i> policy and procedure to expand on steps the PAHP will take to ensure services needed will be provided to members in the event a large provider of services is unable to provide services or other significant gaps in providing services to members exist.		
Required Actions: None.		
Access and Cultural Considerations		
14. The PAHP participates in HHS’s efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex, which includes sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; and sex stereotypes. 42 CFR §438.206(c)(2) 42 CFR §457.1230(a) Contract G.6.01	HSAG Required Evidence: - Policies and procedures - Provider materials, such as the provider manual and provider contract - Cultural competency plan - Cultural competency training plan - Example(s) of provider profiles (e.g., cultural and linguistic capabilities) on provider directory - Provider Network Onboarding Plan (as requested in the PAHP Questionnaire) Evidence as Submitted by the PAHP: - SIV_CS09-INS-CS Member Access with LEP <Pg 1 Procedure A> - SIV_2026.02.26 DRAFT Provider Agreement FQHC<Pg 13, Section 1.15 – Non-Discrimination>	☒ Met ☐ Not Met

Standard IV—Availability of Services		
Requirement	Supporting Documentation	Score
	- SIV_230206 IA MA MC HIX Provider Agreement<Pg 13, Section 1.15 – Non-Discrimination> - SIV_Provider Reference Manual <Pg 51 Section 17.00 Cultural Competency Program> - SIV_DentaQuest Enterprise Cultural Competency Plan <Pg 3 CLAS Standard One> - SIV_cultural-competency-nondiscrimination-training <Full Document> - SIV_2026.02.18 TEMPLATE Provider Training <Full Document> - SIV_Provider Portal screenshot_Languages - SIV_NET01-INS-Network Development Maintenance and Use<Full Document>	
PAHP Description of Process: Note: DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Of note, please refer to Standard II—Member Rights and Member Information, Element 17 for additional findings and recommendations that also apply to the requirements for this element.		
Required Actions: None.		
15. <i>The PAHP addresses the special health needs of members who are poor, homeless, and/or members of a minority population group. The PAHP incorporates in its policies, administration, and service practice, and communicates them to providers and subcontractors, the value of:</i> <i>Honoring members’ beliefs;</i> <i>Sensitivity to cultural diversity;</i>	HSAG Required Evidence: - Policies and procedures - Provider materials, such as the provider manual and provider contract - Subcontractor materials, such as the subcontractor contract, if applicable - Cultural competency plan - Cultural competency training plan	☒ Met ☐ Not Met

Standard IV—Availability of Services		
Requirement	Supporting Documentation	Score
c. <i>Fostering in staff and providers’ attitudes and interpersonal communication styles which respect members’ cultural backgrounds.</i> 42 CFR §438.206(c)(2) 42 CFR §457.1230(a) Contract G.6.02	• Example(s) of provider profiles (e.g., cultural and linguistic capabilities) on provider directory • Provider Network Onboarding Plan (as requested in the PAHP Questionnaire) Evidence as Submitted by the PAHP: • SIV_COM-FED-02-Enrollee Rights<Full Document> • SIV_Provider Reference Manual <Pg 51 Section 17.00 Cultural Competency Program> • SIV_2026.02.26 DRAFT Provider Agreement FQHC<Pg 13, Section 1.15 – Non-Discrimination> • SIV_230206 IA MA MC HIX Provider Agreement<Pg 13, Section 1.15 – Non-Discrimination> • SIV_DentaQuest Enterprise Cultural Competency Plan <Pg 3 CLAS Standard One> • SIV_cultural-competency-nondiscrimination-training <Pg 3 all> • SIV_2026.02.18 TEMPLATE Provider Training <Full Document> • SIV_FAD_Provider Search • SIV_NET01-INS-Network Development Maintenance and Use<Full Document>	
PAHP Description of Process: Note: DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: HSAG recommends that the PAHP enhance the language in its cultural competency plan and training documents to expand on how the PAHP honors members’ beliefs, is sensitive to cultural diversity, and fosters staff and providers’ attitudes and interpersonal communication styles which represent members’ cultural backgrounds.		
Required Actions: None.		

Standard IV—Availability of Services		
Requirement	Supporting Documentation	Score
Accessibility Considerations		
16. The PAHP ensures that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid <i>and/or</i> CHIP members with physical or mental disabilities. 42 CFR §438.206(c)(3) 42 CFR §457.1230(a) Contract E.5.02	HSAG Required Evidence: • Policies and procedures • Provider materials such as the provider manual and provider contract • Mechanism to assess network providers' accessibility • Example(s) of provider profiles (i.e., accessibility accommodations (e.g., wide entries, wheelchair access, accessible exam tables and rooms, lifts, scales, bathrooms, grab bars, or other equipment)) on provider directory • Provider Network Onboarding Plan (as requested in the PAHP Questionnaire) Evidence as Submitted by the PAHP: • SIV_NET07-INS-Access to Dental Services for Members <Pg 4 Procedure D> • SIV_Provider Reference Manual<Pg 20, Member Special Needs Considerations> • SIV_2026.02.26 DRAFT Provider Agreement FQHC<Pg 2, Section 3 d – Non-Discrimination> • SIV_230206 IA MA MC HIX Provider Agreement<Pg 2, Section 3 d – Non-Discrimination> • SIV_DQ3805 Office Profile Credentialing Form_ADA (10.25)<Page 1 Service Office Detail> • SIV_Member_Provider search <Image> • SIV_NET01-INS-Network Development Maintenance and Use<Full Document>	☒ Met ☐ Not Met
PAHP Description of Process: Note: DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made.		

Standard IV—Availability of Services		
Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Of note, please refer to Standard II—Member Rights and Member Information, Element 17 for additional findings and recommendations that also apply to the requirements for this element.		
Required Actions: None.		

Standard IV—Availability of Services						
Met	=	12	X	1	=	12
Not Met	=	4	X	0	=	0
Total	=	16	Total Score	=		12
Total Score ÷ Total					=	75%

Standard V—Assurances of Adequate Capacity and Services

Standard V—Assurances of Adequate Capacity and Services		
Requirement	Supporting Documentation	Score
Basic Rule		
1. The PAHP gives assurances to HHS and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with HHS’s standards for access to care under 42 CFR §438.207, including the standards at §438.68 and §438.206(c)(1). a. The PAHP submits documentation to HHS, in a format specified by HHS, to demonstrate that it complies with the following requirements: i. Offers an appropriate range of preventive, dental primary care, and specialty services available for patient referrals that is adequate for the anticipated number of members for the service area. ii. Maintains a network of providers, actively accepting patient referrals, that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. 42 CFR §438.207(a) 42 CFR §438.207(b) (1-2) 42 CFR §457.1230(b) Contract E.1.01(b) Contract E.1.24 Contract E.1.26-E.1.27 Contract Exhibit C: General Access Standards	HSAG Required Evidence: • Policies and procedures • Provider Network Onboarding Plan (as requested via the Questionnaire) • Plan for network adequacy monitoring • Network adequacy reports/analyses (i.e., provider network and performance target reports, including the projected number of providers required for each provider type and contracting status) • HSAG will also use the results of the Network Adequacy Checklist Evidence as Submitted by the PAHP: • SV_NET01-INS-Network Development Maintenance and Use <Pg 1-2, A. 1, A. 2, A. 3 & A. 4> • SV_NET05-INS-Provider Network Adequacy <Full Document> • SV_SAMPLE Network Analysis - GEO Report <Full Document> • SV_2026.02.04 Iowa Provider Education Plan <Full Document> • SV_NET32-INS Access and Availability Survey <Pg 1-2 Process 1-3>	☐ Met ☒ Not Met
PAHP Description of Process: The Iowa GEO Report will not be available until after go-live; therefore, a sample GEO Report is included to illustrate the process we will use moving forward to monitor and maintain network adequacy.		
HSAG Findings: HSAG’s review identified the following findings:		

Standard V—Assurances of Adequate Capacity and Services		
Requirement	Supporting Documentation	Score
- The PAHP confirmed that its provider network consisted of 28 contracted providers at the time of the review, indicating that substantial gaps remain in the PAHP building an adequate provider network. While HSAG understands that it takes time for a new PAHP to build its provider network and the PAHP indicated it had a plan to outreach to recruit and contract with dental providers and build its network, concerns remain that the PAHP was not able to demonstrate that more progress had been made in building its provider network. - HSAG had requested that the PAHP submit a provider network onboarding plan that included all requirements outlined in question 10 of the <i>Readiness Review Questionnaire</i>; however, the PAHP’s Provider Onboarding Plan did not include the number/mix of provider types by specialty expected to be contracted with the PAHP by July 1, 2026, and the number/mix of provider types by specialty currently contracted with the PAHP, rather included a screenshot of a county analysis that included dental location specific detail and recruitment target, but it did not include all specialty provider types outlined in Contract. Further, while the PAHP indicated as part of its Provider Onboarding Plan that it has a current network in Iowa serving Medicare Advantage members and indicated that the PAHP would use this network to “...accelerate Medicaid network expansion, support continuity of care where applicable, and efficiently scale provider participation to meet Iowa Medicaid managed care program requirements,” it was unclear how many providers are included in this network, if the PAHP has confirmed that these providers will also accept Medicaid members, and if any of these providers are also contracted to serve DWP Adults, DWP Kids, and Hawki members. - The GeoAccess reports the PAHP submitted in follow-up, each type of specialty (i.e., oral surgery, orthodontia, prosthodontia, periodontia, endodontia, and pediatric specialties) was not included but rather reported as a whole, as “specialists.” Without the specificity in the PAHP’s network adequacy reports, it does not provide an accurate picture of whether the PAHP has an adequate network, where provider type gaps exist, and if the PAHP meets the required time and distance access standards. Recommendations: While not specific to this element but this entire standard, HSAG strongly recommends that the PAHP ensure it includes the specific procedures for how the PAHP implements the Iowa-specific contract requirements in its policies. These procedures can be included as an appendix to a policy, SOP, workflow, and/or other formal guidance document.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Demonstrate that significant progress has been made toward achieving an adequate network with an appropriate range of providers to serve members assigned to the PAHP. - Submit the number/mix of provider types by specialty expected to be contracted with the PAHP by July 1, 2026, and the number/mix of provider types by specialty currently contracted with the PAHP for each county and urbanicity. - Submit network adequacy reports routinely that demonstrate significant progress toward establishing a sufficient provider network and include, at a minimum, provider counts by provider type and a time and distance analysis once the PAHP receives an enrollment file from HHS. Additionally, the PAHP must ensure that it calculates the time and distance for each provider type using the personal residences of members.		

Standard V—Assurances of Adequate Capacity and Services		
Requirement	Supporting Documentation	Score
Submit provider listings for the DWP Adults, DWP Kids, and Hawki programs routinely that include the provider’s name, provider location, and program(s) served.		
Timing		
2. The PAHP submits the documentation in 42 CFR §438.207(b) as specified by HHS, but no less frequently than the following: - At the time it enters into a contract with HHS. - On an annual basis. <i>Monthly thereafter.</i> - At any time there has been a significant change (as defined by HHS) in the PAHP’s operations that would affect the adequacy of capacity in services, including: - Changes in PAHP services, benefits, geographic service area, composition of or payments to its provider network; or - Enrollment of a new population in the PAHP. “Significant change” is defined in contract as a change in the PAHP’s operation or the program, changes in services, changes in benefits, changes in payments, enrollment of a new population, or as otherwise requested by HHS. 42 CFR §438.207(c) 42 CFR §457.1230(b) Contract E.1.28 Contract E.1.32	HSAG Required Evidence: - Policies and procedures - Provider Network Onboarding Plan (as requested via the Questionnaire) - Network adequacy reports/analyses (i.e., provider network and performance target reports, including the projected number of providers required for each provider type and contracting status) - Calendar of deliverables to comply with HHS’ reporting requirements, as applicable Evidence as Submitted by the PAHP: - SV_NET05-INS-Provider Network Adequacy <Full Document> - SV_2026.02.04 Iowa Provider Education Plan <Full Document> - SV_2026.02.18 TEMPLATE Provider Training <Full Document> - SV_Iowa PAHP Reporting Manual - July 2026 VXX-Draft <Full Document>	☒ Met ☐ Not Met
PAHP Description of Process: The Reporting Calendar is currently under development and will be finalized prior to the plan go-live.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Of note, in follow-up to the review, the PAHP provided sufficient evidence to receive a <i>Met</i> score for this element.		
Required Actions: None.		

Standard V—Assurances of Adequate Capacity and Services		
Requirement	Supporting Documentation	Score
State Requirements		
3. <i>For the first six months from the PAHP's entry into the Iowa Dental Wellness Plan and Hawki Dental program marketplace, the PAHP shall give providers, who are currently enrolled as Iowa Medicaid providers, the opportunity to be part of its network.</i> Contract E.3.18	HSAG Required Evidence: • Policies and procedures • Process to identify all Iowa Medicaid dental providers • Process to offer inclusion in PAHP's network to all Iowa Medicaid dental providers Evidence as Submitted by the PAHP: • SV_NET05-INS-Provider Network Adequacy <Full Document> • SV_SAMPLE Network Analysis - GEO Report <Full Document> • SV_2026.02.04 Iowa Provider Education Plan <Full Document> • SV_2026.02.18 TEMPLATE Provider Training <Full Document>	☒ Met ☐ Not Met
PAHP Description of Process: The Iowa GEO Report will not be available until after go-live; therefore, a sample GEO Report is included to illustrate the process we will use moving forward to monitor and maintain network adequacy.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Of note, in follow-up to the review, the PAHP provided sufficient evidence to receive a <i>Met</i> score for this element.		
Required Actions: None.		

Standard V—Assurances of Adequate Capacity and Services		
Requirement	Supporting Documentation	Score
4. <i>The PAHP offers to contract with all federally qualified health centers (FQHCs) located in Iowa.</i> a. <i>The PAHP may establish quality standards that FQHCs must meet to be offered network participation and that HHS reviewed and approved.</i> b. <i>The PAHP reimburses all FQHCs the Prospective Payment System (PPS) rate or fee-for-services (FFS) in effect on the date of service for each encounter.</i> c. <i>The PAHP does not enter into alternative reimbursement arrangements without prior approval from HHS.</i> Contract E.1.14	HSAG Required Evidence: • Policies and procedures • One example of an FQHC contract • Quality standards FQHCs must meet to be offered network participation, if applicable (if the PAHP has not set any quality standards, state so in the PAHP Description of Process) • Alternative reimbursement arrangement, if applicable (if the PAHP has not entered into alternative reimbursement arrangement, state so in the PAHP Description of Process) • Network adequacy reports/analyses • Provider Network Onboarding Plan (as requested via the Questionnaire)	☒ Met ☐ Not Met
	Evidence as Submitted by the PAHP: • SV_SAMPLE Network Analysis - GEO Report <Full Document> • SV_2026.02.18 DRAFT Provider Agreement FQHC Pg. 18 ADDENDUM C-1>	
PAHP Description of Process: The Iowa plan is not yet live, so reports cannot be generated. A sample GEO Report illustrates our post-go-live monitoring process.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Of note, in follow-up to the review, the PAHP provided sufficient evidence (e.g., provider onboarding plan) to receive a <i>Met</i> score for this element.		
Required Actions: None.		

Standard V—Assurances of Adequate Capacity and Services		
Requirement	Supporting Documentation	Score
5. <i>The PAHP shall offer to contract with all Screening and Maternal Health Centers and Public Health providers located in Iowa.</i> a. <i>The PAHP must reimburse these provider types for dental services provided under the agency or individual provider number as applicable.</i> Contract E.1.16	HSAG Required Evidence: • Policies and procedures • One example of a screening and maternal health center and public health provider contract • Network adequacy reports/analyses • Documentation of outreach to screening and maternal health centers and public health providers • Provider Network Onboarding Plan (as requested via the Questionnaire)	☒ Met ☐ Not Met
	Evidence as Submitted by the PAHP: • SV_NET05-INS-Provider Network Adequacy <Full Document> • SV_2026.02.04 Iowa Provider Education Plan <Full Document> • SV_2026.02.18 TEMPLATE Provider Training <Full Document>	
PAHP Description of Process: Processes associated with screening and maternal health centers and public health providers remain in development during network build for go-live; therefore, the supporting materials are not yet available.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Of note, in follow-up to the review, the PAHP provided sufficient evidence (e.g., provider onboarding plan) to receive a <i>Met</i> score for this element.		
Required Actions: None.		
6. <i>The PAHP has strategies, policies, and procedures describing how it utilizes and partners with community entities and advocates, including transportation and enabling services, and documents such in the Policy and Procedure Manual (PPM). At a minimum, the PAHP must include strategies for:</i>	HSAG Required Evidence: • Policies and procedures • Community engagement strategies • Community partners resource list	☐ Met ☒ Not Met
	Evidence as Submitted by the PAHP:	

Standard V—Assurances of Adequate Capacity and Services		
Requirement	Supporting Documentation	Score
a. <i>Developing member referral networks with emergency departments and urgent care clinics to provide outreach and referral processes for members who present with urgent and emergent dental conditions and need referral including educating providers on use of the Dental Call Line.</i> Contract E.1.18	SV_Iowa Provider Office Reference Manual <Pg 35 Section 10.06>	
PAHP Description of Process: The strategies and community partner resource list will be developed after go-live, once network development is complete.		
HSAG Findings: The PAHP did not submit policies and procedures as required for this element. In follow-up to the review, the PAHP submitted its <i>DQ Case Management and Care Coordination Manual</i>; however, it did not include information related to a member referral network with emergency departments and urgent care clinics to provide outreach, a referral process for members who present with urgent and emergent dental conditions and require referrals to resources, and educating providers on use of the dental call line.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Develop formal policies and procedures that describe strategies the PAHP utilizes and partner with community entities and advocates, including transportation and enabling services, and, at a minimum, detail strategies for: - Developing member referral networks with emergency departments and urgent care clinics to provide outreach and referral. - Processes for members who present with urgent and emergent dental conditions and need referral. - Educating providers on use of the dental call line.		
7. <i>The PAHP must establish a program of assertive provider outreach to rural areas where services may be less available than in urban areas.</i> a. <i>The PAHP must also monitor utilization across the State and in rural and urban areas to assure equality of service access and availability.</i> b. <i>Where the PAHP's monitoring shows the need for increased access to services, the PAHP must submit an action plan to HHS for approval.</i> Contract E.1.31	HSAG Required Evidence: - Policies and procedures - Network adequacy reports/analyses - Documentation of assertive provider outreach to rural areas - Provider Network Onboarding Plan (as requested via the Questionnaire) Evidence as Submitted by the PAHP: - SV_NET05-INS-Provider Network Adequacy <Full Document>	☒ Met ☐ Not Met

Standard V—Assurances of Adequate Capacity and Services		
Requirement	Supporting Documentation	Score
	- SV_SAMPLE Network Analysis - GEO Report <Full Document> - SV_2026.02.04 Iowa Provider Education Plan <Full Document> - SV_2026.02.18 TEMPLATE Provider Training <Full Document>	
PAHP Description of Process: The provider network is still being built in advance of the 7/1/26 go-live, so network adequacy reports are not yet available. A sample GEO Report is included to show the monitoring process we will use after go-live, including heat maps and geo-location analysis to identify underserved rural areas.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Of note, in follow-up to the review, the PAHP provided sufficient evidence (e.g., provider onboarding plan) to receive a <i>Met</i> score for this element.		
Required Actions: None.		
Exceptions Process		
8. To the extent the State permits an exception to any of the provider-specific network standards. a. <i>For areas of the State where provider availability is insufficient to meet HHS standards, for example in health professional shortage areas and medically underserved areas, the Access standards shall meet the Usual and Customary Standards for the Community. Exceptions to the requirements shall be justified and documented to the State on the basis of community standards.</i> 42 CFR §438.68(d) 42 CFR §438.207 42 CFR §457.1230(b) Contract E.5.08 Contract Exhibit C: General Access Standards	HSAG Required Evidence: - Policies and procedures - Network monitoring report(s) - Exceptions requested by the PAHP, if applicable - Exceptions approved by HHS, if applicable Evidence as Submitted by the PAHP: - SV_NET05-INS-Provider Network Adequacy <Full Document> - SV_2026.02.04 Iowa Provider Education Plan <Full Document> - SV_2026.02.18 TEMPLATE Provider Training <Full Document> - SV_Iowa PAHP Reporting Manual - July 2026 VXX-Draft <Pg. 15, B-3 & Pg. 16, B-11>	☒ Met ☐ Not Met

Standard V—Assurances of Adequate Capacity and Services		
Requirement	Supporting Documentation	Score
PAHP Description of Process: The Reporting Calendar is currently under development and will be finalized prior to the plan go-live. Recruitment is underway and we are still building our network so exceptions are not available.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: Although the <i>NET05-INS-Provider Network Adequacy</i> policy and procedure included the verbatim language of the requirements of this element, HSAG strongly recommends that the PAHP include additional details on the process it will use to determine “usual and customary standards for the community” when determining appropriateness for requesting an exception to the network adequacy standards from HHS.		
Required Actions: None.		
9. The PAHP must demonstrate that there are sufficient Indian Health Care Providers (IHCPs) participating in the provider network to ensure timely access to services available under the Contract from such providers for Indian members who are eligible to receive services. a. If timely access to covered services cannot be ensured due to few or no IHCPs, the PAHP must: - Allow Indian members to access out-of-state IHCPs or show good cause for disenrollment from both the PAHP and Iowa Medicaid’s managed care program in accordance with 42 CFR §438.56(c). - Permit Indian members to obtain services covered under the Contract from out-of-network IHCPs from whom the member is otherwise eligible to receive such services. - Permit an out-of-network IHCP to refer an Indian member to a network provider. 42 CFR §438.14(b)(1–6) 42 CFR §438.56(c) 42 CFR §438.68(d) 42 CFR §438.207 42 CFR §457.1230(b) Contract B.7	HSAG Required Evidence: - Policies and procedures - Network monitoring report(s) for IHCPs - Mechanism to identify Indian members - Provider Network Onboarding Plan Evidence as Submitted by the PAHP: - SV_NET05-INS-Provider Network Adequacy <Full Document> - SV_2026.02.04 Iowa Provider Education Plan <Full Document> - SV_2026.02.18 TEMPLATE Provider Training <Full Document> - SV_SAMPLE Network Analysis - GEO Report <Full Document>	☒ Met ☐ Not Met

Standard V—Assurances of Adequate Capacity and Services		
Requirement	Supporting Documentation	Score
Contract E.9		
PAHP Description of Process: The sample GEO Report fulfills the monitoring requirement and illustrates what Iowa's GEO monitoring will look like after go-live.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: HSAG strongly recommends that the PAHP implement monitoring mechanisms to assess IHCP network providers compared to enrolled members identified as Indian members to evaluate network adequacy and ensure timely access to services are available to Indian members under the Contract.		
Required Actions: None.		

Standard V—Assurances of Adequate Capacity and Services						
Met	=	7	X	1	=	7
Not Met	=	2	X	0	=	0
Total	=	9	Total Score	=		7
Total Score ÷ Total					=	78%

Standard VI—Coordination and Continuity of Care

Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
Care Coordination and Services		
<i>Under 42 CFR §438.208(a)(2) For PIHPs and PAHPs, the State determines, based on the scope of the entity's services, and on the way the State has organized the delivery of managed care services, whether a particular PIHP or PAHP is required to implement mechanisms for identifying, assessing, and producing a treatment plan for an individual with special health care needs, as specified in 42 CFR §438.208(c).</i>		
1. The PAHP 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. a. The member is provided information on how to contact their designated person or entity. 42 CFR §438.208(b)(1) 42 CFR §457.1230(c) Contract G.2.01–G.2.02	HSAG Required Evidence: • Policies and procedures • Care coordination program description • Member materials, such as the member handbook or member notice • Screenshot of member identification (ID) card • Definition of person or entity designated as being primarily responsible for coordinating services • Mechanism to provide information to members on how to contact their designated person or entity • Screenshot of fields designating the assigned care coordinator/case manager • HSAG will also use the results of the system demonstration (i.e., mock care coordination record) Evidence as Submitted by the PAHP: • SVI_IA_DENTAL_CMPDT.01 <Pg 15 Assistance and Desired Outcomes> • SVI_Provider Reference Manual <Pg 14 Sample ID Card>	☒ Met ☐ Not Met
PAHP Description of Process: Note: DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		

Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
2. The PAHP coordinates the services the PAHP furnishes to the member: a. With the services the member receives from any other PAHP or MCO. b. With the services the member receives in fee-for-service (FFS) Medicaid. c. With the services the member receives from community and social support providers. 42 CFR §438.208(b)(2) 42 CFR §457.1230(c) Contract G.2.06–G.2.08	HSAG Required Evidence: • Policies and procedures • Care coordination program description • Transition of care program • Workflow for coordinating with another PAHP • Workflow for coordinating with FFS • Workflow for coordinating with community and social support resources • Workflow for coordinating with MCOs • Workflow for coordinating with the I-Smile Program Evidence as Submitted by the PAHP: • SVI IA DENTAL CMPDT.01 <Pg 6 Care Coordination with other IA Medicaid...>	☒ Met ☐ Not Met
PAHP Description of Process: HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: While the PAHP included in its <i>IA DENTAL CMPDT.01</i> (Dental Case Management Program Description) that it will coordinate services with other MCPs, fee-for-service (FFS) Medicaid, and community and social support services, HSAG strongly recommends that the PAHP develop workflows and/or training documents that specify how care coordinators will coordinate services with each entity type listed in this element. Required Actions: None.		
Clinical Records Documentation		
3. <i>The PAHP maintains in its information system (IS) the information necessary to assist in authorizing and monitoring services as well as providing data necessary for quality assessment and other evaluative activities, and the information</i>	HSAG Required Evidence: • Policies and procedures • Screenshots of information system fields • Staff training materials • HSAG will also use the results of the system demonstration (i.e., mock care coordination record)	☐ Met ☒ Not Met

Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
<i>includes all the requirements listed in the Clinical Records Checklist.</i> Contract K.30	HSAG will also use the results of the Clinical Records Checklist	
	Evidence as Submitted by the PAHP: SVI IA DENTAL CMPDT.01 <Pg 7 Systems and Tools>	
PAHP Description of Process:		
HSAG Findings: HSAG’s review identified the findings below: - For Requirement #2 in the <i>Clinical Records Checklist</i>, PAHP staff members explained that documentation of clinical services requested, services authorized, services provided, and the application of UM criteria would be documented in the PAHP’s Windward system. However, staff members noted that they would not substitute services, so this would not be documented in Windward. However, if, during the course of a PA request, the PAHP identifies alternative services the provider may want to consider that are more clinically appropriate than the service that was requested, the PAHP must document this in its system in a place where care coordinators and case managers will be able to access the information. - For Requirement #3 in the <i>Clinical Records Checklist</i>, PAHP staff members noted that there was not a specific location in Windward (either in the care coordination module or the prior authorization module) to notate the reasons for the non-authorization based on Iowa Administrative Code (IAC) citations and substitutions offered. - For Requirement #4 in the <i>Clinical Records Checklist</i>, PAHP staff members indicated that there is currently no place to document missed appointments and subsequent attempts to follow up with the member in the Windward system and that the PAHP will identify an area to record this information.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Provide evidence (e.g., screenshots) of where in the information system the PAHP will document services substituted when the PAHP identifies alternative services the provider may want to consider that are more clinically appropriate than the service that was requested. - Provide evidence (e.g., screenshots) of where in the information system the PAHP will document services not authorized, including the reasons for the non-authorization based on IAC citations and substitutions offered. - Provide evidence (e.g., screenshots) of where in the information system the PAHP will document missed appointments and subsequent attempts to follow up with the member. - Submit staff training materials that include these Iowa-specific requirements, explaining where this information must be documented in the information system.		

Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
Information Sharing		
4. The PAHP shares with HHS or other PAHPs or MCOs, 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) 42 CFR §457.1230(c) Contract G.2.29	HSAG Required Evidence: • Policies and procedures • Workflow for sharing assessment results with HHS • Workflow for sharing assessment results with other MCOs/PAHPs • Care coordination program description Evidence as Submitted by the PAHP: • SVI_IA_DENTAL_CMPDT.01 <Pg 6 Care Coordination with other IA Medicaid...> • SVI_CM02-INS-MCD-Continuity and Coordination of Care <Pg 2 Procedure B 2>	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
5. The PAHP ensures that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards. 42 CFR §438.208(b)(5) 42 CFR §457.1230(c) Contract G.2.30	HSAG Required Evidence: • Policies and procedures • Care coordination program description • Provider materials, such as the provider manual and provider contract • Method(s) for monitoring provider member health records Evidence as Submitted by the PAHP: • SVI_Provider Reference Manual <Pg 30 first bullet>	☐ Met ☒ Not Met
PAHP Description of Process: Note: DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made.		
HSAG Findings: The information related to the patient health record found on pages 38–41 of the <i>Provider Office Reference Manual (ORM)</i> included standards for organization, content, and compliance; however, the PAHP did not cite other documents for this element. During the review, HSAG requested		

Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
the process for how the PAHP will ensure that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards (e.g., a chart audit process). HSAG also requested the <i>HIPAA Companion Guide</i> referenced on page 38 of the <i>ORM</i> . However, these documents were not submitted as requested.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Develop and submit a process for how the PAHP will ensure that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards (i.e., a chart audit process). - Submit the <i>HIPAA Companion Guide</i> referenced in the <i>ORM</i>.		
6. The PAHP ensures that in the process of coordinating care, each member’s privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable. 42 CFR §438.208(b)(6) 42 CFR §457.1230(c) 45 CFR Part 160 45 CFR Part 164, Subparts A and E Contract G.2.33	HSAG Required Evidence: - Policies and procedures - Care coordination program description - Method(s) for monitoring adherence to privacy rules - Staff training materials Evidence as Submitted by the PAHP: - SVI_IA_DENTAL_CMPDT.01 <Pg 5 DentaQuest Annual Trainings> - SVI_PRIV01-ENT-Privacy Policy <Pg 1 Policy and References>	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
Initial Oral Health Risk Screening		
7. The PAHP makes a best effort to conduct an initial screening of each member’s needs within 90 days of the effective date of enrollment for all new members including subsequent attempts if the initial attempt to contact the member is unsuccessful.	HSAG Required Evidence: - Policies and procedures - Care coordination program description - Initial screening template - Initial screening tracking and monitoring mechanisms - Staff training materials	☐ Met ☒ Not Met

Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
a. <i>The PAHP must document at least three attempts to conduct the screening.</i> 42 CFR §438.208(b)(3) 42 CFR §457.1230(c) Contract G.2.09–10 Contract G.2.13	- HSAG will also use the results of the system demonstration (i.e., mock care coordination record) Evidence as Submitted by the PAHP: - SVI_IA_DENTAL_CMPDT.01 <Pg 7 Oral Health Screening and Equity Self-Assessment Tools> - SVI_CM02-INS-MCD-Continuity and Coordination of Care <Pg 2 Procedure B 1>	
PAHP Description of Process: HSAG Findings: During the review, PAHP staff members explained that once the telephonic screening process is completed, it will include an instructions document that will be provided to the vendor, TrachMar, which is the vendor that will be delegated to conduct the initial screenings. The PAHP provided an example instructions document that would be provided to TrachMar; however, the document was for another state and did not confirm the process that will be implemented for Iowa. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Provide the procedure document that outlines how the PAHP will conduct an initial screening of each member’s needs within 90 days of the effective date of enrollment for all new members, including the process for documenting at least three call attempts if the initial attempt to contact the member is unsuccessful. - Submit the Iowa-specific instructions document that will be provided to TrachMar, which must include the appropriate time frames for making the initial screening calls and the three attempts required by HHS.		
Comprehensive Assessment		
8. The PAHP implements mechanisms to comprehensively assess each Medicaid member identified by HHS and identified to the PAHP by HHS as having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. a. The assessment mechanisms use appropriate providers or individuals meeting service coordination requirements of HHS or PAHP as appropriate. 42 CFR §438.208(c)(2)	HSAG Required Evidence: - Policies and procedures - Care coordination program description - Documentation (e.g., program description, quality strategy, etc.) defining members with special dental healthcare needs - Comprehensive assessment template - Tracking and monitoring mechanisms for timely completion of additional assessments - HSAG will also use the results of the system demonstration (i.e., mock care coordination record)	☒ Met ☐ Not Met

Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
42 CFR §457.1230(c) Contract G.2.16	Evidence as Submitted by the PAHP: SVI_IA_DENTAL_CMPDT.01 <Pg 7 Oral Health Screening and Equity Self-Assessment Tools; Pg 9 Comprehensive Oral Health Risk Assessment; Pg 10 identifying Potentially At-Risk members >	
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
Direct Access to Specialists		
9. For members with special health <i>or dental</i> care needs determined through an <i>exam or dental hygiene</i> assessment to need a course of treatment or regular care monitoring, the PAHP must have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member’s condition and identified needs.	HSAG Required Evidence: - Policies and procedures - Care coordination program description - Member materials, such as the member handbook or benefits grid - Provider materials, such as the provider manual or provider contracts Evidence as Submitted by the PAHP: - SVI_IA_DENTAL_CMPDT.01 <Pg 15 Assistance and Desired Outcomes> - SVI_CM01-INS-MCD-Care Coordination and Referral <Pg 1-3 Procedures C, D, E, F> - SVI Provider Reference Manual <Pg 17 Section 4.02>	☒ Met ☐ Not Met
PAHP Description of Process: Note: DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		

Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
Recommendations: Although the <i>IA_DENTAL_CMPDT.01</i> program description and <i>ORM</i> included the appropriate information for this element, the three member handbooks (i.e., DWP Adult, DWP Kids, and Hawki) indicated that members may need a referral to see a special dentist and that the PAHP can help the member obtain the referral. However, this element requires that for members with special health or dental care needs determined through an exam or dental hygiene assessment to need a course of treatment or regular care monitoring, the PAHP must have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member’s condition and identified needs. HSAG recommends that the PAHP include this information in its member handbooks.		
Required Actions: None.		
State Care Coordination Program Requirements		
10. <i>The PAHP complies with all HHS-required care coordination program requirements as specified in the Care Coordination Checklist.</i> Contract G.2	HSAG Required Evidence: • Policies and procedures • Care coordination program description • Initial health risk screening tool template • Initial health risk screening tracking and monitoring mechanisms • Comprehensive health risk assessment tool template • Comprehensive assessment tracking and monitoring mechanisms • Process for monitoring dental treatment plan • Member outcomes tracking and reporting mechanisms • Method(s) for monitoring the effectiveness of the care coordination program • Staff training materials • HSAG will use the results of the Care Coordination Checklist • HSAG will also use the results of the system demonstration (i.e., mock care coordination record) Evidence as Submitted by the PAHP: • SVI_IA_DENTAL_CMPDT.01 • SVI_CM02-INS-MCD-Continuity and Coordination of Care	☒ Met ☐ Not Met
PAHP Description of Process:		

Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: Although the components of Requirement #1 of the <i>Care Coordination Checklist</i> are met, HSAG recommends that the PAHP ensure the process is approved by HHS. Required Actions: None.		
Transition/Continuity of Care		
11. The PAHP must implement a transition of care policy that is consistent with federal requirements and at least meets HHS' defined transition of care policy. The PAHP implements mechanisms to ensure the continuity of care of members transitioning in and out of the PAHP's enrollment pursuant to all requirements in 42 CFR §438.62. The PAHP demonstrates the following components are implemented to ensure continuity of care during transitions: - The member has access to services consistent with the access they previously had and is permitted to retain their current provider <i>for 90 days if that provider is enrolled in Iowa Medicaid</i>. - The member is referred to appropriate providers of services that are in the network. - The member is referred to appropriate providers of services that are in the network. - HHS, in the case of FFS, or the PAHP that was previously serving the member, fully and timely complies with requests for historical utilization data from the new PAHP in compliance with Federal and State law. - Consistent with Federal and State law, the member's new provider(s) are able to obtain copies of the member's medical records, as appropriate.	HSAG Required Evidence: - Policies and procedures - Care coordination program description - Member materials, such as the member handbook and welcome packet - Mechanisms to ensure continuity of care - Staff training materials - Transition of care program, including a process to obtain historical data (PAs, claims) from State and/or previous PAHP - Process to use historical data for transitions of care (e.g., add PAs to system) - Process to allow members to retain current providers Evidence as Submitted by the PAHP: - SVI_IA_DENTAL_CMPDT.01 <Pg 15 Assistance and Desired Outcomes>	☐ Met ☒ Not Met

Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
f. Any other necessary procedures as specified by the Secretary to ensure continued access to services to prevent serious detriment to the member’s health or reduce the risk of hospitalization or institutionalization. Possible transitions include but are not limited to: (i) initial program implementation; (ii) initial enrollment with the PAHP; (iii) transitions between PAHPs during the first 90 days of a member’s enrollment; and (iii) at any time for cause as described in Contract Section B.5.05. 42 CFR §438.62(b)(1)(i-vi) Contract G.2.34–G.2.35		
PAHP Description of Process: HSAG Findings: While the PAHP’s policies and procedures included the appropriate transition of care time frame, the member handbooks indicated that members may be able to keep seeing their current dentist for at least 30 days, even if the dentist is not in the PAHP’s network and that the PAHP will notify the member if a longer time applies. However, the requirement for Iowa Medicaid is that members can see their current dentist for 90 days. Additionally, the member handbooks were in draft form. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Update its member handbooks to ensure members have access to services consistent with the access they previously had and are permitted to retain their current provider for 90 days if that provider is enrolled in Iowa Medicaid. - Submit the final draft of the member handbooks with HHS’ approval.		

Standard VI—Coordination and Continuity of Care						
Met	=	7	X	1	=	7
Not Met	=	4	X	0	=	0
Total	=	11	Total Score		=	7
Total Score ÷ Total					=	64%

Standard VII—Coverage and Authorization of Services

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
Utilization Management Program		
1. <i>The PAHP develops, operates, and maintains a written utilization management (UM) program.</i> <i>The UM program assigns responsibility to appropriate individuals.</i> <i>The UM program description is exclusive to Iowa and does not contain documentation from other State Medicaid programs or product lines operated by the PAHP.</i> <i>Notification of the PAHP’s UM strategies, including identification of criteria to be utilized by the plan, is provided to the provider community 30 days prior to implementation or change.</i> Contract G.3.01 Contract G.3.03	HSAG Required Evidence: - UM program description - UM work plan required under G.3.03 - Organizational chart for UM department - Job descriptions for UM staff - Notice of UM criteria to providers Evidence as Submitted by the PAHP: - SVII_UM Program Description <Full Document> - SVII_UM Workplan <Full Document> - SVII_DentaQuest UM Organizational Chart <Full Document - SVII_NET01-INS-Network Development Maintenance and Use <page 3, Procedure 5. Provider Training, Element e>	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: While not critical to program implementation, the PAHP must implement the recommendations below: - After the review, the PAHP made updates to create a <i>UM Program Description</i> that is exclusive to the Iowa Medicaid managed care program. However, there were still a few instances where additional edits should be made to ensure all narrative is exclusive to Iowa. For example, “When indicated by a plan, written member notification will be provided for an approved benefit...” and “Requests for prepayment review are determined within 30 calendar days of receipt or as specified by the plan/state requirements.” As the PAHP should be aware of HHS’ contract requirements, these statements should reflect HHS’ contract. The PAHP must ensure that the <i>UM Program Description</i> is solely reflective of the Iowa Medicaid managed care program. - As the “Appeals of Denied Determinations” section of the <i>UM Program Description</i> included inaccurate information, HSAG requested that it review and update this section. While the PAHP made some corrections, the <i>New Program Description</i> submitted after the review continued to indicate that “[u]nder certain circumstances, the requestor may be required to follow the verbal request with a written statement or verification of the verbal request.” During the review, HSAG reiterated, more than once, that members are not required to follow a verbal appeal request with a written appeal request. As		

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
such, HSAG recommends that the PAHP conduct a thorough review of the “Appeals of Denied Determinations” section of the <i>UM Program Description</i> and make any necessary edits to correct inaccuracies. Further, during the review, HSAG also suggested that the PAHP may want to consider including a high-level summary of the appeal process and refer the reader to the PAHP’s appeal policy for specific details. HSAG continues to make this recommendation as the PAHP did not make all changes requested by HSAG. - The <i>UM Workplan</i> only included high-level “Objectives” and “Planned Activities to Accomplish Goals” and did not include any Specific, Measurable, Achievable, Relevant, and Time-bound (SMART) goals to promote appropriate utilization of dental services and improve dental-related health outcomes. While the PAHP does not yet have data to assess and monitor its UM program, the PAHP could include a SMART goal related to service authorization turnaround times (TATs); for example, “the PAHP will complete 100 percent of standard service authorizations within seven calendar days and 100 percent of expedited service authorizations within 72 hours.” As the PAHP’s UM program is implemented and data are available, the PAHP must continue to establish SMART goals. - As the <i>UM Workplan</i> was dated “2025,” HSAG requested that the workplan be updated to reflect the appropriate time span for the PAHP’s Iowa Medicaid managed care program, which did not exist in 2025, and clarify if the program and quarterly reviews occur on a state fiscal year (SFY) or calendar year (CY). The <i>Utilization Management Workplan 2025</i> submitted after the review continued to apply to 2025, and the PAHP did not clarify the time span (i.e., SFY or CY). The PAHP must update its workplan to align with program implementation for the Iowa Medicaid managed care program (i.e., 2026). - The requirements of sub-element (c) were included in the <i>NET01-INS-Network Development Maintenance and Use</i> policy. However, HSAG recommends that the PAHP develop a tracking and reporting mechanism to monitor adherence to the 30-day time frame standard, including a description of the change, the implementation date of the change, and the date the provider community is notified of the change. - The <i>UM Program Description</i> and <i>UM08-INS-Authorization Review</i> policy included a 30-calendar-day time frame (with a possible 14-calendar-day extension) for “retrospective” or “prepayment reviews.” However, the provisions under 42 CFR §438.210 do not address “retrospective” or “prepayment review” processes or time frames for completion. Therefore, the PAHP must consult with HHS on its process and time frame for completing these decisions (i.e., conducting medical necessity reviews of claims submitted after services have been rendered).		
Required Actions: None.		
2. <i>The UM program provides for methods of:</i> <i>Assuring the appropriateness of dental care.</i> <i>Analyzing emergency services utilization and diversion efforts.</i> <i>Monitoring patient data related to dental related illnesses and outpatient dental surgery.</i>	HSAG Required Evidence: - Policies and procedures - UM program description - UM work plan required under G.3.03 - Plan to monitor the provision of dental services and utilization patterns - Mock utilization monitoring reports	☒ Met ☐ Not Met

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
d. <i>Monitoring provider utilization practices and trends for any providers who appear to be operating outside of peer standards (i.e., aberrant provider practice patterns).</i> e. <i>Identifying instances of over- and under-utilization of dental emergency and limited exam services and other dental health care services.</i> f. <i>Evaluating efficiency and appropriateness of service delivery, facilitate program management and long-term quality and identify critical quality of care issues.</i> Contract G.3.03–G.3.04	Evidence as Submitted by the PAHP: - SVII_UM Program Evaluation <page 4, Under/Over Utilization Monitors> - SVII_UM Program Evaluation <page 10, Last paragraph > - SVII_FPR04-INS-DENT-Fraud Detection <page 2, Procedure B. Provider Outlier Report, C. Standard Deviation Report – Over Utilization, D. Standard Deviation Report – Under Utilization>	
PAHP Description of Process: PAHP systems are still being configured and developed. Mock reporting is not available yet.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: While not critical to program implementation, the PAHP must implement the recommendations below: The PAHP submitted its <i>UM Program Evaluation</i>, which did not address the requirements of this element and is not an appropriate document to support readiness as the data included in the evaluation are unrelated to the Iowa Medicaid managed care program. The <i>FPR04-INS-DENT-Fraud Detection</i> policy was not a UM policy and during the interview session, PAHP staff members did not provide assurances that it was a policy used by the UM department. While the <i>UM Program Description</i> included language to support some of the requirements of this element, this document was not cited as evidence for this element. During the interview session, HSAG requested that the PAHP review its <i>UM Program Description</i> and ensure all Iowa-specific UM program requirements are sufficiently addressed. HSAG further suggested that the PAHP consider including a sub-heading for each of the sub-elements included in this element with a narrative description for how the PAHP will meet the requirements. During the interview session, HSAG also acknowledged that there may be language already included in the <i>UM Program Description</i> that meets the intent of at least some of the sub-elements; however, the PAHP must understand Iowa-specific program requirements and ensure it is clearly aware of its processes to implement Iowa-specific program requirements. After the review, the PAHP explained, “UM Program Evaluation will be submitted to HSAG on 3/31/2026 reflecting 2025 data.” The PAHP’s response to HSAG’s request is concerning as the PAHP cannot have a <i>UM Program Evaluation</i> for the Iowa Medicaid managed care program prior to implementation; HSAG requested that the <i>UM Program Description</i> be reviewed and updated and not the <i>UM Program Evaluation</i>, and it is unknown what “2025 data” the PAHP is referring to as the program effective date is July 1, 2026. That said, HSAG has determined that the <i>UM Program Description</i> meets the minimum intent of the requirement as it included processes for monitoring of over- and underutilization of services, provider profiling, monitoring the quality and quantity of services rendered, and peer reviews, which are appropriate processes to meet sub-elements (a-f). However, as the <i>UM Program Description</i> did not include specific details for all components (e.g., emergency services utilization and		

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diversion efforts), HSAG recommends that the PAHP ensure that as it collects, reports, and monitors data after program implementation, that the PAHP’s analysis includes all requirements of this element and be incorporated into its workplan and evaluation.		
Required Actions: None.		
3. <i>The UM program is not limited to traditional UM activities, such as PA.</i> a. <i>The PAHP maintains a UM program that integrates with other functional units as appropriate and is supported by the quality management and improvement program.</i> b. <i>The UM program links members to the PAHP’s care coordination program as described in Contract Section G.2.</i> c. <i>The UM program works in tandem with the PAHP’s care coordination function to coordinate dental treatment needs, ongoing prevention services, and alleviate member barriers in accessing dental services.</i> Contract G.3.03–G.3.04	HSAG Required Evidence: • UM program description • UM work plan required under G.3.03 • Workflow for communication/coordination with care management program • Workflow for communication/coordination with quality program Evidence as Submitted by the PAHP: • SVII_UM Program Description <page 13, Care Coordination; • SVII_UM Program Description <page 14, Quality Oversight Committee > • SVII_UM Program Description <page 16, Program Evaluation>	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: During the review, while PAHP care management staff members were able to clearly describe processes to coordinate with UM staff, UM staff were unable to articulate any process for coordinating with the care management staff. HSAG recommends that its training for UM staff assigned to the Iowa Medicaid managed care program include education on coordinating with other departments, including care management.		
Required Actions: None.		

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4. <i>The PAHP has a UM committee directed by the PAHP's Dental Director. The committee is responsible for:</i> a. <i>Monitoring providers' requests for rendering dental health care services to its members.</i> b. <i>Monitoring the medical appropriateness and necessity of dental health care services provided to its members.</i> c. <i>Reviewing the effectiveness of the utilization review process and making changes to the process as needed.</i> d. <i>Writing policies and procedures for UM that conform to industry standards including methods, timelines and individuals responsible for completing each task.</i> e. <i>Confirming the PAHP has an effective mechanism in place for assuring dental service access in areas, including within the State's identified Dental Health Professional Shortage Areas (DHPSAs).</i> Contract G.3.05	HSAG Required Evidence: • Policies and procedures • UM program description • UM committee charter • Current and planned UM committee members and plan to initiate UM committee meetings • Identified DHPSAs • Plan to assure access to dental services in DHPSAs Evidence as Submitted by the PAHP: • SVII_UM Program Description <page 14, Utilization Management Committee> • SVII_DentaQuest Utilization Management Committee Charter <Full Document> • SVII_DentaQuest UM Organizational Chart <Full Document>	☐ Met ☒ Not Met
PAHP Description of Process: HSAG Findings: HSAG's review identified the findings below: • HSAG noted multiple inconsistencies between the <i>UM Program Description</i>, <i>DentaQuest Utilization Management Committee Charter</i>, <i>DentaQuest UM Organizational Chart</i>, and the <i>Iowa Staffing Plan</i> as they related to responsible UM program staff positions. • The <i>UM Program Description</i> and <i>DentaQuest Utilization Management Committee Charter</i> included discrepant information on meeting frequency and meeting responsibilities. • The <i>DentaQuest Utilization Management Committee Charter</i> referenced Medicare federal requirements, which are not applicable to the Iowa Medicaid managed care program. • The PAHP's Dental Director's involvement and responsibilities related to UM were not clear. • During the review, HSAG requested that the PAHP reconcile all documents to ensure they consistently and accurately reflect the PAHP's UM program structure, committee structure, and staffing; and meet Iowa-specific UM staffing and committee requirements. HSAG specifically requested that the PAHP address processes confirming that the PAHP has an effective mechanism in place for assuring dental service access in areas, including within HHS' identified Dental Health Professional Shortage Areas (DHPSAs), as the documentation submitted did not specifically address this requirement,		

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and language within the <i>UM08-INS-Authorization Review</i> policy indicated that requests for services from OON providers would be systematically denied. Since OON service requests would be systematically denied, it is unclear how the PAHP assures that members residing in DHPSAs will have access to dental services, and when the PAHP has an inadequate provider network where a member resides, that may necessitate the approval of OON services in accordance with 42 CFR §438.206(b)(4). - After the review, the PAHP provided a <i>New Program Description</i> and an <i>Updated DentaQuest Organizational Chart</i>. However, the organizational chart did not meet contract requirements. The “Utilization Management Director” key staff person “[m]anages all elements of the UM program and staff under the supervision of the Dental Director. This includes but is not limited to functions related to PA, medical necessity determinations, concurrent and retrospective reviews, and other programs as described in the Contract.” However, the key staff person is identified as the “Associate Director, UM Technology,” who has no UM direct reports and there is no dotted line between the “Associate Director, UM Technology” and the “Iowa Dental Director.” Further, the “Clinical Review Specialists” and “Utilization Management Administrative Staff” report directly to the “Manager, Utilization Management,” who reports to the “Director, Utilization Management.” The “Associate Director, UM Technology,” who the PAHP identified as the UM key staff person, does not have a direct linkage to UM staff. This organizational structure does not meet the intent of the requirement, “Manages all elements of the UM program and staff under the supervision of the Dental Director.” Further, the organizational chart has the “Director, Utilization Management” reporting to herself, which would not be appropriate. - While the <i>DentaQuest-Iowa Personnel Organizations Structure-03.31.2026</i> provided after the review suggested that the “Clinical Review Specialists” report to the “Utilization Management Director,” this conflicts with the <i>Updated DentaQuest Organizational Chart</i> also provided after the review, which indicated that the “Clinical Review Specialists” report to the “Manager, Utilization Management,” who is not the same person identified as the “Utilization Management Director” key staff person. Additionally, the <i>DentaQuest-Iowa Personnel Organizations Structure-03.31.2026</i> provided no linkage between the “Utilization Management Director” key staff person and the “Iowa Dental Director.” However, the “Utilization Management Director” key staff person is responsible for managing all elements of the UM program and staff under the supervision of the “Dental Director.” - After the review, the PAHP updated the Iowa exhibit to its <i>UM08</i> policy to include the requirements of this element and identified the PAHP’s Dental Director as the UM committee chair. The <i>New Program Description</i> also indicated that the chair of the UM committee was the “Iowa Dental Director.” However, while the <i>Breakdown of UM Committees</i> document included the UM committee’s “Frequency & Meeting Overview,” “Attendees,” and “Voting Attendees,” the PAHP’s Dental Director was not listed as either an “Attendee” or “Voting Attendee” even though the PAHP’s contract requires the UM committee to be directed by the PAHP’s Dental Director. The <i>IDAC Draft 4</i> document, also submitted after the review, which was the <i>Iowa Dental Advisory Committee Charter</i>, did list the PAHP’s Dental Director as a member; however, this was not the UM committee charter. The <i>Breakdown of UM Committees</i> document and <i>New Program Description</i> specifically reference a UM committee and does not include a committee referred to as the Iowa Dental Advisory Committee as part of the UM committee structure. Further, while the <i>New Program Description</i> suggested that the chair of the UM committee is an attendee of the UM subcommittees, the <i>Breakdown of UM Committees</i> document did not list the PAHP’s Dental Director as a member of any sub-committee. Lastly, while the <i>Breakdown of UM Committees</i> document confirmed that the “Care Delivery and Compliance Committee” and the “Quality Initiatives Task Force Subcommittee” are no longer free-standing committees and instead were rolled into the		

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“Quality Oversight Committee,” these committees were still referenced under the “Utilization Management Committee” section of the <i>New Program Description</i>. HSAG was unable to reconcile the conflicting information presented in the PAHP’s documents. While the Iowa exhibit to its <i>UM08</i> policy was updated and included the requirements of sub-element (e), it provided no context of how the PAHP will implement the requirement. Additionally, the <i>Updated UM08-INS-SOP-Insufficient Information Received</i> and <i>UM08</i> policies submitted after the review addressed processes to obtain missing clinical information from requesting providers to make coverage decisions, and the Iowa exhibit indicated that the process pertained to “contracted providers” under the “Provider outreach for Prior Authorizations” sub-heading. The <i>UM08</i> policy also continued to indicate that “[a]ny out of network or ineligible Providers are systemically denied, unless allowed under contract or regulation.” Based on HSAG’s desk review, discussion during the interview sessions, and review of documents submitted after the review, HSAG could not confirm that the PAHP had adequate mechanisms in place for assuring member access to dental services, including within the HHS’ identified DHPSAs.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Reconcile all documents submitted by the PAHP for this element to accurately and consistently reflect the UM staffing and committee structure and the role of the PAHP’s Dental Director. All discrepant information must be corrected. - Update its organizational chart to demonstrate the “Utilization Management Director” key staff person required by Contract meets contract requirements (i.e., manages all elements of the UM program and staff under the supervision of the Dental Director, including but is not limited to functions related to PA, medical necessity determinations, concurrent and retrospective reviews, and other programs as described in the Contract). - Provide a detailed plan for how, from a UM perspective, it will assure member access to dental services in all service areas, including HHS’ identified DHPSAs and in areas in which the PAHP may have an insufficient provider network.		
5. <i>The PAHP’s Dental Director participates in monthly Iowa Medicaid Medical Director meetings to provide recommendations for clinical criteria to ensure clinical policies are implemented consistently.</i> a. <i>The PAHP’s Dental Director communicates critical information from the Iowa Medicaid Medical Director meetings internally to ensure policies and procedures are implemented as agreed upon by the clinical team.</i> Contract G.3.05	HSAG Required Evidence: - UM program description - Dental Director job description - Workflow for communicating critical information from HHS meetings to internal UM staff or other departments, as applicable	☐ Met ☒ Not Met
	Evidence as Submitted by the PAHP: - SVII_UM Program Description <pages 2-4, Org structure and resources; pages 14-15, Committee Structure> - SVII DentaQuest UM Organizational Chart	
PAHP Description of Process:		

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HSAG Findings: The documents cited by the PAHP did not include the requirements of this element. HSAG requested that the PAHP include the requirement in its Iowa-specific <i>UM Program Description</i> . The PAHP submitted a <i>New Program Description</i> after the review, however, cited no page number. HSAG searched for associated key words and was unable to locate the specific requirement.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Provide documentation to support awareness of the PAHP’s Dental Director’s required participation in monthly Iowa Medicaid Medical Director meetings and the process for how the Dental Director will communicate critical information from the Iowa Medicaid Medical Director meetings internally to ensure policies and procedures are implemented as agreed upon by the clinical team.		
Coverage		
6. The PAHP: a. Identifies, defines, and specifies the amount, duration, and scope of each service that the PAHP is required to offer. b. Ensures the services are furnished in an amount, duration, and scope for the same services furnished to members under fee-for-service (FFS) Medicaid, as set forth in 42 CFR §440.230, and for members under the age of 21, as set forth in 42 CFR §441 Subpart B. c. Ensures each service is sufficient in the amount, duration, and scope to reasonably achieve its purpose. 42 CFR §438.210(a)(1-2) 42 CFR §438.210(a)(3)(i) 42 CFR §440.230 42 CFR §441 Subpart B 42 CFR §457.1230(d) Contract F.6.01–F.6.04	HSAG Required Evidence: - Policies and procedures - Member materials, such as the member handbook and benefits grid - UM program description - Hierarchy of coverage guidelines/criteria - Process for applying the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit - Staff training materials Evidence as Submitted by the PAHP: - SVII_UM08-INS-Authorization Review <pages 4-6, Procedure A 4-6> - SVII_UM01-INS-Clinical Algorithms <pages 1-2, Procedure A> - SVII_UM Program Description <page 8, EPSDT>	☐ Met ☒ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG’s review identified the findings below: - The <i>Provider Reference Manual</i> and the <i>ORM</i> submitted after the review were not final and did not include a benefit grid for Hawki. - The PAHP submitted an affirmation statement confirming it will conduct a final analysis to ensure the benefits are aligned with the Iowa Medicaid managed care program; however, the claims scenario review suggested that the PAHP did not consistently follow HHS’ <i>Iowa Medicaid DWP CDT Codes Requiring Prior Authorization</i> and <i>Iowa Medicaid Dental Wellness Plan CDT Codes Requiring Additional Documentation with the Claim</i>.		

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During the review, PAHP staff members implied that the PAHP’s coverage policies could not be more restrictive than HHS. HSAG requested that the PAHP clarify with HHS whether the PAHP must follow HHS’ PA and claim payment review (i.e., documentation requirements for claims processing/prepayment review [PPR]) policies or if the PAHP has the flexibility to define its internal coverage policies as long as they are no more restrictive than HHS. Documentation submitted after the review did not confirm that the PAHP sought HHS’ guidance. However, after the review, HHS confirmed that the PAHP must adhere to 42 CFR 438.210, which requires the PAHP’s service authorization processes to be no more restrictive than the State Medicaid program. - The three versions of the member handbook (i.e., DWP Adult, DWP Kids, and Hawki) included “Covered Dental Services” and “Non-Covered Benefits” sections; however, the handbooks were in draft form. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Provide a detailed project plan to reconcile its PA and PPR processing policies to ensure they are no more restrictive than HHS’ requirements (as the claims scenario demonstrations did not provide assurances that the claims processed in alignment with HHS [e.g., PPR review was required by the PAHP when HHS does not require additional documentation to be submitted for the dental code]). - Submit the final draft of the member handbooks with HHS’ approval. - Submit the final draft of the <i>ORM</i> with a completed Hawki benefit grid with HHS’ approval.		
7. The PAHP may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the member. 42 CFR §438.210(a)(3)(ii) 42 CFR §440.230(c) 42 CFR §457.1230(d) Contract F.6.05	HSAG Required Evidence: - Policies and procedures - UM program description - Hierarchy of coverage guidelines/criteria - Staff training materials Evidence as Submitted by the PAHP: - SVII_UM Program Description <page 4, Bullet 1 “Dental Consultants are responsible for the completion...> - SVII_UM01-INS-Clinical Algorithms <page 2, Procedure A 10>	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		

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8. The PAHP may place appropriate limits on a service on the basis of criteria applied under the <i>Medicaid State Plan (MSP)</i>, the <i>Children's Health Insurance Program (CHIP) State Plan</i>, and/or the <i>Iowa Administrative Code (IAC)</i>, such as medical necessity, or on utilization control procedures, or otherwise permitted under an approved <i>State Plan waiver</i>, provided that: a. The services furnished can reasonably achieve their purpose. 42 CFR §438.210(a)(4) 42 CFR §441.20 42 CFR §440.230(d) 42 CFR §457.1230(d) Contract F.6.06 Contract F.6.09	HSAG Required Evidence: • Policies and procedures • UM plan • Member materials, such as the member handbook • Hierarchy of coverage guidelines/criteria • Staff training materials Evidence as Submitted by the PAHP: • SVII_UM01-INS-Clinical Algorithms <page 1-2, Procedure A> • SVII_Member Handbook Prev Implementation DRAFT <page 40>	☐ Met ☒ Not Met
PAHP Description of Process: HSAG Findings: HSAG's review identified the findings below: • The <i>Provider Reference Manual</i> and the <i>ORM</i> submitted after the review were not completed and did not include a benefit grid for Hawki. • The PAHP submitted an affirmation statement confirming it will conduct a final analysis to ensure the benefits are aligned with the Iowa Medicaid managed care program; however, the claims scenario review suggested that the PAHP did not consistently follow HHS' <i>Iowa Medicaid DWP CDT Codes Requiring Prior Authorization</i> and <i>Iowa Medicaid Dental Wellness Plan CDT Codes Requiring Additional Documentation with the Claim</i>. During the review, PAHP staff members implied that the PAHP's coverage policies could not be more restrictive than HHS. HSAG requested that the PAHP clarify with HHS whether the PAHP must follow HHS' PA and claim payment review (i.e., documentation requirements for claims processing/PPR) policies or if the PAHP has the flexibility to define its internal coverage policies as long as they are no more restrictive than HHS. Documentation submitted after the review did not confirm that the PAHP sought HHS' guidance. However, after the review, HHS confirmed that the PAHP must adhere to 42 CFR 438.210, which requires the PAHP's service authorization processes to be no more restrictive than the State Medicaid program. • The three versions of the member handbook (i.e., DWP Adult, DWP Kids, and Hawki) included "Covered Dental Services" and "Non-Covered Benefits" sections; however, the handbooks were in draft form. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: • Provide a detailed project plan to reconcile its PA and PPR processing policies to ensure they are no more restrictive than HHS' requirements (as the claims scenario demonstrations did not provide assurances that the claims processed in alignment with HHS [e.g., PPR review was required by the PAHP when HHS does not require additional documentation to be submitted for the dental code]).		

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- Submit the final draft of the member handbooks with HHS’ approval. - Submit the final draft of the <i>ORM</i> with a completed Hawki benefit grid with HHS’ approval.		
9. The PAHP specifies what constitutes “medically necessary services” in a manner that: a. Is no more restrictive than that used by the <i>Iowa Medicaid managed care program</i>, including quantitative and non-quantitative treatment limits (<i>QTL</i>) (<i>NQTL</i>), as indicated in <i>Iowa</i> statutes and regulations, the <i>MSP</i>, and other <i>Iowa</i> policy and procedures; and b. Addresses the extent to which the PAHP is responsible for covering services that address: i. The prevention, diagnosis, and treatment of a member’s disease, condition, and/or disorder that results in health impairments and/or disability. ii. The ability for a member to achieve age-appropriate growth and development. iii. The ability for a member to attain, maintain, or regain functional capacity. 42 CFR §438.210(a)(5) Contract F.6.24 Contract F.6.28—F.6.30 Contract Exhibit B: Glossary of Terms/Conditions	HSAG Required Evidence: - Policies and procedures - UM program description - Member materials, such as the member handbook - Provider materials, such as the provider manual - Staff training materials Evidence as Submitted by the PAHP: - SVII_UM01-INS-Clinical Algorithms <pages 1-2, Procedure A> - SVII_Member Handbook Prev Implementation DRAFT (page 65>	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		

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10. <i>The PAHP ensures the provision of covered benefits in accordance with the member’s eligibility group.</i> a. <i>The PAHP provides benefits to members of CHIP (known as “Hawki”) as described in Special Contract Exhibits D and E. Members not otherwise specified in Contract Section F.6.16 or who are enrolled in the Hawki program who are enrolled with the PAHP are eligible for all medically necessary covered benefits in Iowa’s State Plan as amended and all waivers approved by CMS.</i> b. <i>The PAHP ensures that individuals eligible for the Iowa Dental Wellness Plan (DWP) receive Iowa DWP benefits as described in the State Plan and summarized in Special Contract Exhibit E.</i> Contract F.6.16–F.6.18 Contract Exhibit D: Eligible Enrolled Members and Excluded Populations Contract Exhibit E: Covered Benefits	HSAG Required Evidence: • Benefits grid • Member materials, such as the member handbook • Provider materials, such as the provider manual • Staff training materials Evidence as Submitted by the PAHP: • SVII_Provider Reference Manual <pages 69-135, Exhibit A Benefits Covered> • SVII_Member Handbook Prev Implementation DRAFT <full document>	☐ Met ☒ Not Met
PAHP Description of Process: HAWKI benefits are currently in process of being configured. Once completed, the benefits will be in the Provider Reference Manual mimicking the layout of pages 69-135 Exhibit A. The benefits will also be displayed within the Member Handbook. DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made.		
HSAG Findings: HSAG’s review identified the findings below: • The <i>Provider Reference Manual</i> and the <i>ORM</i> submitted after the review were not completed and did not include a benefit grid for Hawki. • The PAHP submitted an affirmation statement confirming it will conduct a final analysis to ensure the benefits are aligned with the Iowa Medicaid managed care program; however, the claims scenario review suggested that the PAHP did not consistently follow HHS’ <i>Iowa Medicaid DWP CDT Codes Requiring Prior Authorization</i> and <i>Iowa Medicaid Dental Wellness Plan CDT Codes Requiring Additional Documentation with the Claim</i>. During the review, PAHP staff members implied that the PAHP’s coverage policies could not be more restrictive than HHS. HSAG requested that the PAHP clarify with HHS whether the PAHP must follow HHS’ PA and claim payment review (i.e., documentation requirements for claims processing/PPR) policies or if the PAHP has the flexibility to define its internal coverage policies as long as they are no more restrictive than HHS. Documentation submitted after the review did not confirm that the PAHP sought HHS’ guidance. However, after the review, HHS confirmed that the PAHP must adhere to 42 CFR 438.210, which requires the PAHP’s service authorization processes to be no more restrictive than the State Medicaid program. • The three versions of the member handbook (i.e., DWP Adult, DWP Kids, and Hawki) included “Covered Dental Services” and “Non-Covered Benefits” sections; however, the handbooks were in draft form.		

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After the review, the PAHP submitted screenshots confirming its system has the capability to assign and track the Iowa Medicaid managed care program's eligibility groups (i.e., DWP Adults, DWP Kids, Hawki); however, the PAHP's system was not configured with the Iowa Medicaid managed care program benefit package for each eligibility group.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Provide a detailed project plan to reconcile its PA and PPR processing policies to ensure they are no more restrictive than HHS' requirements (as the claims scenario demonstrations did not provide assurances that the claims processed in alignment with HHS [e.g., PPR review was required by the PAHP when HHS does not require additional documentation to be submitted for the dental code]). - The final draft of the member handbooks with HHS' approval. - The final draft of the <i>ORM</i> with a completed Hawki benefit grid with HHS's approval. - Confirmation that its system is configured to align with the Iowa Medicaid managed care program benefit package for DWP Adults, DWP Kids, and Hawki.		
11. <i>The PAHP provides EPSDT services to all DWP members under 21 years of age in accordance with law.</i> a. <i>EPSDT covers dental services regardless of whether these services are provided under the State Plan and regardless of any restrictions that may be imposed on coverage.</i> b. <i>The PAHP partners with Maternal Health, Screening Center, and Public Health agencies to ensure the completion of dental screens and preventive visits in accordance with the EPSDT periodicity schedule.</i> c. <i>The PAHP implements outreach, monitoring, and evaluation strategies for EPSDT, including collaboration with local community stakeholders and public health agencies.</i> d. <i>The PAHP develops provider and member education activities that increase beneficiary awareness of and access to applicable EPSDT services.</i> e. <i>The PAHP does not require a PA or PCP (if applicable) referral for the provision of EPSDT screening services.</i>	HSAG Required Evidence: - Policies and procedures - Benefits grid - Member materials, such as the member handbook - Provider materials, such as the provider manual - Process for applying the EPSDT benefit - Claims payment algorithm for EPSDT - Staff training materials Evidence as Submitted by the PAHP: - SVII_Member Handbook Prev Implementation DRAFT <full document> - SVII_UM08-INS-Authorization Review <page 8, Procedure E> - SVII_UM08-INS-Authorization Review <page 10 Exhibit AY bullets 1, 2> - SVII_Qual Mgmt Plan – Outreach <Full Document>	☐ Met ☒ Not Met
Contract F.6.25–F.6.26 Contract G.3.09(c)		

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PAHP Description of Process: HSAG Findings: HSAG’s review identified the findings below: - During the review, PAHP staff members explained that its system has “rejects” that would trigger a clinical review for services under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. However, no evidence of this system functionality was provided to confirm the process for implementation. - After the review, the PAHP submitted its DWP Adult member handbook, which specified that no PA or PCP referral was needed for EPSDT services and that each service is reviewed for medical necessity even when the service is not normally a covered benefit. However, this information was missing from the DWP Kids and Hawki member handbooks. - The <i>ORM</i> submitted after the review was updated to include information on the EPSDT benefit and indicated that no PA is required for EPSDT screening services but may be required for diagnostic or treatment services. However, the DWP Adult member handbook submitted after the review indicated that EPSDT services do not require a PA (i.e., implying PA is not required for any EPSDT service). The <i>UM08-INS-Authorization Review</i> policy indicated that for EPSDT services, PA is required and PAs need to adhere to the IAC. This policy did not differentiate between screening services and diagnostic or treatment services. - The <i>UM08-INS-Authorization Review</i> policy indicated if the PAHP finds an EPSDT service (i.e., “code”) medically necessary but does not meet IAC criteria, that a “Waiver of Administrative Rule” (referred to as an “Exception to Policy”) can be submitted to Iowa Medicaid. While the PAHP’s contract with HHS indicates that if the PAHP makes a determination that a service typically not covered by Medicaid may be medically necessary, that an Exception to Policy may be initiated. However, it is unclear if the PAHP’s process meets HHS’ expectations (e.g., does HHS require an Exception to Policy for EPSDT services determined to be medically necessary but do not meet IAC criteria, or is the PAHP required to approve the service according to the EPSDT benefit and medical necessity [i.e., without an Exception to Policy]). Recommendations: HSAG’s review identified the recommendations below: - The DWP Kids and Hawki member handbooks had a paragraph repeated twice under the EPSDT section (i.e., “For information about EPSDT services that are NOT dental (like medical check-ups, mental healthcare, or other health services)...Contact your medical managed care organization...They handle all the other EPSDT benefits”). HSAG recommends that the PAHP correct this prior to finalizing these handbooks. - HSAG recommends that the PAHP be prepared to demonstrate the authorization of services covered under the EPSDT benefit when requested or rendered when the services are not covered under the Iowa Medicaid benefit (e.g., non-covered service, benefit limit reached). - While the <i>IA_DENTAL_CMPDT.03</i> document (i.e., case management program description) submitted after the review generally addressed provisions for partnering with I-Smile Coordinators and community partners, HSAG recommends that the PAHP’s UM staff training include processes for ensuring the completion of dental screens and preventive visits in accordance with the EPSDT periodicity schedule by partnering with maternal health, screening centers, and public health agencies.		

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- HSAG recommends that the PAHP review, through its UM committee, the provision of EPSDT benefits; for example, review data related to services that were denied under the Iowa Medicaid benefit but approved under the EPSDT benefit, and review data related to services denied for members under the age of 21 to determine if there are opportunities for improvement or gaps in the PAHP’s PA and PPR processes. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Submit evidence of its process to authorize the provision of services under the EPSDT benefit (e.g., “reject” codes, system screenshots, claims scenario, mock PA or PPR). Note, according to the PAHP’s contract with HHS, “...screenings need not be conducted by a Medicaid provider to trigger EPSDT coverage for follow up diagnostic services and medically necessary treatment by a qualified Medicaid provider.” Therefore, the PAHP’s submission must also demonstrate compliance with this expectation. - Reconcile and update, where appropriate, the <i>ORM</i>, the member handbooks (i.e., DWP Adult, DWP Kids, and Hawki), and <i>UM08-INS-Authorization Review</i> policy to ensure they accurately and consistently reflect the PAHP’s PA requirements for EPSDT services, including screening and diagnostic and treatment services, and if and how they differ. - Provide HHS’ confirmation if the PAHP’s Exception to Policy for EPSDT meets contract requirements.		
Coordination With Medicare		
12. <i>The PAHP provides medically necessary covered services to members who are also eligible for Medicare if the service is not covered by Medicare.</i> a. <i>The PAHP ensures that services covered and provided under the Contract are delivered without charge to members who are dually eligible for Medicare and Medicaid.</i> b. <i>The PAHP coordinates with Medicare payers, Medicare Advantage Plans, and Medicare providers as appropriate to coordinate the care and benefits of members who are also enrolled with Medicare.</i> c. <i>The PAHP develops and documents a plan to coordinate care for duals.</i> Contract J.4.10	HSAG Required Evidence: - Policies and procedures - UM program description - Plan to coordinate care with other payors - Staff training materials Evidence as Submitted by the PAHP: - SVII_UM Program Description <page 13, Care Coordination>	☐ Met ☒ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG requested that the PAHP update its <i>UM Program Description</i>, or submit any other documentation, to address processes for coordinating the provision of dental benefits for members who are dual eligible. After the review, the PAHP cited the <i>New Program Description</i>; however,		

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the PAHP provided no citation or page number. HSAG searched for associated key words and was unable to determine the PAHP’s process for coordinating care with members who are also eligible for Medicare. The only references to Medicare HSAG located were the following statements: “...in the dental context, the concept of ‘post-stabilization of care’ generally does not apply in the same way for Medicaid, Medicare Advantage, or commercial dental plans” and “...in the event that the involved plan covers Medicaid or Medicare members, the State Dental Consultant will be requested to submit an opinion as to coverage under the state program.” The PAHP also cited the <i>Utilization Management Workplan 2025</i> as evidence after the review; however, HSAG was unable to correlate it to the requirements of this element. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Submit documentation that adequately addresses processes for coordinating the provision of dental benefits for members who are dual eligible.		
Authorization of Services		
13. The PAHP and its subcontractors have in place, and follow, written policies and procedures for the processing of requests for initial and continuing authorization of services. a. <i>UM policies and procedures are exclusive to Iowa and do not contain documentation from other State Medicaid programs or product lines operated by the PAHP.</i> 42 CFR §438.210(b)(1) 42 CFR §457.1230(d) Contract G.3.03 Contract G.3.06 Contract G.3.11	HSAG Required Evidence: - Policies and procedures - UM program description - List of delegated entities performing UM functions - Delegated written contracts (for entities responsible for delegated UM functions) - Delegation oversight of policies and procedures - Oversight and monitoring plan for delegated UM functions - Staff training materials Evidence as Submitted by the PAHP: - SVII_11a_DQ_IA2026_PAHP_RR_File Review_Delegation_D1 <Universe File Template tab> - SVII_UM Program Description <Full Document>	☐ Met ☒ Not Met
PAHP Description of Process:		
HSAG Findings: The PAHP’s UM policies were not exclusive to Iowa. Instead, the PAHP submitted corporate policies with, or without, an Iowa exhibit, when applicable. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Create and submit UM policies that are specific to the Iowa Medicaid managed care program; or alternatively, - Submit HHS’ approval that corporate policies, with or without an Iowa exhibit, when applicable, are acceptable for the Iowa Medicaid managed care program.		

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14. The PAHP has in effect mechanisms to ensure consistent application of review criteria for authorization decisions <i>that are no more restrictive than the State Medicaid FFS program and/or the State Plan Amendment.</i> 42 CFR §438.210(b)(2)(i) 42 CFR §457.1230(d) Contract G.3.06 Contract G.3.12	HSAG Required Evidence: • Policies and procedures • UM program description • Hierarchy of coverage guidelines/criteria • Process to assure coverage guidelines/criteria are not more restrictive than the Iowa State Medicaid FFS program and/or the Iowa State Plan Amendment • Plan for ensuring the consistent application of review criteria (e.g., conducting interrater reliability [IRR] activities, file review audits) • Staff training materials Evidence as Submitted by the PAHP: • SVII 11a DQ IA2026 PAHP RR File Review_Delegation_D1 <Universe File Template tab> • SVII UM Program Description <Full Document>	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: While the <i>UM Program Description</i> described the PAHP’s IRR program, it did not specifically confirm that the IRR process includes any Iowa-specific nuances related to the application of coverage criteria and decision making in accordance with the Iowa FFS program or the State Plan Amendment. As such, the PAHP must ensure its IRR process, or other mechanisms to ensure consistent application of review criteria, consider any Iowa-specific coverage criteria and the associated authorities (e.g., contract, IAC).		
Required Actions: None.		

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15. The PAHP consults with the requesting provider for dental services when appropriate. 42 CFR §438.210(b)(2)(ii) 42 CFR §457.1230(d) Contract G.3.06 Contract G.3.13	HSAG Required Evidence: • Policies and procedures • UM program description • Provider materials, such as the provider manual, provider communications • Process to obtain all necessary information prior to rendering a decision • Mechanism for documenting peer-to-peer (P2P) consults prior to rendering a denial decision • Staff training materials Evidence as Submitted by the PAHP: • SVII_Provider Reference Manual <page 38, 11.00 Bullet 5 Peer Review Process> • SVII_UM Program Description <page 14> • SVII_UM08-INS-SOP-Peer to Peer Review < Full Document> • SVII_UM11-INS-Utilization Management Staff-FINAL<Full Document>	☒ Met ☐ Not Met
PAHP Description of Process: DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: The <i>UM08-INS-SOP-Peer to Peer Review</i> policy focused on peer-to-peer (P2P) discussions that occur after a denial decision has been rendered. However, HSAG requested evidence of a process to consult with the requesting provider for dental services, when appropriate, during the service authorization review process. After the review, the PAHP cited the <i>Utilization Management Workplan 2025</i>, which did not address HSAG’s request. However, the PAHP also provided the <i>Updated UM08-INS-SOP-Insufficient Information Received</i> policy, which addressed procedures for processing PA requests when insufficient information is received from a provider in order to make a clinical determination for medical necessity. The <i>UM08</i> policy submitted after the review also included an updated Iowa exhibit, which included the provision that the PAHP will consult with the requesting provider for dental services, when appropriate, and included specific procedures for outreach attempts to obtain missing information. As such, the PAHP received a <i>Met</i> score for this element. However, HSAG recommends that the PAHP consider processes for the PAHP to consult with a requesting provider (i.e., P2P), when		

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appropriate, during the service authorization review process and prior to rendering a denial decision, as the intent of the requirement is to ensure that the PAHP has all the information needed to make an informed decision.		
Required Actions: None.		
16. The PAHP ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by <i>an oral health professional (e.g., dentists and dental hygienists)</i> who has appropriate expertise in addressing the member’s <i>condition or disease</i>. a. <i>The PAHP uses appropriate licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of UM, including PA and decision making.</i> b. <i>The PAHP develops, implements, and adheres to written procedures which follow guidance from evidence-based organizations (e.g., American Dental Association, American Academy of Pediatrics) to assist in making medical necessity determinations.</i> c. <i>The PAHP develops, implements, and adheres to written procedures documenting access to dentists and dental hygienists to assist in making medical necessity determinations.</i> 42 CFR §438.210(b)(3) 42 CFR §457.1230(d) Contract F.6.08 Contract G.3.07 Contract G.3.15	HSAG Required Evidence: • Policies and procedures • UM program description • Organizational chart of UM department • Qualifications of individuals who can render denial decisions • Specialty of PAHP’s chief dental officer and dental directors on staff (e.g., general dentist, orthodontist, endodontist) • Hierarchy of UM decision makers • System screenshot field where the decision-maker (name and credentials) is documented • HSAG will also use the results of the system demonstration (i.e., mock service authorization cases) • Staff training materials Evidence as Submitted by the PAHP: • SVII_UM08-INS-Authorization Review <pages 3-6, Procedure A> • SVII_UM Program Description <pages 2-5, Organizational Structure and Resources> • SVII_DentaQuest UM Organizational Chart <full document>	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		

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Recommendations: After the review, the PAHP submitted <i>WW rendered decisions screenshots</i> documents; however, the “User ID” and “Pend Queue” were redacted. Based on discussion with PAHP staff members during the interview session, while redacted, these fields will show who rendered the denial decision (i.e., Dental Consultant). The PAHP staff members also explained that the specialty of the Dental Consultant is not included in each denial record but can be made available through other documentation that is maintained outside of the denial record. As such, HSAG recommends that the PAHP ensure that evidence of each Dental Consultant’s specialty is maintained and provided during future denial case file reviews.		
Required Actions: None.		
Notice of Adverse Benefit Determination		
17. The PAHP notifies the requesting provider of any decision by the PAHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. 42 CFR §438.210(c) 42 CFR §457.1230(d) Contract H.9.07	HSAG Required Evidence: • Policies and procedures • UM program description • Provider notice template • Staff training materials • System screenshot of field where notice to provider is documented • HSAG will also use the results of the system demonstration (i.e., mock service authorization cases) Evidence as Submitted by the PAHP: • SVII_UM01-INS-Clinical Algorithms <page 2, Procedure A 10> • SVII_UM08-INS-Authorization Review <page 8, Procedure D> • SVII_PDL letter template – standard <Full Document>	☒ Met ☐ Not Met
PAHP Description of Process: Staff Training materials are currently being developed. They will be submitted by May 1, 2026. PAHP systems are still being configured and developed. Mock reporting is not available yet.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Of note, while the denial notice template to the provider (i.e., <i>PDL letter template</i>) was submitted, the PAHP was unable to demonstrate how the notice was generated and maintained during the system demonstration. As such, the PAHP will be required to conduct a system demonstration of this capability during		

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the follow-up sessions that will occur with HSAG prior to July 1, 2026. Any failure to demonstrate a sufficient production environment may result in a <i>Not Ready</i> status in the UM program area.		
Required Actions: None.		
18. The PAHP defines an ABD as: - The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. - The reduction, suspension, or termination of a previously authorized service. - The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a “clean claim” is not an ABD. - The failure to provide services in a timely manner, as defined by HHS. - The failure of the PAHP to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals. - For a resident of a rural area with only one PAHP, the denial of a member's request to exercise his or her right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network. - The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities. 42 CFR §438.52(b)(2)(ii) 42 CFR §438.400(b)(1-7) 42 CFR §438.408(b)(1-2) 42 CFR §457.1260(a)(2) Contract Exhibit B: Glossary of Terms/Definitions	HSAG Required Evidence: - Policies and procedures - Member materials, such as the member handbook - Provider materials, such as the provider manual - Staff training materials Evidence as Submitted by the PAHP: - SVII_UM08-INS-Authorization Review <page 8, Procedure C> - SVII_Member Handbook Prev Implementation DRAFT - SVII_Provider Reference Manual	☒ Met ☐ Not Met

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PAHP Description of Process: Staff Training materials are currently being developed. They will be submitted by May 1, 2026.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Recommendations: As the <i>UM08</i> policy submitted after the review included a simplified definition of an ABD, HSAG recommends that the PAHP ensure that training materials for UM staff include the definition of an ABD as outlined in this element. Additionally, the member handbooks defined an ABD as a “letter.” However, an ABD itself is not a letter but rather an action taken by the PAHP (e.g., denial of services), and the ABD notice (i.e., letter) is sent to a member with the explanation of the ABD and the rational for the ABD. As such, HSAG recommends that the PAHP update the member handbooks accordingly.		
Required Actions: None.		
19. The PAHP gives members written notice of any decision by the PAHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The ABD notice includes the following: - The ABD the PAHP has made or intends to make. - The reasons for the ABD, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member’s ABD. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. - The member’s right to request an appeal of the PAHP’s ABD, including information on exhausting the PAHP’s one level of appeal, described at 42 CFR §438.402(b), and right to request a State fair hearing (SFH) consistent with 42 CFR §438.402(c). - The procedures for exercising the rights <i>to appeal</i> as specified in 42 CFR §438.402(b). - The circumstances under which an appeal process can be expedited and how to request it. - The member’s right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the	HSAG Required Evidence: - Policies and procedures - UM program description - ABD notice template with taglines - Quality assurance process to monitor ABD notices (e.g., required content, easily understood, grammatical/typographical errors) - Staff training materials - System screenshot of field where ABD notice to member is documented - HSAG will also use the results of the system demonstration (i.e., mock service authorization cases) Evidence as Submitted by the PAHP: - SVII_UM04-INS-Notice of Action Letters <page 3, Section B2, - SVII_UM04-INS-Notice of Action Letters <page 6, Exhibit F> - SVII_IA Medicaid NABD letter template - SVII_IA Medicaid MLI - SVII_IA Medicaid Auth Approval Template	☒ Met ☐ Not Met

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circumstances, consistent with State policy, under which the member may be required to pay the costs of these services. g. The notice must be consistent with the requirements of 42 CFR §438.10. 42 CFR §438.10 42 CFR §438.210(c) 42 CFR §438.402(b-c) 42 CFR §438.404(a-b) 42 CFR §457.1230(d) 42 CFR §457.1260(b)(1) 42 CFR §457.1260(c)(1-2) Contract C.1 Contract H.2.01–H.2.06		
PAHP Description of Process: Staff Training Materials are currently being developed. They will be submitted by May 1, 2026.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Recommendations: HSAG’s review identified the recommendations below: - The <i>IA Medicaid NABD letter template with RGL</i> submitted after the review included information on continuation of benefits with instructions to only include this section of the ABD when the PAHP “reduces, ends, or denies covered services.” However, the <i>Mock ABD letter - IA Medicaid standard PA denial</i> notice was a denial of services; therefore, based on the instructions included in the <i>IA Medicaid NABD letter template with RGL</i>, continuation of benefits information should have been included (i.e., the PAHP denied covered services). This finding suggests that there may be confusion when continuation of benefits applies. HSAG recommends that staff training include education on continuation of benefits, and the PAHP must review and update, where necessary, its procedures for generating ABD notices with continuation of benefits information. Alternatively, the PAHP should include continuation of benefits information in every ABD notice but include language informing the member when continuation of benefits applies (e.g., “If we are stopping or reducing services that have already been approved, you may be able to keep services during the appeal.”). - The PAHP’s ABD notices were generated with denial explanations that are associated with a denial reason code. These codes and explanations are system generated (and exactly the same for every ABD notice when the code applies), and the PAHP does not enter any free narrative text. However, there are circumstances in which additional context may be helpful for a member to decide whether to appeal. For example, if the denial is based on a benefit limitation, the PAHP should consider including additional details supporting the denial based on the member reaching a benefit limitation (e.g., “You received [service] on [date] from [dental provider]. We can only cover this service once a year.”). HSAG recommends that the PAHP consider procedural changes that can be made to include these details. As another example, related to this denial reason explanation,: “To qualify for a partial		

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denture, you must have less than eight back teeth that touch. This means that you have less than four upper back teeth that touch four of your lower back teeth when you bite down. The teeth that touch can include either natural or fake teeth. Our dentist looked at the x-rays your dentist sent. The x-rays show that you have eight or more teeth that touch. A partial denture is not medically necessary for you. We have also told your dentist. Please talk to your dentist about your treatment choices.” While the reason explained that the member’s x-ray shows “eight or more teeth that touch,” it is not member-specific (i.e., explaining how many teeth touched [e.g., eight, nine]). While the reading grade level of the ABD notice template was provided, evidence of the reading grade level of denial code explanations was not provided. However, the denial code explanations included in the mock ABD notices appeared to meet the intent of the plain language requirement. Therefore, this finding was not considered a deficiency. However, HSAG recommends that the PAHP be prepared to provide the reading grade level of denial reason codes in the future as part of denial case file reviews.		
Required Actions: None.		
Timeframe for Decisions		
20. For standard authorization decisions, the PAHP provides notice as expeditiously as the member’s condition requires and within HHS established time frames that may not exceed seven calendar days following receipt of the request for service. 42 CFR §438.210(d)(1) 42 CFR §438.404(c)(3) 42 CFR §457.1230(d) 42 CFR §457.1260(c)(3)	HSAG Required Evidence: - Policies and procedures - UM program description - Tracking and reporting mechanism(s) (i.e., screenshots of UM system, mock report template to monitor timeliness) - Staff training materials - System screenshots of field where the date of receipt of the request and the date of the mailing of the ABD notice are documented - HSAG will also use the results of the system demonstration (i.e., mock service authorization cases) Evidence as Submitted by the PAHP: - SVII_UM08-INS-Authorization Review <page 3, Procedure A. Prior Auth Review 2.>	☐ Met ☒ Not Met
PAHP Description of Process: PAHP systems are still being configured and developed. Mock reporting is not available yet. Staff Training materials are currently being developed. They will be submitted by May 1, 2026.		
HSAG Findings: HSAG’s review identified the findings below:		

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- HSAG requested that the PAHP update its provider manual to include the seven-calendar-day time frame for standard PAs. While the PAHP submitted the <i>ORM</i> after the review, it provided no citation or page number. HSAG searched for associated keys words/numbers and was unable to confirm that the PAHP updated the provider manual as requested. - While the PAHP’s system had the capability to track and report the date of receipt of a PA request and the date the ABD notice was generated, PAHP staff members explained that its mail gets picked up at 12:00 p.m. and 4:00 p.m.; notices generated after 4:00 p.m. will be mailed the following day; and that its printing and mailing department is working seven days a week with the exception of holidays. HSAG requested the PAHP’s print and fulfillment process to confirm the PAHP’s stated process; however, it was not provided after the review. - Discussion confirmed that the PAHP did not currently have the capability to consider mail pick up times when calculating PA TATs. As TATs must be calculated from the date of receipt to the date the ABD notice was sent to the member, the PAHP’s processing and reporting procedures must consider mail pick up times since ABD notices may not be mailed on the same day they are generated. Further, if letters are dated prior to the actual mailing date, the PAHP is not providing members with their full appeal filing time frames. Recommendations: The PAHP’s policy allows 30 calendar days and the option for a 14-calendar-day extension for a PPR (i.e., post-service review of claim for payment). As 42 CFR 438.210 includes no specific time frames for PPRs, HSAG recommends that the PAHP consult with HHS to verify if its process meets HHS’ expectations. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Update and resubmit its <i>ORM</i> to include the required seven-calendar-day PA TAT. - Provide its print and fulfillment process. - Develop a plan and timeline for calculating TATs using the date the ABD notice enters the mailing stream.		
21. For cases in which a provider indicates, or the PAHP determines, that following the standard timeframe could seriously jeopardize the member’s life or health or ability to attain, maintain, or regain maximum function, the PAHP must make an expedited authorization decision and provide notice as expeditiously as the member’s health condition requires and no later 72 hours after receipt of the request for service. 42 CFR §438.210(d)(2)(i) 42 CFR §438.404(c)(6) 42 CFR §457.1230(d) 42 CFR §457.1260(c)(3) Contract G.3.18	HSAG Required Evidence: - Policies and procedures - UM program description - Tracking and reporting mechanism(s) (i.e., screenshots of UM system, mock report template to monitor timeliness) - Staff training materials - System screenshot of field where the date and time of receipt of the request and the date and time of the mailing of the ABD notice are documented - HSAG will also use the results of the system demonstration (i.e., mock service authorization cases) Evidence as Submitted by the PAHP:	☐ Met ☒ Not Met

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Contract H.3.10	SVII_UM08-INS-Authorization Review <page 3, Procedure A. Prior Auth Review 2.>	
PAHP Description of Process: PAHP systems are still being configured and developed. Mock reporting is not available yet. Staff Training materials are currently being developed. They will be submitted by May 1, 2026.		
HSAG Findings: HSAG’s review identified the findings below: - HSAG requested that the PAHP update its provider manual to include the 72-hour time frame for expedited PAs. While the PAHP submitted the <i>ORM</i> after the review, it provided no citation or page number. HSAG searched for associated keys words/numbers and was unable to confirm that the PAHP updated the provider manual as requested. HSAG did note that “expedited” is a term used to identify a claim related to emergency dental treatment; however, expedited reviews and the 72-hour TAT for expedited reviews apply to PA (i.e., pre-service) and not claims (i.e., post-service). - While the PAHP updated its member handbooks to include time frames for processing expedited PAs, it indicated that the time frame was “72 hours (3 days).” However, 72 hours does not necessarily equate to three days; for example, if the PA request was received on January 5, 2026, at 9:00 a.m., and the ABD notice entered the mailing stream on January 8, 2026, at 4:00 p.m., the PAHP’s TAT for this PA is noncompliant (i.e., while the notice entered the mailing stream on day three, the TAT calculation is 79 hours). TATs must be calculated in hours, not days. - While the PAHP’s system had the capability to track and report the date of receipt of a PA request and the date the ABD notice was generated, PAHP staff members explained that its mail gets picked up at 12:00 p.m. and 4:00 p.m.; notices generated after 4:00 p.m. will be mailed the following day; and that its printing and mailing department is working seven days a week with the exception of holidays. HSAG requested the PAHP’s print and fulfillment process to confirm the PAHP’s stated process; however, it was not provided after the review. - Discussion confirmed that the PAHP did not currently have the capability to consider mail pick up times when calculating PA TATs. As TATs must be calculated from the date/time of receipt to the date/time the ABD notice was sent to the member, the PAHP’s processing and reporting procedures must consider mail pick up times since ABD notices may not be mailed on the same day/time they are generated. Further, if letters are dated prior to the actual mailing date, the PAHP is not providing members with their full appeal filing time frames. Recommendations: HSAG’s review identified the recommendations below: - The PAHP appeared to use the terms “emergent” and “urgent” interchangeably as an expedited PA review process. While a rendering provider, based on clinical judgment, is responsible for determining whether to request an expedited PA (i.e., pre-service expedited request) or render emergency services to treat an emergency dental condition (i.e., submits a claim for emergency services post-service), they are distinct processes which should be clearly delineated. HSAG also acknowledges that the PAHP is using the same system for processing PAs and claims, and a medical necessity review may occur for both processes. However, HSAG recommends that the PAHP review and update all policies and the provider manual to ensure the language aligns with the federal rule (i.e., use of the term “expedited” when referring to the PA requests [i.e., pre-service] in which following the standard time frame could seriously jeopardize the member’s life or health or ability to attain, maintain, or regain maximum function) and use of the term “emergency” when referring to claims for emergency services (i.e., post-service).		

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Requirement	Supporting Documentation	Score
The PAHP’s policy allows for 30 calendar days and the option for a 14-calendar-day extension for a PPR (i.e., post-service review of claim for payment). As 42 CFR §438.210 includes no specific time frames for PPRs, HSAG recommends that the PAHP consult with HHS to verify if its process meets HHS’ expectations.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Update and resubmit its <i>ORM</i>, including the 72-hour time frame for expedited PAs. - Update and resubmit the member handbooks. - Provide its print and fulfillment process. - Develop a plan and timeline for calculating TATs using the date/time the ABD notice entered the mailing stream.		
22. For standard and expedited authorization decisions, the PAHP may extend the resolution timeframe up to an additional 14 calendar days if: a. The member, or the provider, requests the extension; or b. The PAHP justifies to HHS upon request a need for additional information and how the extension is in the member’s interest. 42 CFR §438.210(d)(1)(i-ii) 42 CFR §438.210(d)(2)(ii) 42 CFR §457.1230(d) 42 CFR §457.1260(c)(3) Contract G.3.17 Contract H.3.06–H.3.07 Contract H.3.11	HSAG Required Evidence: - Policies and procedures - UM program description - Tracking and reporting mechanism(s) (i.e., screenshots of UM system, mock report template to monitor timeliness) - Extension notice template - Staff training materials - System screenshot of the field where the date of the extension and rationale for extension are documented - HSAG will also use the results of the system demonstration (i.e., mock service authorization cases) Evidence as Submitted by the PAHP: - SVII_UM08-INS-Authorization Review <page 4, Procedure A. Prior Auth Review 4.>	☐ Met ☒ Not Met
PAHP Description of Process: PAHP systems are still being configured and developed. Mock reporting is not available yet. Staff Training Materials are currently being developed. They will be submitted by May 1, 2026.		
HSAG Findings: HSAG’s review identified the findings below: - The <i>UM08-INS-Authorization Review</i> policy included misleading and inaccurate information related to the extension process for standard and expedited appeals and potentially intermingled Medicaid, Medicare, and commercial requirements. Specifically: “The extension period, within which a decision must be made by DentaQuest begins...On the date when DentaQuest receives the provider’s response (even if not all the information is provided), or...At the end of the time given to the provider to supply the information if no response is		

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Requirement	Supporting Documentation	Score
received from the provider. DentaQuest may deny the request if the information is not received within the timeframe, and the member may appeal the denial.” This language inaccurately suggests that the PAHP would stop the TAT clock when an extension is applied. – “DentaQuest may extend the urgent pre-service timeframe due to a lack of information, once, for forty-eight (48) hours, under the following conditions...Within twenty-four (24) hours of receipt of the urgent pre-service request, DentaQuest asks the provider, member, or the member’s representative for the specific information necessary to make the decision...DentaQuest gives the provider, member, or member’s authorized Representative at least forty-eight (48) hours to provide the information...The extension period, within which a decision must be made by DentaQuest, begins is stated above in section A, part 5.” This language inaccurately suggests that the extension period for expedited PAs is only 48 hours, that members are responsible for providing missing information, and that the PAHP would stop the TAT clock when an extension is applied. After the review, the PAHP cited an updated <i>UM08</i> policy that included the requirements of this element verbatim in an Iowa exhibit; however, the inaccurate language in the body of the policy remained mostly unchanged. Since the Iowa exhibit included no context for its process of implementation, it was unclear if the extension procedures in the body of policy still applied. Further, the following statement was added to the expedited PA extension provisions, “The timeframe with which a determination is required to be made does not stop when the request is pending for additional information to complete the determination”; however, this same clarification was not made under the standard PA extension provisions. It is concerning that the PAHP did not attempt to make any changes to the body of the document as HSAG communicated to the PAHP that the policy was noncompliant for all Medicaid lines of business (LOBs). • During the review, PAHP staff members explained that extensions are tracked within its system when the case shows it is pending for documentation. However, this would imply that any case pending for documentation equates to an extension, which is not accurate. The PAHP could request and receive documentation prior to the due date and would not necessitate an extension in all instances. Further, an extension should not automatically be applied when requesting additional documentation but rather when the PAHP has not received the requested documentation by the PA due date. Therefore, HSAG requested a screenshot for how the PAHP’s system would differentiate between an actual extension as opposed to a case that was pending for documentation. This documentation was not submitted as requested. • After the review, the PAHP cited its <i>Updated UM08-INS-SOP-Insufficient Information Received</i> policy; however, it addressed procedures for requesting additional clinical information, which may result in an extension but did not provide clarity into the PAHP’s process as described in policy <i>UM08</i>. • Under Element 23, HSAG requested that an extension template be provided. After the review, the PAHP submitted two <i>IA Medicaid PA denial that needed ext</i> notices. Both notices were ABD notices. An extension is very different from an ABD, and an ABD notice is not an appropriate notice to send to a member when an extension is applied. Further, the ABD notice provides members with appeal rights; however, members have grievance rights and not appeal rights for extensions. • After the review, the PAHP submitted an <i>IA Medicaid preservice pend</i> notice template which, based on the content of the template, may be aligned with the extension provisions. However, this notice template was not cited as evidence for Elements 22 and 23 and cited as evidence for Element 28, which is a different requirement than the extension provisions. It also did not include grievance rights.		

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Requirement	Supporting Documentation	Score
The culmination of these findings is concerning and confirms that the PAHP does not have effective procedures in place for extensions and that PAHP staff members do not understand the extension provisions. Recommendations: The PAHP’s policy allows 30 calendar days and the option for a 14-calendar-day extension for a PPR (i.e., post-service review of claim for payment). As 42 CFR §438.210 includes no specific time frames for PPRs, HSAG recommends that the PAHP consult with HHS to verify if its process meets HHS’ expectations. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Update and resubmit its <i>UM08-INS-Authorization Review</i> policy to include accurate procedures for extensions. - Submit evidence that its system has the capability to track extensions. - Submit staff training materials on extensions (e.g., extension time frames, when an extension can be applied [i.e., when additional clinical information is pending from a provider and not solely for the convenience of the PAHP]; and extensions should not be applied prematurely but when the PAHP is unable to make a decision by the due date).		
23. If the PAHP meets the criteria set forth for extending the timeframe for standard and expedited service authorization decisions consistent with 42 CFR §438.210(d)(1)(ii) and 42 CFR §438.210(d)(2)(ii), it: - Gives the member written notice of the reason for the decision to extend the timeframe and informs the member of the right to file a grievance if he or she disagrees with that decision; and - Issues and carries out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires. 42 CFR §438.210(d)(1)(ii) 42 CFR §438.210(d)(2)(ii) 42 CFR §438.404(c)(4)(i-ii) 42 CFR §457.1230(d) Contract H.3.08–H.3.09	HSAG Required Evidence: - Policies and procedures - UM program description - Tracking and reporting mechanism(s) (i.e., screenshots of UM system, mock report template to monitor timeliness) - Extension notice template - Staff training materials - System screenshot of the field where the notice of extension is documented - HSAG will also use the results of the system demonstration (i.e., mock service authorization cases) Evidence as Submitted by the PAHP: - SVII_UM08-INS-Authorization Review <page 3-4, Procedure A. Prior Auth Review 3, 4 & 8>	☐ Met ☒ Not Met
PAHP Description of Process: PAHP systems are still being configured and developed. Mock reporting is not available yet.		
HSAG Findings: HSAG’s review identified the findings below: The <i>UM08-INS-Authorization Review</i> policy indicated that an extension notice with grievances rights would be provided to a member for standard PAs; however, this same requirement was not included in the policy for expedited PA extensions. This was not corrected after the review as requested by HSAG.		

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Requirement	Supporting Documentation	Score
- HSAG requested that an extension template be provided as one was not originally provided as requested. After the review, the PAHP submitted two <i>IA Medicaid PA denial that needed ext</i> notices. Both notices were ABD notices. An extension is very different from an ABD, and an ABD notice is not an appropriate notice to send to a member when an extension is applied. Further, the ABD notice provides members with appeal rights; however, members have grievance rights and not appeal rights for extensions. - After the review, the PAHP submitted an <i>IA Medicaid preservice pend</i> notice template which, based on the content of the template, may be aligned with the extension provisions. However, this notice template was not cited as evidence for Elements 22 and 23 and cited as evidence for Element 28, which is a different requirement than the extension provisions. It also did not include grievance rights. The culmination of these findings is concerning and confirms that the PAHP does not have effective procedures in place for extensions and that PAHP staff members do not understand the extension provisions. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Update and resubmit its <i>UM08-INS-Authorization Review</i> policy to include accurate procedures for extensions. - Submit an extension notice with member grievance rights. - Submit evidence that its system has the capability to generate and maintain extension notices. - Submit staff training materials on extensions (e.g., use of correct extension notice template).		
24. For termination, suspension, or reduction of previously authorized Medicaid-covered services, the PAHP mails the ABD notice to the member at least 10 days before the date of action, except as permitted under 42 CFR §431.213 and §431.214. 42 CFR §431.211 42 CFR §431.213 42 CFR §431.214 42 CFR §438.210(c) 42 CFR §438.404(c)(1) 42 CFR §457.1230(d) Contract H.3.01	HSAG Required Evidence: - Policies and procedures - UM program description - Advance ABD notice template(s) - Tracking and reporting mechanism(s) (i.e., screenshots of UM system, mock report template to monitor timeliness) - Staff training materials - Mock advance ABD notice to member for the termination, suspension, or reduction of a previously authorized service - System screenshot of the field where the advance notice is documented, including the date of the ABD notice and effective date of the action - HSAG will also use the results of the system demonstration Evidence as Submitted by the PAHP: - SVII UM08-INS-Authorization Review <page 7-8, Procedure C. Reduction, Suspension, or Termination>	☒ Met ☐ Not Met

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Requirement	Supporting Documentation	Score
	- SVII_IA Medicaid NABD letter template <Full document> - SVII_UM01-INS-Clinical Algorithms <page 2, Procedure A. Formulation/Establishment 10.>	
PAHP Description of Process: PAHP systems are currently being developed and configured. Mock reporting is not available yet. Staff Training materials are currently under development. They will be submitted by May 1, 2026. HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: HSAG’s review identified the recommendations below: - During the review, PAHP staff members confirmed that ABD notices related to the termination, suspension, or reduction (TSR) of previously authorized services would be generated and maintained in the same system as PAs and PPRs, and the same ABD notice template would be used. However, HSAG recommends that the PAHP ensure that the effective date of the action is documented in each record. - During the review, PAHP staff members originally stated that they do not TSR previously authorized services but later provided circumstances for when this may occur (e.g., orthodontia). However, HSAG is reminding the PAHP that while the TSR of a previously authorized service may be an infrequent occurrence for a dental PAHP, the PAHP cannot make a general statement indicating that it does not TSR previously authorized services as the PAHP must have processes to TSR previously authorized services, when indicated. HSAG recommends that staff training include education for when the PAHP may be required to TSR a previously authorized service. - As 42 CFR §438.404(c)(1) requires the PAHP to send notice according to 42 CFR §431.211, which HHS is required to comply with (i.e., as the “State or local agency”), HSAG recommends that the PAHP consult with HHS should it have any clarifying questions on HHS’ expectations for providing members with a 10-day advance notice (e.g., when a member ages out of an eligibility program with active PAs on file). - HSAG recommends that the PAHP expand on the procedures for implementation and incorporate any guidance received by HHS, if applicable. Required Actions: None.		
25. The PAHP <i>mails the</i> notice not later than the date of action if: - The PAHP has factual information confirming the death of a member; - The PAHP receives a clear written statement signed by a member that: - The member no longer wishes services; or	HSAG Required Evidence: - Policies and procedures - UM program description - ABD notice template(s) - Tracking and reporting mechanism(s) (i.e., screenshots of UM system, mock report template to monitor timeliness) - Staff training materials - Three mock examples of an ABD notice sent to a member that meets one of the criteria of this element (e.g., one	☐ Met ☒ Not Met

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Requirement	Supporting Documentation	Score
ii. Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information; c. The member has been admitted to an institution where the member is ineligible under the plan for further services; d. The member’s whereabouts are unknown and the post office returns agency mail directed to the member indicating no forwarding address; e. The PAHP establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth; or f. A change in the level of medical care is prescribed by the member’s physician. 42 CFR §431.213 42 CFR §438.210(c) 42 CFR §438.404(c)(1) 42 CFR §457.1230(d) Contract H.3.03	example for a deceased member, one example for a member who no longer wishes to receive services, and one example for member who is no longer eligible for services through the PAHP [e.g., member incarcerated]) - System screenshot of the field where the date of the ABD notice, reason for the ABD, and effective date of the action are documented for advance notices - HSAG will also use the results of the system demonstration Evidence as Submitted by the PAHP: - SVII_UM Program Description < - SVII_IA Medicaid NABD letter template <Full Document> - SVII_INT02-INS-Undeliverable Member Mail <page 2, Procedure B. Undeliverable Mail Returned>	
PAHP Description of Process: PAHP systems are currently being developed and configured. Mock reporting is not available yet. HSAG Findings: The documentation cited as evidence by the PAHP did not include the requirements of this element, and discussion during the review did not provide assurances of an understanding of a process for implementation. HSAG requested that the requirements of this element be incorporated into its policy. However, after the review, the PAHP submitted a <i>CS10.01-INS-SOP Change in Enrollee Circumstances</i> policy, which addressed program integrity procedures for notifying HHS about changes in a member’s circumstance that may affect a member’s eligibility (i.e., change in residence or death of a member). However, this policy does not fully address this element. The PAHP did not incorporate the requirements of this element in a UM policy or indicate that an ABD notice would be sent by the date of the action when one of the listed scenarios occurs. Recommendations: HSAG’s review identified the recommendations below: - As 42 CFR §438.404(c)(1) requires the PAHP to send notice according to 42 CFR §431.213, which HHS is required to comply with (i.e., as the “State or local agency”), HSAG recommends that that PAHP consult with HHS should it have any clarifying questions on HHS’ expectations for providing members with an ABD notice when the PAHP is aware when any of the scenarios outlined in 42 CFR §431.213 occur. - HSAG recommends that the PAHP expand on the procedures for implementation and incorporate any guidance received by HHS, if applicable.		

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Requirement	Supporting Documentation	Score
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Incorporate the requirements of this element in its <i>UM08-INS-Authorization Review</i> policy. - Incorporate the requirements of this element and procedures for implementation in staff training materials.		
26. The PAHP may shorten the period of advance notice to five days before the date of action if: - The PAHP has facts indicating that action should be taken because of probable fraud by the member; and - The facts have been verified, if possible, through secondary sources. 42 CFR §431.214 42 CFR §438.210(c) 42 CFR §438.404(c)(1) 42 CFR §457.1230(d) Contract H.3.02	HSAG Required Evidence: - Policies and procedures - UM program description - ABD notice template(s) - Tracking and reporting mechanisms (e.g., screenshots of UM system, mock report template to monitor timeliness) - Workflow/communication channels to ensure ABD notice is mailed to members due to probable fraud by the member - One mock example of an ABD notice sent to a member due to probable fraud - Staff training materials Evidence as Submitted by the PAHP: - SVII_UM Program Description - SVII IA Medicaid NABD letter template <Full Document>	☐ Met ☒ Not Met
PAHP Description of Process: PAHP systems are currently being configured and developed. Mock reporting is not available yet. Staff Training materials are currently being developed. They will be submitted by May 1, 2026.		
HSAG Findings: The documentation cited as evidence by the PAHP did not include the requirements of this element, and discussion during the review did not provide assurances of an understanding of a process for implementation. HSAG requested that the requirements of this element be incorporated into its policy. However, after the review, the PAHP submitted a <i>CS10.01-INS-SOP Change in Enrollee Circumstances</i> policy, which addressed program integrity procedures for notifying HHS about changes in a member’s circumstance that may affect a member’s eligibility (i.e., change in residence or death of a member). However, this policy does not address this element. The PAHP did not incorporate the requirements of this element in policy or indicate that an ABD notice would be sent at least five days prior to the date of the action due to probable member fraud.		
Recommendations: HSAG’s review identified the recommendations below: - As 42 CFR §438.404(c)(1) requires the PAHP to send notice according to 42 CFR §431.214, which HHS is required to comply with (i.e., as the “State or local agency”), HSAG recommends that that PAHP consult with HHS should it have any clarifying questions on HHS’ expectations for providing members with a five day advance notice due to member fraud. - HSAG recommends that the PAHP expand on the procedures for implementation and incorporate any guidance received by HHS, if applicable.		

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Requirement	Supporting Documentation	Score
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Incorporate the requirements of this element in its <i>UM08-INS-Authorization Review</i> policy. - Incorporate the requirements of this element and procedures for implementation of staff training materials.		
27. The PAHP mails the ABD notice for denial of payment at the time of any action affecting the claim. 42 CFR §438.210(c) 42 CFR §438.404(c)(2) 42 CFR §457.1230(d) Contract H.3.04	HSAG Required Evidence: - Policies and procedures - Workflow/guidelines for payment denial on a claim to trigger ABD notice - UM program description - ABD notice template for denial of payment - Tracking and reporting mechanism(s) (e.g., screenshots of UM system, mock report template to monitor timeliness) - Staff training materials - One mock ABD notice to a member for the denial of payment on a claim, including screenshots of the date of receipt of the claim and the date of the action on the claim (using test data) - HSAG will also use the results of the system demonstration Evidence as Submitted by the PAHP: - SVII_UM Program Description < page 7, Prepayment review> - SVII_IA Medicaid NABD letter template <Full Document> - SVII_CORR-02 INS Claim letter templates <Pg 1 Procedure A. Denial Notification b. i.>	☐ Met ☒ Not Met
PAHP Description of Process: PAHP systems are currently being configured and developed. Mock reporting is not available yet. Staff Training materials are currently under development. They will be submitted by May 1, 2026.		
HSAG Findings: The <i>CORR-02 INS Claim letter templates</i> policy indicated that the PAHP can send claim denial letters for all denials or for a subset of denial categories and that the PAHP will work with the “plan” to define the situations in which claim denial letters will be sent. As the PAHP is the “plan,” this latter statement is unclear. HSAG questioned if the PAHP is sending ABD notices for all denial categories or a subset of denial categories and how the PAHP defined the situations in which ABD notices for claim payment denials will be sent. PAHP staff members explained that when an “N” status is applied		

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Requirement	Supporting Documentation	Score
to a record, it triggers the generation of an ABD notice. However, PAHP staff members later clarified that the “N” status only applies to PAs. However, this element solely applies to ABD notices sent to members due to the denial of payment on a claim (i.e., post-service claim for payment and not a pre-service PA request). HSAG requested that the PAHP submit documentation demonstrating how it determines when an ABD notice is sent to a member (or not) when the PAHP denies a post-service request for payment (i.e., claim). - After the review, the PAHP submitted an <i>IA Medicaid PA denial that needed ext</i> notice. However, based on the title of the document (i.e., “PA denial”), this notice does not apply to the requirement (i.e., claim payment denial post-service). As such, HSAG could not determine the PAHP’s intent for submitting the <i>IA Medicaid PA denial that needed ext</i> notice as evidence. Further, as the title of the notice implied it was related to an “extension” (i.e., “ext”), HSAG struggled to understand the applicability of the notice. Recommendations: The PAHP’s policy allows 30 calendar days and the option for a 14-calendar-day extension for a PPR (i.e., post-service review of claim for payment). As 42 CFR §438.210 includes no specific time frames for PPRs, HSAG recommends that the PAHP consult with HHS to verify if its process meets HHS’ expectations. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Provide evidence of its business rules that trigger or do not trigger the generation of an ABD notice for claim payment denials. This must address any claim payment denials if the payment for services was denied through PPR (e.g., Dental Consultant review) or without manual review, and “clean” claims versus claims that do not meet the definition of a “clean” claim.		
28. For standard and expedited service authorization decisions not reached within the required timeframes specified in 42 CFR §438.210(d) (which constitutes a denial and is thus an ABD), the PAHP provides notice on the date that the timeframes expire. 42 CFR §438.210(c-d) 42 CFR §438.404(c)(5) 42 CFR §457.1230(d) Contract H.3.12–H.3.13	HSAG Required Evidence: - Policies and procedures - UM program description - ABD notice template for untimely determination - Tracking and reporting mechanism(s) (i.e., screenshots of UM system, mock report template to monitor timeliness) - Tracking and reporting mechanism(s) (e.g., to track ABD notices sent for untimely decisions versus denials for medical necessity) - Staff training materials - One mock case example of an untimely authorization decision, including the date of receipt of the authorization request and ABD notice - HSAG will also use the results of the system demonstration Evidence as Submitted by the PAHP:	☐ Met ☒ Not Met

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Requirement	Supporting Documentation	Score
	- SVII_UM08-INS-Authorization Review <page10-11, Exhibit AY - Iowa> - SVII_UM Program Description <page 7, Prior Authorization Review> - SVII IA Medicaid NABD letter template <Full document>	
PAHP Description of Process: PAHP systems are currently being configured and developed. Mock reporting is not available yet. Staff Training Materials are currently under development. They will be submitted by May 1, 2026.		
HSAG Findings: HSAG’s review identified the findings below: - HSAG was unable to locate the requirements of this element based on the PAHP’s citations in the <i>UM08-INS-Authorization</i> policy and <i>UM Program Description</i>. During the interview session, HSAG requested clarification as to how the PAHP documents and tracks denials for untimeliness versus denials based on medical necessity. Discussion with PAHP staff members suggested that it was documented and tracked based on the denial code and denial code explanation. HSAG requested the denial code and denial code explanation for untimely decisions and the associated ABD notice. - After the review, the PAHP submitted four notice templates (i.e., <i>IA Medicaid standard PA denial</i>, <i>IA Medicaid preservice pend</i>, <i>IA Medicaid PA denial that needed ext</i>, and <i>IA Medicaid expedited PA denial</i>), none of which applied to an untimely service authorization. - The denial code and denial explanation referenced by the PAHP in the interview session were not provided after the review. The culmination of these findings is concerning and confirms that the PAHP does not have effective procedures in place for processing untimely service authorizations and that PAHP staff members do not understand the requirement. As a reminder, if the PAHP fails to render the service authorization decision timely (i.e., within seven calendar days or 72 hours [with a possible extension, when applicable]), the service request is considered a denial, and the PAHP is required to send an ABD notice on the date that the authorization review expired.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Incorporate the requirements of this element in its <i>UM08-INS-Authorization Review</i> policy. - Submit system screenshots or other evidence demonstrating a process to track service authorization denials due to the PAHP’s failure to make a decision timely. - Provide a mock ABD notice for the PAHP’s failure to make a decision timely. - Incorporate the requirements of this element and procedures for implementation in staff training materials.		

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Requirement	Supporting Documentation	Score
Tracking and Reporting		
29. <i>The PAHP tracks all PA requests in its information system.</i> a. <i>All notes in the PAHP's PA tracking system are signed by clinical staff and include the appropriate credentials.</i> b. <i>For PA approvals, the PAHP provides a PA number to the requesting provider and maintains a record of the following information, at a minimum, in the PAHP's information system:</i> i. <i>Name and title of caller or submitter.</i> ii. <i>Date and time of call, fax or online submission,</i> iii. <i>Prior authorization number.</i> iv. <i>Time to determination, from receipt.</i> v. <i>Approval/denial count.</i> Contract G.3.10(a) Contract K.46	HSAG Required Evidence: • Policies and procedures • One mock example of a PA, including field for clinical staff signature with credentials • One mock example of PA approval notice to provider • One mock example of PA denial notice to provider Evidence as Submitted by the PAHP: • SVII_PDL letter template – standard <Full document>	☒ Met ☐ Not Met
PAHP Description of Process: The PDL template provided shows both approvals and denials. PAHP systems are still being configured and developed. Mock reporting is not available yet.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Of note, while the PAHP's system will have the capability to comply with the requirements of this element, the PAHP will be required to demonstrate its system for the Iowa Medicaid managed care program in the production environment during follow-up sessions with HSAG that will occur prior to July 1, 2026. Any failure to demonstrate a sufficient production environment may result in a <i>Not Ready</i> status in the UM program area.		
Required Actions: None.		

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Requirement	Supporting Documentation	Score
30. For all denials of PA requests, the PAHP maintains a record of the following information, at a minimum, in the PAHP's information system: - Name and title of caller or submitter. - Date and time of call or submission. - Clinical synopsis inclusive of timeframe of illness or condition, diagnosis and treatment plan. - Clinical guidelines or other rationale supporting the denial (i.e., insufficient documentation). Contract G.3.10(b) Contract K.47	HSAG Required Evidence: - Policies and procedures - Mock example of a completed PA (i.e., screenshots of UM system using test data) Evidence as Submitted by the PAHP: - SVII_UM Program Description <page 15-16, Information Systems>	☒ Met ☐ Not Met
PAHP Description of Process: PAHP systems are still being configured and developed. Mock reporting is not available yet.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Of note, while the PAHP's system will have the capability to comply with the requirements of this element, the PAHP will be required to demonstrate its system for the Iowa Medicaid managed care program in the production environment during follow-up sessions with HSAG that will occur prior to July 1, 2026. Any failure to demonstrate a sufficient production environment may result in a <i>Not Ready</i> status in the UM program area.		
Required Actions: None.		
Compensation for Utilization Management Activities		
31. The PAHP provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member. 42 CFR §438.210(e) 42 CFR §438.3(i) 42 CFR §422.208 42 CFR §457.1230(d) Contract G.3.21	HSAG Required Evidence: - Policies and procedures - UM program description - New hire and ongoing training for staff - Three examples of staff attestations Evidence as Submitted by the PAHP: - SVII_UM22-ENT-UM Staff De-Incentives <Full Document>	☒ Met ☐ Not Met

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Requirement	Supporting Documentation	Score
	- SVII_UM Program Description <page 10-11 New Hire Training> - SVII_UM Program Evaluation <page 2-3 Resources for UM Program>	
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
Transition of Care		
32. During the first two years of the contract, the PAHP honors all existing authorizations for covered benefits for a minimum of 90 days, without regard to whether such services are being provided by contract or non-contract providers, when a member transitions to the PAHP from another source of coverage. a. The PAHP honors existing exceptions to policy granted by the Director for the scope and duration designated. b. At all other times, the PAHP honors all existing authorizations for a minimum of 30 days when a member transitions to the PAHP from another source of coverage, without regard to whether services are being provided by contract or non-contract providers. c. When a member transitions to another program contractor, the PAHP provides the receiving entity with information on any current service authorizations, utilization data and other applicable clinical information such as disease management or care coordination notes. Contract F.16.09 Contract G.2.36	HSAG Required Evidence: - Policies and procedures - Transition of care claim edits - Transition of care program, including a process to obtain historical data (PAs, exceptions to policy [ETP], claims) from relinquishing PAHP - Process to use historical data for transitions of care (e.g., add PAs and ETP to system) - Staff training materials Evidence as Submitted by the PAHP: - SVII_UM17-INS-GOV-Continuation of Care <page 1 Policy and Procedure> - SVII_UM17-INS-GOV-Continuation of Care <page 4, Exhibit M –Iowa>	☐ Met ☒ Not Met
PAHP Description of Process: Staff Training materials are currently in development. They will be submitted by May 1, 2026.		

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
HSAG Findings: HSAG’s review identified the findings below: - During the interview session, PAHP staff members confirmed that a file with existing PAs and claims history will be provided by HHS. PAHP staff members further explained that PAs will be integrated into the PAHP’s system to ensure member access and provider payment for services and that claims history will be made available to staff. After the review, the PAHP provided the following statement: “The detail file is scheduled to be received between 4/1 and 4/23. Authorizations were scheduled for 2/9-3/9 but this has not been received.” - HSAG requested clarification as to whether the transition of care file from HHS also includes approved exceptions to policy. No additional information was provided by the PAHP after the review. - The PAHP originally submitted a 2024 version of the member handbook, which included the statement, “Before 90 days, your provider must check with us to keep giving your services to you. If your provider is not in our plan, we will help you find a new provider that is in our plan, schedule an appointment, and move your health records to the new provider.” This statement contradicts the contract requirement to honor all existing authorizations for covered benefits for a minimum of 90 days, without regard to whether such services are being provided by contracted or non-contracted providers. HSAG reviewed the revised member handbooks after the review and noted that this language was no longer included. However, it is unknown how the PAHP is informing members of the transition of care requirements, which is critical information for a member to know. - After the review, HSAG could not locate documentation that the <i>ORM</i> specifically informed providers of the 90-day transition of care time frame requirements for the Iowa Medicaid managed care program, which is critical information for a provider to know. Required Actions: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. - Confirmation that the transition of care file(s) has been received from HHS and integrated into the PAHP’s system. - Evidence for how the PAHP is informing members of the transition of care requirements (e.g., member handbook). - Evidence for how the PAHP is informing providers of the 90-day transition of care period (e.g., <i>ORM</i>).		
Public Reporting Prior Authorization Metrics		
33. The PAHP makes the following data (excluding covered drugs) from the previous calendar year publicly accessible by posting them on its website: - A list of all items and services that require PA. - The percentage of standard PA requests that were approved, aggregated for all items and services. - The percentage of standard PA requests that were denied, aggregated for all items and services.	HSAG Required Evidence: - Policies and procedures - List of all services requiring a PA - Plan to publicly report list of services requiring a PA - Screenshot of website with list of services requiring a PA - Plan to publicly report PA metrics	☐ Met ☒ Not Met
	Evidence as Submitted by the PAHP:	

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
d. The percentage of standard PA requests that were approved after appeal, aggregated for all items and services. e. The percentage of PA requests for which the timeframe for review was extended, and the request was approved, aggregated for all items and services. f. The percentage of expedited PA requests that were approved, aggregated for all items and services. g. The percentage of expedited PA requests that were denied, aggregated for all items and services. h. The average and median time that elapsed between the submission of a request and a determination by the PAHP, for standard PA, aggregated for all items and services. i. The average and median time that elapsed between the submission of a request and a decision by the PAHP, for expedited PAs, aggregated for all items and services. 42 CFR §438.210(f) 42 CFR §457.1230(d)	SVII_Provider Reference Manual <pages 69-135 Exhibit A Benefits grid (see column labeled “Prior Authorization Required”)>	
PAHP Description of Process: The provider portal and member websites are still in development phases. Furthermore, Iowa is a new plan and has no data to aggregate for PAs at this time. This process will be developed. DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made.		
HSAG Findings: While the PAHP’s <i>ORM</i> included PA and PPR requirements for each dental code, it does not meet the intent of the requirements of this element. No documentation was provided to support the PAHP’s awareness that a list of all items and services that require PA are required to be posted on the PAHP’s website. If the PAHP intends to use its <i>ORM</i> as the mechanism to report this information, the PAHP must have a readily accessible webpage for members and stakeholders to know where to locate this information.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Provide clarification on the format for how the PAHP will post a list of all items and services that require PA on its website. - Provide a link to the landing page(s) for where the list of all items and services that require a PA will be posted.		

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
Submit documentation supporting awareness of the public reporting of PA metrics (i.e., sub-elements ([b]–[i]) and a plan to ensure it will be able to accurately report on the PA metrics to publicly post by March 31, 2027.		

Standard VII—Coverage and Authorization of Services						
Met	=	15	X	1	=	15
Not Met	=	18	X	0	=	0
Total	=	33	Total Score		=	15
Total Score ÷ Total					=	45%

Standard VIII—Provider Selection

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
General Rules		
1. The PAHP implements written policies and procedures for selection and retention of network providers and those policies and procedures, at a minimum, meet the requirements of 42 CFR §438.214. a. The PAHP develops, implements, and adheres to written policies and procedures related to provider credentialing and recredentialing, which includes standards of conduct that articulate the PAHP's understanding of the requirements and that direct and guide PAHP's and subcontractors' compliance with all applicable federal and State standards related to provider credentialing, including those required in 42 CFR. Parts 438 and 455, Subpart E [provider screening and enrollment], which includes the following: i. A training plan designed to educate staff in the credentialing and re-credentialing requirements. ii. Provisions for monitoring and auditing compliance with credentialing standards. iii. Provisions for prompt response and corrective action when non-compliance with credentialing standards is detected. iv. A description of the types of providers that are credentialed. v. Methods of verifying credentialing assertions, including any evidence of prior provider sanctions. 42 CFR §438.214(a) 42 CFR §438.214(b)(2) 42 CFR §438.214(e)	HSAG Required Evidence: • Policies and procedures • Credentialing training plan, including State or Iowa-specific requirements • Staff training materials • List of delegates performing credentialing functions • Credentialing monitoring and auditing plan for credentialing functions performed by the PAHP and delegates Evidence as Submitted by the PAHP: • SVIII_PEC01-INS-Credentialing Guidelines<Full Document> • SVIII_NET01-INS-Network Development Maintenance and Use<Pages 1-2, Procedure A. Initial Network Development, Element 1-4, • SVIII_NET01-INS-Network Development Maintenance and Use Pages 5-6, Procedure B. Network Retention, Element C. Ongoing Recruitment> • SVIII_PEC04-INS-Provider Maintenance and Ongoing Monitoring <Page 4, Procedure F. Ongoing Monitoring> • SVIII_Credentialing Plan Description<Full Document> • SVIII_QA04-INS-Credentialing Quality Audits-FINAL<Full Document> • SVIII_Quality Assurance Credentialing Methodology 2025<Full Document> • SVIII_2023_DentaQuest_NCQA_Certificate • SVIII_Credentials Committee Charter	☐ Met ☒ Not Met

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
42 CFR §457.1233(a) Contract E.3.02–E.3.03		
PAHP Description of Process: Staffing materials are currently under development. They will be submitted by May 1, 2026.		
HSAG Findings: HSAG’s review identified the findings below: • HSAG requested that the PAHP update its policies and/or Iowa exhibit with the state-specific requirements (i.e., sub-elements [a] and [i]-[v]) of this element; however, HSAG was unable to locate those updates. • While the PAHP submitted its <i>IA State-Specific Training</i> document in follow-up, HSAG was unable to determine if this training plan was used to ensure staff were trained on Iowa-specific requirements when credentialing providers for the Iowa Medicaid managed care program. • The PAHP did not clarify its provisions for prompt response and corrective action, or provide sufficient evidence to address noncompliance with credentialing standards when detected. Recommendations: While not specific to this element but the entire standard, HSAG recommends that the PAHP proceed with its plan to update and finalize its <i>ORM</i> and ensure it provides sufficient information to providers and reflects the requirements of this standard. Further, the PAHP must ensure its <i>ORM</i> reflects all appropriate content for the Iowa Medicaid managed care program. Finally, although additional findings were documented in Standard II—Member Rights and Member Information related to the provider directory, HSAG strongly recommends that the PAHP ensure it has a sufficient process and is following up with providers as necessary to obtain information regarding specific accessibility accommodations (e.g., equipment such as accessible exam chairs) so that the provider directory can be updated appropriately.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: • Include the state-specific requirements (i.e., sub-elements [a] and [i]-[v]) within its policies and procedures. • Provide an updated training plan that includes completed and expected completion training dates for Iowa-specific requirements. • Develop and submit policies and procedures for promptly responding to and requiring corrective action when noncompliance with credentialing standards is detected.		
2. The PAHP follows a documented process for credentialing and recredentialing of network providers that meets HHS’ requirements for each of the following provider types: - General dentist. - Oral surgery. - Orthodontia. - Prosthodontia. - Periodontia. - Endodontia.	HSAG Required Evidence: • Policies and procedures • Staff training materials Evidence as Submitted by the PAHP: • SVIII_PEC01-INS-Credentialing Guidelines<Full Document references “all provider”>	☒ Met ☐ Not Met

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
g. Pediatric specialties. 42 CFR §438.214(b)(1-2) 42 CFR §438.214(e) 42 CFR §457.1233(a) Contract E.3.04 Contract E.3.09 Contract Exhibit C: General Access Standards		
PAHP Description of Process: Staff Training materials are currently under development. They will be submitted by May 1, 2026.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
Nondiscrimination		
3. The PAHP network provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment, consistent with 42 CFR §438.12. 42 CFR §438.12 42 CFR §438.214(c) 42 CFR §457.1233(a) Contract E.3.10	HSAG Required Evidence: • Policies and procedures • Nondiscrimination statement for credentialing committee members • Plan to monitor for discriminatory practices • Staff training materials Evidence as Submitted by the PAHP: • SVIII_PEC01-INS-Credentialing Guidelines<Full Document> • SVIII_PEC01-INS-Credentialing Guidelines<page 9, F. Credentials Committee Review, 5. Nondiscriminatory Credentialing> • SVIII_PEC01-INS-Credentialing Guidelines<page 9, F. Credentials Committee Review, 5. Nondiscriminatory Credentialing, Element c>	☒ Met ☐ Not Met
PAHP Description of Process: Staff Training materials are currently under development. They will be submitted by May 1, 2026.		

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
4. The PAHP may not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. a. If the PAHP declines to include individual or groups of providers in its provider network, it must give the affected providers <i>and HHS</i> written notice of the reason for its decision. b. In all contracts with network providers, the PAHP must comply with the requirements specified in 42 CFR §438.214. 42 CFR §438.12(a)(1-2) 42 CFR §438.214 42 CFR §457.1233(a) Contract E.2.01 Contract E.3.01 Contract E.3.19 Contract E.4.01	HSAG Required Evidence: • Policies and procedures • Provider notice template(s) for adverse credentialing and/or contracting decisions • Example of one individual and one organizational executed provider contracts • Nondiscrimination statement for credentialing committee members • Plan to monitor for discriminatory practices • HSAG will also use the results of the Practitioner and Organizational Credentialing and Recredentialing File Review Evidence as Submitted by the PAHP: • SVIII_PEC01-INS-Credentialing Guidelines<page 1, Policy> • SVIII_PEC01-INS-Credentialing Guidelines<page 10, F. Credentials Committee Review, 6. Limited Approval, Element b> • SVIII_PEC01-INS-Credentialing Guidelines<page 9, F. Credentials Committee Review, 5. Nondiscriminatory Credentialing> • SVIII_PEC01-INS-Credentialing Guidelines<page 9, F. Credentials Committee Review, 5. Nondiscriminatory Credentialing, Element c>	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
Required Actions: None.		
Provider Manual		
5. <i>The PAHP provides and maintains a written program manual for use by the PAHP’s provider network.</i> a. <i>The manual is made available electronically, and in hard copy (upon a provider’s request) to all network providers, without cost.</i> b. <i>The provider manual includes the requirements in the Provider Manual Checklist.</i> Contract E1.03	HSAG Required Evidence: • Policies and procedures • Provider manual • Link to the provider manual on the PAHP’s website • HSAG will also use the results of the Provider Manual Checklist Evidence as Submitted by the PAHP: • The Provider Portal is in the development phase. Once it is complete, we can store documents for providers to access, including the Provider Reference Manual.	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: HSAG recommends that the PAHP proceed with its plan to finalize and approve the <i>ORM</i>. While the PAHP received a <i>Met</i> score on all elements of the <i>Provider Manual Checklist</i>, HSAG strongly recommends that the PAHP describe cost-sharing requirements to ensure providers know if cost-sharing requirements apply. Although there was a description provided for Indian Health Care Providers, in particular, the PAHP must clarify if there are groups of individuals subject to cost-sharing charges or if cost sharing does not apply to its network. HSAG requested further information on this during the review; however, nothing was submitted in follow-up on the <i>Post-Site Review Tracker</i>. Additionally, the PAHP’s <i>NET01-INS Network Development, Maintenance, and Use</i> policy indicated that practitioners will be given access to the manual by sharing a link. HSAG strongly recommends that the PAHP revise its language and/or include an Iowa exhibit to incorporate that a provider may receive a hard copy of the manual upon the provider’s request at no cost. Further, the provider manual references the PAHP’s members in multiple terms including “member,” “enrollee,” and “patient.” As such, HSAG recommends that the PAHP revise this language and refer to members using one term throughout, whichever name the PAHP prefers. Lastly, HSAG recommends that the PAHP incorporate feedback and recommendations provided throughout the readiness review from other standards to ensure network providers will have access to pertinent information. Of note, as appropriate, the PAHP should obtain HHS approval and upload the provider manual to its website prior to July 1, 2026, to ensure availability to its provider network. The PAHP will be required to attest that the Iowa-specific provider manual was		

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
finalized and posted to its website prior to July 1, 2026, through a follow-up session that will occur with HSAG. Any failure to demonstrate that a final provider manual has been disseminated to providers may result in a <i>Not Ready</i> status.		
Required Actions: None.		
Provider Contracting		
6. <i>In accordance with 42 CFR §438.206, the PAHP establishes written agreements with all network providers.</i> a. <i>Provider agreements comply with all of the requirements in the Provider Contract Checklist.</i> Contract E1.06	HSAG Required Evidence: • Policies and procedures • Two examples of a provider agreement/contract template for a practitioner (one each for Hawki and DWP) • Two examples of a provider agreement/contract template for an organizational provider (one each for Hawki and DWP) • HSAG will also use the results of the Provider Contract Checklist Evidence as Submitted by the PAHP: • SVIII_230206 IA MA MC HIX Provider Agreement <Full document> • SVIII_2026.02.18 DRAFT Provider Agreement FQHC <Full document>	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: HSAG recommends that the PAHP proceed with its plan to finalize and approve the provider agreement template. While the PAHP received a <i>Met</i> score on all elements of the <i>Provider Contract Checklist</i>, HSAG strongly recommends that the PAHP clarify if it has capitated payments for certain providers or if it does not have capitated payments. Additionally, HSAG recommends that the PAHP explain if it has an alternative payment schedule. HSAG requested further information on both items during the review; however, nothing was submitted in follow-up. The PAHP must ensure these items are included in the <i>Provider Agreement</i>, if they are applicable.		
Required Actions: None.		

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
Practitioner Verification of Credentials		
7. <i>For credentialing and recredentialing, the PAHP primary source verifies that the practitioner has a current and valid license to practice in all states where the practitioner provides care to members within 120 calendar days of the credentialing decision.</i> a. <i>The PAHP verifies the license directly from the state licensing or certification agency (or its website).</i> b. <i>When individuals providing services are not required to be licensed, accredited or certified, the PAHP ensures, based on applicable State licensure rules and/or program standards, that they are appropriately educated, trained, qualified, and competent to perform their job responsibilities.</i> 42 CFR §438.214(e) Contract E.3.06 Contract G.7.03 Note: References to G.7.03 refers to the PAHP's responsibilities for adhering to NCQA credentialing and recredentialing requirements which are outlined throughout this tool (Elements 7-19).	HSAG Required Evidence: • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review Tool Evidence as Submitted by the PAHP: • SVIII_PEC01 INS <page 4-6, Credentialing Guidelines Procedure, A. Credentialing Process, 1. Credentialing Application, Element c • SVIII_PEC01 INS <page 4-6, Credentialing Guidelines Procedure, A. Credentialing Process, 2. Primary Source Verification, Element b	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
8. <i>For credentialing and recredentialing, the PAHP verifies that the practitioner's Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate is valid and current in each state where the practitioner provides care to members at the time of the credentialing decision.</i>	HSAG Required Evidence: • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review Tool Evidence as Submitted by the PAHP:	☒ Met ☐ Not Met

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
a. <i>This requirement does not apply to practitioners who are not qualified to write prescriptions.</i> 42 CFR §438.214(e) Contract G.7.03	- SVIII_PEC01 INS <page 4-6, Credentialing Guidelines Procedure, A. Credentialing Process, 1. Credentialing Application, Element d - SVIII_PEC01 INS <page 4-6, Credentialing Guidelines Procedure, A. Credentialing Process, 2. Primary Source Verification, Element e	
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: HSAG strongly recommends that the PAHP review its process for verification of practitioners' Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificates and ensure it verifies state-specific controlled substance registrations, where applicable. Throughout the desk review, HSAG was unable to locate verification of two providers' (Sample 1 and Over Sample 1) Controlled Substance Act (CSA) registrations, an Iowa-specific requirement for providers who have DEA certificates. HSAG was also unable to locate verification of one provider's (Sample 4) DEA certificate of its Kansas registration. This provider (Sample 4) was licensed in three states, Iowa included, in which all dental licenses and DEA certificates were verified, except for the Kansas DEA registration. The PAHP must ensure the DEA certificate is valid and current in each state where the practitioner provides care to members at the time of credentialing. During the review, HSAG requested that the PAHP provide a narrative and corrective action plan (CAP) as to why the CSAs were not verified at the time of credentialing as well as to why the Kansas DEA registration was not verified for Sample 4. In follow-up, the PAHP submitted verifications of the CSAs for both providers; however, the date of verification was the week before the readiness review and, as such, verification was conducted almost two years after the time of the credentialing decision. The PAHP did not submit any narrative to address these issues as HSAG had requested, therefore it was not clear if the verification was conducted based on the readiness review process. This finding was scored as a <i>Not Met</i> on Element 1, that the PAHP must have provisions for prompt response and corrective action when noncompliance with credentialing standards is detected.		
Required Actions: None.		
9. <i>For credentialing, the PAHP verifies the highest of the following three levels of education and training obtained by the practitioner as appropriate prior to the credentialing decision:</i> a. <i>Board certification;</i> b. <i>Residency; or</i> c. <i>Graduation from medical or professional school.</i>	HSAG Required Evidence: - Policies and procedures - HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review Tool Evidence as Submitted by the PAHP:	☒ Met ☐ Not Met

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
42 CFR §438.214(e) Contract G.7.03	- SVIII_PEC01 INS <page 3-4, Credentialing Guidelines Procedure, A. Credentialing Process, 1. Credentialing Application, Element a-b - SVIII_PEC01 INS <page 5, Credentialing Guidelines Procedure, A. Credentialing Process, 2. Primary Source Verification, Element a>	
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
10. <i>For credentialing and recredentialing, the PAHP verifies the practitioner’s board certification status, if applicable, within 120 calendar days of the credentialing decision.</i> a. <i>Verification of board certification does not apply to nurse practitioners (NPs) or other health care professionals unless the PAHP communicates board certification to members.</i> 42 CFR §438.214(e) Contract G.7.03	HSAG Required Evidence: - Policies and procedures - HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review Tool Evidence as Submitted by the PAHP: - SVIII_PEC01 INS <page 4, Credentialing Guidelines, Procedure, A. Credentialing Process, 1. Credentialing Application, Element b> - SVIII_PEC01 INS <page 5, Credentialing Guidelines, Procedure, A. Credentialing Process 2. Primary Source Verification, Element c>	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
11. <i>For credentialing, the PAHP verifies the practitioner’s work history (minimum of the most recent five years of work history) within 120 calendar days of the credentialing decision.</i> a. <i>If the practitioner has fewer than five years of work history, the timeframe starts at the initial licensure date.</i> b. <i>If a gap in employment exceeds six months, the practitioner clarifies the gap verbally or in writing. The PAHP documents a verbal clarification or includes the written notice in the practitioner’s credentialing file.</i> c. <i>If the gap in employment exceeds one year, the practitioner clarifies the gap in writing and the PAHP documents its review.</i> 42 CFR §438.214(e) Contract G.7.03	HSAG Required Evidence: • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review Tool Evidence as Submitted by the PAHP: • SVIII_PEC01 INS <page 5, Credentialing Guidelines, Procedure, A. Credentialing Process, 1. Credentialing Application, Element h. Work History>	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
12. <i>For credentialing and recredentialing, the PAHP verifies a five-year history of professional liability claims (from the malpractice carrier or the National Practitioner Databank [NPDB]), that resulted in settlement or judgment paid on behalf of the practitioner within 120 calendar days of the credentialing decision.</i> a. <i>The five-year period may include residency or fellowship years.</i>	HSAG Required Evidence: • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review Tool Evidence as Submitted by the PAHP: • SVIII_PEC01 INS <page 5, Credentialing Guidelines, Procedure A. Credentialing Process, 2. Primary Source Verification, Element f>	☒ Met ☐ Not Met

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
b. <i>The PAHP is not required to obtain confirmation from the carrier for practitioners who had a hospital insurance policy during a residency or fellowship.</i> 42 CFR §438.214(e) Contract G.7.03		
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
13. <i>The PAHP notifies practitioners of initial credentialing decisions and recredentialing denials within 30 calendar days from the credentialing decision.</i> 42 CFR §438.214(e) Contract G.7.03	HSAG Required Evidence: • Policies and procedures • Timeliness tracking and reporting mechanisms (e.g., system screenshots, mock report) • Provider notice template(s) for credentialing decisions • HSAG will also use the results of the Practitioner Credentialing File Review Tools Evidence as Submitted by the PAHP: • SVIII_PEC01 INS <page 9, Credentialing Guidelines, F. Credentials Committee Review, 3. Decision Notification>	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
Practitioner Sanction Information		
14. <i>For credentialing and recredentialing, the PAHP verifies State sanctions, restrictions on licensure, and limitations of scope of practice within 120 days of the credentialing decision</i> a. <i>The PAHP verifies State sanctions, restrictions on licensure, and limitations on scope of practice in all states where the practitioner provides and/or provided care to members within the most recent five-year period available.</i> b. <i>If practitioners were licensed in more than one state in the most recent five-year period, the query must include all states in which they provided care.</i> 42 CFR §438.214(e) Contract G.7.03	HSAG Required Evidence: - Policies and procedures - HSAG will also use the results of the Practitioner Credentialing File Review Tool Evidence as Submitted by the PAHP: - SVIII_PEC01 INS <page, 3-4, Credentialing Guidelines, Procedure A. Credentialing Process, 1 Element c> - SVIII_PEC01 INS <page 5, Credentialing Guidelines, Procedure A. Credentialing Process, 2. Primary Source Verification b-f>	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
15. <i>For credentialing and recredentialing, the PAHP verifies the Medicare and Medicaid sanctions and exclusions within 120 days of the credentialing decision.</i> 42 CFR §438.214(e) Contract G.7.03	HSAG Required Evidence: - Policies and procedures - HSAG will also use the results of the Practitioner Credentialing File Review Tool Evidence as Submitted by the PAHP: - SVIII_PEC01 INS <page 6, Credentialing Guidelines, Procedure A. Credentialing Process, 2. Primary Source Verification>	☒ Met ☐ Not Met
PAHP Description of Process:		

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
Practitioner Credentialing Application/Attestation		
16. <i>For credentialing and recredentialing, the PAHP ensures the application and attestation, respectively include:</i> <i>Reasons for inability to perform the essential functions of the position.</i> <i>Lack of present illegal drug use.</i> <i>History of loss of license and felony convictions.</i> <i>History of loss or limitation of privileges or disciplinary actions.</i> <i>Current malpractice insurance coverage.</i> <i>Practitioner race, ethnicity, and language*.</i> <i>Current and signed attestation confirming the correctness and completeness of the application.</i> <i>*Note: The PAHP's application includes fields to enter race, ethnicity and language, and a statement that the organization does not discriminate or base credentialing decisions on an applicant's race, ethnicity or language, and that providing the information is optional.</i> 42 CFR §438.214(e) Contract G.7.03	HSAG Required Evidence: - Policies and procedures - HSAG will also use the results of the Practitioner Credentialing File Review Tool Evidence as Submitted by the PAHP: - SVIII_PEC01 INS <page 3-4, Credentialing Guidelines, Procedure A. Credentialing Process, Element g. iii-v.>	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
Practitioner Monitoring		
17. <i>The PAHP develops and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints, and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identifies occurrences of poor quality. The PAHP implements ongoing monitoring by:</i> <i>Collecting and reviewing Medicare and Medicaid sanctions and exclusions.</i> <i>Collecting and reviewing sanctions, and limitations and expiration on licensure.</i> <i>Collecting and reviewing complaints.</i> <i>The PAHP investigates all practitioner-specific member complaints upon their receipt and evaluates the practitioner’s history of complaints if applicable.</i> <i>The PAHP evaluates the history of all complaints for all practitioners at least every six months.</i> <i>Collecting and reviewing information from identified adverse events at least monthly.</i> 42 CFR §438.214(e) Contract G.7.03	HSAG Required Evidence: - Policies and procedures - Practitioner monitoring plan Evidence as Submitted by the PAHP: - SVIII_PEC01 INS <page 7, Credentialing Guidelines 4. Ongoing Monitoring c.i>	☐ Met ☒ Not Met
PAHP Description of Process:		
HSAG Findings: While the PAHP submitted its <i>CGA04-INS Monitoring of Complaints</i> policy after the review, the policy did not clearly indicate how often adverse events are collected and reviewed (i.e., at least monthly). Recommendations: HSAG strongly recommends that the PAHP align ongoing monitoring language across three policies shared, including <i>PEC01-INS Credentialing Guidelines</i>, <i>CGA04-INS Monitoring of Complaints</i>, and <i>PEC04-INS Provider Directory Maintenance and Ongoing Monitoring</i>, as it is unclear at what point a complaint is referred to the PAHP’s Peer Review Committee. Both policies <i>PEC01-INS Credentialing Guidelines</i> and <i>PEC04-INS Provider Directory Maintenance and Ongoing Monitoring</i> indicate that “[a]ny complaint identified as involving Quality of Care [QOC] is referred to the		

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
Company’s Peer Review Committee for evaluation.” In contrast, the <i>CGA04-INS Monitoring of Complaints</i> policy indicates that “Minor Complaints are tracked as they are resolved until Complaints total three (3) or more in a month to include a six (6) month look back period. At that point, a Clinical Quality Committee Member reviews the Provider file and a recommendation is made to the Clinical Quality Committee and a copy of the committee minutes are sent to the credentialing committee for review and recommendations.” Additionally, the policy does not clearly define a minor QOC complaint versus a significant QOC complaint. Required Actions: In order to receive a <i>Met</i> score, the PAHP must: Update policies and procedures to include that identified adverse events are collected and reviewed at least monthly.		
Organizational Verification of Credentials		
18. <i>For credentialing and recredentialing, the PAHP confirms that the provider is in good standing with State and federal regulatory bodies.</i> a. <i>The PAHP ensures that all facilities including, but not limited to, hospitals and dental offices, are licensed as required by the HHS.</i> 42 CFR §438.214(e) Contract E.3.05 Contract E.3.07 Contract G.7.03	HSAG Required Evidence: - Policies and procedures - List of organizational provider types and corresponding licensing body in the State of Iowa - HSAG will also use the results of the Organizational Credentialing File Review Tool Evidence as Submitted by the PAHP: - SVIII_PEC01 INS <page 14, Credentialing Guidelines Exhibit FF: Iowa> - SVIII_PEC01 INS <page 3-6, Credentialing Guidelines, Procedure A. Credentialing Process, Elements 1-3>	☐ Met ☐ Not Met ☒ NA
PAHP Description of Process:		
HSAG Findings: This element was scored as <i>NA</i> as the PAHP does not credential organizations.		
Required Actions: None.		
19. <i>For credentialing and recredentialing, the PAHP confirms that the provider has been reviewed and approved by an accrediting body.</i>	HSAG Required Evidence: - Policies and procedures - Onsite assessment review tool/template - HSAG will also use the results of the Organizational Credentialing File Review Tool	☐ Met ☐ Not Met ☒ NA

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
a. <i>If the provider is not accredited, the PAHP conducts an onsite quality assessment.</i> i. <i>The PAHP has a process for ensuring that the provider credentials their practitioners.</i> 42 CFR §438.214(e) Contract G.7.03	Evidence as Submitted by the PAHP: - SVIII_PEC01 INS <Credentialing Guidelines, Full Document> - SVIII_PEC06 INS <Site Review and Record Review, Full Document>	
PAHP Description of Process:		
HSAG Findings: This element was scored as <i>NA</i> as the PAHP does not credential organizations.		
Required Actions: None.		
Timeframes		
20. <i>The PAHP completes credentialing of all providers applying for network provider status as follows:</i> a. <i>Eighty-five percent within 30 days.</i> b. <i>Ninety-eight percent within 45 days.</i> c. <i>One hundred percent within 60 days.</i> <i>Note: The credentialing performance metric start time begins when the provider submits a formal request to contract and/or participate in the PAHP's network. If a provider has not submitted all necessary credentialing materials, the PAHP notifies the provider of all additional materials required within seven days from initial receipt of the formal request to contract and/or participate in the network. If the PAHP requests additional materials, not already submitted by the provider, the time to complete credentialing/contracting shall not be measured while the PAHP is waiting for the requested materials. Once the provider submits the additional materials, the measurement of time to complete credentialing/contracting will resume. Completion time ends when written communication is mailed, emailed, or faxed to the provider notifying them of the PAHP's decision. Per</i>	HSAG Required Evidence: - Policies and procedures - Timeliness and reporting mechanisms (e.g., system screenshots, timeliness report) - HSAG will also use the results of the Practitioner and Organizational Credentialing File Review Tools Evidence as Submitted by the PAHP: - SVIII_PEC01 INS <page 14, Credentialing Guidelines - Exhibit FF: Iowa>	☒ Met ☐ Not Met

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
<i>Exhibit B of the Contract, days is defined as calendar days unless otherwise specified.</i> 42 CFR §438.214(e) 42 CFR §457.1233(a) Contract E.1.29		
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
21. <i>The PAHP will complete recredentialing of all contracted providers no less than every three years.</i> 42 CFR §438.214(e) Contract E.1.30	HSAG Required Evidence: • Policies and procedures • Timeliness tracking and reporting mechanisms (e.g., system screenshots, mock report) • HSAG will also use the results of the Practitioner and Organizational Credentialing File Review Tools Evidence as Submitted by the PAHP: • SVIII_PEC01 INS <page 7-8, Credentialing Guidelines, C. Initial/Recredentialing/Re-Apply/Reinstatement, Element 1>	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		

Standard VIII—Provider Selection						
Met	=	17	X	1	=	17
Not Met	=	1	X	0	=	0
Total ³	=	19	Total Score		=	17
Total Score ÷ Total					=	89%

³ Two elements (Elements 18 and 19) were not included in the total count as they were not scored for the PAHP (i.e., *NA*).

Standard IX—Confidentiality

Standard IX—Confidentiality		
Requirement	Supporting Documentation	Score
General Rule		
1. For medical records and any other health and enrollment information that identifies a particular member, the PAHP uses and discloses such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable. a. The PAHP designates a privacy official who is responsible for the development and implementation of the policies and procedures of the PAHP. b. The PAHP designates a contact person or office who is responsible for receiving privacy-related complaints and who is able to provide further information about matters covered by the notice required by 45 CFR §164.520. c. The PAHP trains all members of its workforce on the policies and procedures with respect to protected health information (PHI) as necessary and appropriate for the members of the workforce to carry out their functions within the PAHP as outlined in 45 CFR §164.530. d. The PAHP has appropriate administrative, technical, and physical safeguards to protect the privacy of PHI. 42 CFR §438.224 42 CFR §457.1110 45 CFR §164.520 45 CFR §164.530 45 CFR Parts 160 and 164, Subparts A and E Contract G.2.33	HSAG Required Evidence: • Policies and procedures (should address all components of 45 CFR part 164 subpart E) • Workflow for adhering to State law for addressing confidentiality of information about minors, privacy of minors, and substance use disorder (SUD) records • Provider materials, such as provider contract and provider manual, requiring providers to have mechanisms to guard against unauthorized or inadvertent disclosure of confidential information • Employee-facing materials • Disclosure form(s) or other forms used by the PAHP to take action regarding member PHI • Organizational chart that includes the PAHP’s privacy official(s) • Staff training materials • Staff training tracking mechanism(s) Evidence as Submitted by the PAHP: • SIX_PRIV-ENT – Entire Document • SIX_PRIV01-ENT – 6 & 11 • SIX_COM07-ENT-Training and Education - Pages 1–4 • SIX_Provider Agreement Template - Section 3(f) (1–8), Pages 2–3 and 8-9 • SIX_Notice of Privacy Practices (NOPP) 2026 Pages 1-3 • SIX_360 Privacy Incident and Inquiry Module Pages 1-4 • SIX_PHI Authorization Form – DQ Page 1 • SIX_Compliance Org Chart 2026 <Full Document>	☒ Met ☐ Not Met

Standard IX—Confidentiality		
Requirement	Supporting Documentation	Score
	- SIX_2025 DQ Compliance Training Completion Status Report (sample) Page 1-2 - SIX_2025 Privacy Computer Information Security Training (1) Pages 1-21	
PAHP Description of Process: DentaQuest’s Workflow for adhering to State law for addressing confidentiality of information about minors, privacy of minors, and substance use disorder (SUD) records in found within our policy PRIV-ENT Pages 6 &11.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Recommendations: HSAG strongly recommends that the PAHP implement the following:		
- Consult with HHS to determine whether an Iowa address is required in documentation related to the Standard IX—Confidentiality elements because members, or their designees, may provide written requests and inquiries, such as authorization forms for information requests, protected health information (PHI) amendment and restriction requests, accountings of disclosure requests, privacy-related complaints, notice of privacy practices inquiries, and breach reports and inquiries. HHS noted that pursuant to the PAHP’s RFP Response and incorporated by reference into the Contract with Iowa Medicaid, the PAHP is required to have an Iowa mailing address for the purpose of meeting member and provider requirements in the Contract and federal managed care regulations. - If directed by HHS to use an Iowa address, revise its documentation related to the Standard IX—Confidentiality elements, including but not limited to <i>NOPP</i>, <i>PHI Release Form</i>, other relevant member and provider materials (member handbooks and the <i>ORM</i>, policies, and procedures, training materials, to include an Iowa address in all forms [paper and electronic]). - If HHS does not require the PAHP to include an Iowa address in documentation related to the Standard IX—Confidentiality elements, standardize the contact title, phone number, and postal address on the <i>DQ Long Form Notice 2026 - 3.24.2026</i> as well as the PAHP’s website because under the <i>Privacy Policy</i>, <i>PRIV-ENT(I)(1)(c)(vi)</i> and <i>(viii)</i>, the PAHP states that it will “designate a single contact office (or person) who is responsible for receiving complaints and who can provide further information about matters described in the Privacy Practices Notices” and “publish a single privacy practices notice.” The PAHP provided the <i>DQ Long Form Notice 2026 - 3.24.2026</i> in the <i>Post-Site Review Tracker</i> that contained contact information “privacy@dentaquest.com, 888-278-7310 or mail: SLF US Compliance Department 96 Worcester Street, Wellesley Hills, MA 02481, Attention: HIPAA Privacy Officer (DentaQuest),” which conflicts with DentaQuest’s <i>NOPP</i> on its website located at Notice of Privacy Practices DentaQuest “privacy@dentaquest.com, phone 800-451-1249 or mail: Attn: Privacy Officer P.O. Box 2906, Milwaukee, WI 53201-2907,” and is contrary to the PAHP’s <i>Privacy Policy</i>. - Ensure the PAHP creates a workflow for adhering to Iowa-specific requirements for confidentiality of information requirements about minors, privacy of minors, and substance use disorder (SUD) records.		
Required Actions: None.		

Standard IX—Confidentiality		
Requirement	Supporting Documentation	Score
Uses and Disclosures of PHI		
2. The PAHP and its business associates may not use or disclose PHI except as permitted or required by 45 CFR §164.502 or by 45 CFR §160 subpart C. The PAHP is permitted to use or disclose PHI as follows: - To the individual. - For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR §164.506. - Incident to a use or disclosure otherwise permitted or required by 45 CFR §164.502, provided that the PAHP has complied with the applicable requirements of 45 CFR §164.502(b), §164.514(d), and §164.530(c). - Except for uses and disclosures prohibited under 45 CFR §164.502(a)(5)(i), pursuant to and in compliance with a valid authorization under 45 CFR §164.508. - Pursuant to an agreement under, or as otherwise permitted by 45 CFR §164.510. - As permitted by and in compliance with 45 CFR §164.512, §164.514(e), (f), or (g). 45 CFR §164.502(a)(1-3) 45 CFR §164.502(a)(5)(i) 45 CFR §164.502(b) 45 CFR §164.506 45 CFR §164.508 45 CFR §164.510 45 CFR §164.512 45 CFR §164.514(d-g) 45 CFR §164.530(c) 42 CFR §457.1110(a-b) 45 CFR §160 Subpart C Contract G.2.33	HSAG Required Evidence: - Policies and procedures - Business associate agreement (BAA) template - One example of an executed BAA - Authorization template to comply with 45 CFR §164.508 - Staff training materials Evidence as Submitted by the PAHP: - SIX_PRIV-ENT Pages 7–11, 11-12 - SIX_BAA Template - DQ as CE Pages 1-10 (entire document) - SIX_BancTec_BAA_Executed Pages 1-8 (Entire Document) - SIX_PHI Authorization Form – DQ Page 1 - SIX_2025 Privacy Computer Information Security Training Pages 2-3, 9, 11, 19-20	☒ Met ☐ Not Met

Standard IX—Confidentiality		
Requirement	Supporting Documentation	Score
PAHP Description of Process: NA		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
3. The PAHP, and its business associate as permitted or required by its business associate contract, is required to disclose PHI: a. To an individual, when requested under, and required by 45 CFR §164.524 or §164.528. b. When required by the Secretary to investigate or determine the PAHP's compliance with 45 CFR §160 subpart C. 45 CFR §164.502(a)(2-4) 45 CFR §164.524 45 CFR §164.528 42 CFR §457.1110(d) 45 CFR §160 Subpart C Contract G.2.33	HSAG Required Evidence: • Policies and procedures • BAA template • One example of an executed BAA • Staff training materials Evidence as Submitted by the PAHP: • SIX_COM07-ENT - Pages 1–4 • SIX_PRIV-ENT - Pages 7–10, 11-12, 16–18 • SIX_BAA Template – Pages 1-10 (entire document) • SIX_BancTec_BAA_Executed Pages 1-8 (Entire Document) • SIX_SIX_2025 Privacy Computer Information Security Training Pages 2–3, 9, 11, 19–20	☒ Met ☐ Not Met
PAHP Description of Process: NA		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
Minimum Necessary		
4. When using or disclosing PHI or when requesting PHI from another covered entity or business associate, the PAHP makes reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. 45 CFR §164.502(b)	HSAG Required Evidence: • Policies and procedures • Workflow and template(s) that will be used to request PHI from another covered entity (e.g., MCO, PAHP) Evidence as Submitted by the PAHP: • SIX_PRIV-ENT - Pages 5	☒ Met ☐ Not Met

Standard IX—Confidentiality		
Requirement	Supporting Documentation	Score
42 CFR §457.1110 Contract G.2.33	SIX_2025 Privacy Computer Information Security Training - Pages 9, 11	
PAHP Description of Process: NA		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
5. Minimum necessary does not apply to: a. Disclosures to or requests by a health care provider for treatment. b. Uses or disclosures made to the individual. c. Uses or disclosures made pursuant to an authorization under 42 CFR §164.508. d. Disclosures made to the Secretary regarding compliance and investigations under 45 CFR Part 160. e. Uses or disclosures that are required by law as described in 45 CFR §164.512(a). f. Uses or disclosures that are required for compliance with applicable requirements of 45 CFR §164.502. 45 CFR §164.502 45 CFR §164.508 45 CFR §164.512(a) 45 CFR Part 160 42 CFR §457.1110 Contract G.2.33	HSAG Required Evidence: - Policies and procedures Evidence as Submitted by the PAHP: - SIX_PRIV-ENT— Pages 7-12 - SIX_2025 Privacy Computer Information Security Training (1).pdf — Pages 11, 19–20	☒ Met ☐ Not Met
PAHP Description of Process: NA		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		

Standard IX—Confidentiality		
Requirement	Supporting Documentation	Score
Uses and Disclosures Requiring Authorizations		
6. Except as otherwise permitted or required by 45 CFR Part 164 Subpart E, a covered entity may not use or disclose PHI without a valid authorization. When a covered entity obtains or receives a valid authorization for its use or disclosure of PHI such use or disclosure must be consistent with such authorization. a. If a covered entity seeks an authorization from an individual for a use or disclosure of PHI, the covered entity provides the individual with a copy of the signed authorization. 45 CFR §164.508 45 CFR Part 164 Subpart E 42 CFR §457.1110 Contract G.2.33	HSAG Required Evidence: • Policies and procedures • Authorization for use and disclosure form Evidence as Submitted by the PAHP: • SIX_PRIV-ENT -Pages 7–10 • SIX_2025 Privacy Computer Information Security Training (1).pdf — Pages 11, 19–20 • SIX_PHI Authorization Form – DQ Page 1	☒ Met ☐ Not Met
PAHP Description of Process: NA		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
Privacy Rights		
7. The PAHP complies with the member’s right to request privacy protection for PHI and the requirements under 45 CFR §164.522. 45 CFR §164.522 42 CFR §457.1110 Contract G.2.33	HSAG Required Evidence: • Policies and procedures • Member request form for privacy protection • Process workflow/system screenshots for tracking member’s request for privacy protection, including documentation of the request and completion of the privacy protection request • Staff training materials Evidence as Submitted by the PAHP: • SIX_PRIV-ENT - Pages 14-19 • SIX_Notice of Privacy Practices Pages 1-3	☒ Met ☐ Not Met

Standard IX—Confidentiality		
Requirement	Supporting Documentation	Score
	- SIX_C360 Privacy Incident and Inquiry Module Pages 1-4 (Entire Document) - SIX_Mockup of Internal Tracking Page 1 - SIX_2025 Privacy Computer Information Security Training - Pages 9, 19-20	
PAHP Description of Process: NA		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: HSAG strongly recommends that the PAHP develop detailed policies and procedures that outline the requirements and steps the PAHP takes to ensure compliance with member rights requests under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule. At a minimum, the written documentation should include the procedures for intaking the request from the member (e.g., use of a template to be completed by the member, field in the system to note the request, staff responsible for intaking the request and staff responsible for responding to the request); the system(s) and fields used to document the privacy rights request; tracking mechanism(s) for monitoring completion of the request to ensure time frame compliance (when applicable); steps taken to update the health information system to notate any implemented requests (e.g., alerts, record modifications); internal notification requirements to obtain information as necessary and to ensure the appropriate individuals (e.g., staff members, providers) are informed of the right(s) exercised by the member; location of the system where copies of information provided to members (when required) are maintained; and the method for providing the member with confirmation of completion of the rights request (e.g., mailed notices, copies of documentation requested when appropriate). The PAHP should also consider developing request forms (as applicable) and notification template letters specific to each privacy right request. Of note, these recommendations apply to all member rights requests outlined in Elements 7 through 10.		
Required Actions: None.		
8. The PAHP complies with the member’s right to access PHI and the requirements under 45 CFR §164.524. a. The PAHP acts on a request for access no later than 30 days after receipt of the request. b. The PAHP provides the member with access to the PHI in the form and format requested by the member, if it is readily producible in such form and format, or if not, in a readable hard copy form or such other form and format as agreed to by the PAHP and member.	HSAG Required Evidence: - Policies and procedures - Member request form to access PHI - Process workflow/system screenshots for tracking member’s request to access PHI, including documentation of the request and timely completion of the PHI access request - Staff training materials Evidence as Submitted by the PAHP: - SIX_PRIV-ENT- Section D Pages 14–19 Section D&F	☒ Met ☐ Not Met

Standard IX—Confidentiality		
Requirement	Supporting Documentation	Score
45 CFR §164.524 CFR §457.1110 Contract G.2.33	- SIX_MKT04-Health Literacy Redacted Pages 2-3 - SIX_C360 Privacy Incident and Inquiry Module Pages 1-4 (Entire Document) - Privacy Computer Information Security Training — Pages 9, 11, 19–20	
PAHP Description of Process: NA		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
9. The PAHP complies with the member’s right to have the PAHP amend PHI or a record about the member in a designated record set for as long as the PHI is maintained in the designated record set. The PAHP complies with the requirements under 45 CFR §164.526. a. The PAHP acts on the member’s request for an amendment no later than 60 days after receipt of such a request. 45 CFR §164.526 42 CFR §457.1110(e) Contract G.2.33	HSAG Required Evidence: - Policies and procedures - Member request form to amend PHI - Process workflow/system screenshots for tracking member’s request to amend PHI, including documentation of the request and timely completion of the amendment request - Process workflow/system screenshots for tracking of a denial of an amendment and notification to the member - Staff training materials Evidence as Submitted by the PAHP: - SIX_PRV-ENT - Pages 14–15, 18-19 - SIX_360 Privacy Incident and Inquiry Module Pages 1-4 (Entire Document) - SIX_2025 Privacy Computer Information Security Training - Pages 9, 11, 19–20	☒ Met ☐ Not Met
PAHP Description of Process: DentaQuest accepts all Privacy Rights Requests when they are submitted in writing and does not require members to use a specific form. For guidance on processing and tracking all Privacy Requests, refer to the SIX_360 Privacy Incident and Inquiry Module, pages 1–4. Once Iowa members are actively enrolled, DentaQuest will provide a screenshot of the Iowa client activity screen.		

Standard IX—Confidentiality		
Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
10. The PAHP complies with the member’s right to receive an accounting of disclosures of PHI made by the PAHP in the six years prior to the date on which the accounting is requested, in compliance with the requirements under 45 CFR §164.528. a. The PAHP acts on the member’s request for an accounting, no later than 60 days after receipt of such a request. b. The PAHP documents the accounting of disclosures and retains the documentation as required by 45 CFR §164.530(j). 45 CFR §164.528 45 CFR §164.530(j) 42 CFR §457.1110 Contract G.2.33	HSAG Required Evidence: • Policies and procedures • Member request form for an accounting of disclosures of PHI • Mechanism to track disclosures (e.g. where reports to Adult Protective Services are documented within the system for retrieval for the accounting of disclosure) • Process workflow/system screenshots for tracking of a member’s request for an accounting of disclosures, including documentation of the request and timely completion of the accounting of disclosure request • Process workflow/system screenshots documenting how the record of the accounting of disclosures is retained • Staff training materials Evidence as Submitted by the PAHP: • SIX_PRV-ENT_ - Pages 14–15, 17–18, 23 • SIX_360 Privacy Incident and Inquiry Module Pages 1-4 (Entire Document) • DQ Record Retention Schedule Pages 3-6 • SIX_2025 Privacy Computer Information Security Training - Pages 9, 11, 19–20	☒ Met ☐ Not Met
PAHP Description of Process: DentaQuest accepts all Privacy Rights Requests when they are submitted in writing and does not require members to use a specific form. For guidance on processing and tracking all Privacy Requests, refer to the SIX_360 Privacy Incident and Inquiry Module, pages 1–4. Once Iowa members are actively enrolled, DentaQuest will provide a screenshot of the Iowa client activity screen.		

Standard IX—Confidentiality		
Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
Breach of Unsecured PHI		
11. The PAHP, following the discovery of a breach of unsecured PHI, notifies each individual whose unsecured PHI has been, or is reasonably believed by the PAHP to have been accessed, acquired, used, or disclosed as a result of such breach. a. Breach and unsecured PHI are as defined in 45 CFR §164.402. 45 CFR §164.402 45 CFR §164.404(a)(1) Contract G.2.33	HSAG Required Evidence: • Policies and procedures • Breach notification letter template • Incident risk assessment tool • Unauthorized disclosure/breach tracking mechanism • Staff training materials Evidence as Submitted by the PAHP: • SIX_PRIV-ENT - Pages 14–15, 21–22, 23. • SIX_PRIV01-ENT-SOP Breach Investigation Page 1 • SIX_Notification Letter Template • SIX_HHS Incident Report Form (1-4) Entire Form • SIX_360 Privacy Incident and Inquiry Module Pages 1-4 (Entire Document) • SIX_Mock-up of Internal Tracking Pages 1-4 • SIX_2025 Privacy Computer Information Security Training - Pages 9, 11, 19–20	☒ Met ☐ Not Met
PAHP Description of Process: NA		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		

Standard IX—Confidentiality		
Requirement	Supporting Documentation	Score
12. <i>The PAHP must appoint a managed care plan (MCP) Liaison.</i> a. <i>The MCP Liaison is the dedicated individual responsible for the entire incident reporting process. This individual will:</i> i. <i>Serve as the main point of contact for the Iowa Medicaid Health Insurance Portability and Accountability Act (HIPAA) Liaison.</i> ii. <i>Review the Iowa Department of Health and Human Service (HHS) Incident Report 470-5134, located at Health Insurance Portability & Accountability Act Health & Human Services, to ensure it is completed correctly and accurately and contains all of the necessary detail.</i> iii. <i>Ensure all required information and documentation is included.</i> iv. <i>Submit all incident reports and documentation per Medicaid Policy Clarification #PC000217.1 Managed Care Plan Security Incident Process and the HHS BAA.</i> v. <i>Respond timely to requests for additional information from the Iowa Medicaid HIPAA Liaison and gather all additional materials as needed from the MCP incident reporters.</i> vi. <i>Submit updated HHS Incident Reports and documentation when the issue is initially reported as “under investigation.”</i> vii. <i>Track all incidents through completion.</i> Medicaid Policy Clarification #PC000217.1 Managed Care Plan Security Incident Process	HSAG Required Evidence: • Policies and procedures • Breach notification letter template • Incident risk assessment tool • Unauthorized disclosure/breach tracking mechanism • Staff name of appointed MCP Liaison • Staff training materials Evidence as Submitted by the PAHP: • SIX_PRIV-ENT - Pages 21, 23 • SIX_PRIV01-ENT-SOP Breach Investigation Page 1 • SIX_PRIV01.02-ENT-SOP-Iowa Medicaid Privacy Final Pages 1-5 • SIX_Notification Letter Template Page 1 • SIX_HHS Incident Report Form Pages 1-4 • SIX_Mock-up of Internal Tracking Page 1-4 • SIX_360 Privacy Incident and Inquiry Module Pages 1-4 (Entire Document) • SIX_Iowa MCP Liaison - Contact Card Page 1 • SIX_2025 Privacy Computer Information Security Training - Pages 9, 11, 19–20	☒ Met ☐ Not Met
PAHP Description of Process: NA		

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Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: HSAG strongly recommends that the PAHP develop a tracking mechanism to ensure all breach incidents are reported as required by this element. Additionally, HSAG recommends that the PAHP adhere to any guidance from HHS related to breach reporting and notifications. Required Actions: None.		
13. <i>In the event that the PAHP discovers a breach of unsecured PHI, the PAHP agrees to take the following measures immediately (i.e., within 72 hours) after the PAHP first discovers the incident:</i> a. <i>To notify HHS of any breach (within three business days of discovery of the incident/breach). Such notice will be provided without reasonable delay, except where a law enforcement official determines that a notification would impede a criminal investigation or cause damage to national security.</i> b. <i>To include to the extent possible the identification of the individual whose unsecured PHI has been, or is reasonably believed to have been the subject of a breach.</i> c. <i>To complete and submit the HHS Incident Report form located on HHS' website.</i> d. <i>To draft a letter for HHS to utilize to notify the individuals that their unsecured PHI has been, or is reasonably believed to have been, the subject of a breach.</i> Iowa Department of Human Services, Business Associate Agreement Medicaid Policy Clarification #PC000217.1 Managed Care Plan Security Incident Process	HSAG Required Evidence: • Policies and procedures • Workflow to notify HHS • HHS Incident Report template • Unauthorized disclosure/breach tracking mechanism demonstrating timeliness tracking • Staff training materials Evidence as Submitted by the PAHP: • SIX_PRIV-PRIV01-ENT_Redacted - Pages 21, 23 • SIX_PRIV01-ENT-SOP Breach Investigation Page 1 • SIX_PRIV01.02-ENT-SOP-Iowa Medicaid Privacy Final Pages 1-5 • SIX_HHS Incident Report Form.pdf Pages 1-4 (Entire Document) • SIX_Mock-up of Internal Tracking Pages 1 • SIX_360 Privacy Incident and Inquiry Module Pages 1-4 (Entire Document) • SIX_Notification Letter Template Page 1 • SIX_2025 Privacy Computer Information Security Training - Pages 19-20	☒ Met ☐ Not Met
PAHP Description of Process: NA		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		

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Requirement	Supporting Documentation	Score
Recommendations: HSAG recommends that the PAHP develop a tracking and reporting mechanism to monitor adherence to the “immediately” and three-business-day time frame standards. Additionally, HSAG recommends that the PAHP adhere to any guidance from HHS related to breach reporting and notifications.		
Required Actions: None.		
14. The PAHP for the purposes of 45 CFR §164.404(a)(1), 45 CFR §164.406(a), and 45 CFR §164.408(a), a breach is treated as discovered by the PAHP as of the first day on which such breach is known to the PAHP, or, by exercising reasonable diligence would have been known to the PAHP. a. The PAHP shall be deemed to have knowledge of a breach if such breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the breach, who is a workforce member or agent of the PAHP. 45 CFR §164.404(a) 45 CFR §164.406(a) 45 CFR §164.408(a) Contract G.2.33	HSAG Required Evidence: • Policies and procedures • Incident risk assessment tool • Unauthorized disclosure/breach tracking mechanism Evidence as Submitted by the PAHP: • SIX_PRIV-PRIV01-ENT_Redacted - Page 21 • SIX_PRIV01-ENT-SOP Breach Investigation • SIX_PRIV01.02-ENT-SOP-Iowa Medicaid Privacy Final Pages 1-5 • SIX_HHS Incident Report Form (Risk Assessment Tool) Pages 1-4 (Entire Document) • SIX_360 Privacy Incident and Inquiry Module Pages 1-4	☒ Met ☐ Not Met
PAHP Description of Process: NA		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
15. Except as provided in 45 CFR §164.412, the PAHP must provide the notification without unreasonable delay and in no case later than 60 calendar days after discovery of such a breach. 45 CFR §164.404(b) 45 CFR §164.412	HSAG Required Evidence: • Policies and procedures • Unauthorized disclosure/breach tracking mechanism demonstrating timeliness tracking Evidence as Submitted by the PAHP: • SIX_PRIV-PRIV01-ENT_Redacted Page 21	☒ Met ☐ Not Met

Standard IX—Confidentiality		
Requirement	Supporting Documentation	Score
Contract G.2.33	- SIX_360 Privacy Incident and Inquiry Module Pages 1-4 (Entire Document) - SIX Mock-up of Internal Tracking Pages 1	
PAHP Description of Process: NA		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: HSAG recommends that the PAHP develop a tracking and reporting mechanism to monitor adherence to the 60-day time frame standard.		
Required Actions: None.		
16. The notification (to individuals, and to media outlets, if required) must be written in plain language and include, to the extent possible: - A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known. - A description of the types of unsecured PHI that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved). - Any steps individuals should take to protect themselves from potential harm resulting from the breach. - A brief description of what the PAHP is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches. - Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an email address, web site, or postal address.	HSAG Required Evidence: - Policies and procedures - Breach notification letter template - Quality assurance process to monitor breach notices (e.g., required content, easily understood, grammatical/typographical errors) Evidence as Submitted by the PAHP: - SIX_PRIV-PRIV01-ENT_Redacted - Page 21 - SIX_PRIV01-ENT-SOP Breach Investigation - SIX_PRIV01.02-ENT-SOP-Iowa Medicaid Privacy Final Pages 1-5 - SIX_MKT04-Health Literacy Redacted Pages 2 - SIX_Notification Letter Template (Entire Document) - SIX_360 Privacy Incident and Inquiry Module Pages 1-4 (Entire Document)	☒ Met ☐ Not Met

Standard IX—Confidentiality		
Requirement	Supporting Documentation	Score
45 CFR §164.404(c) 45 CFR §164.406(c) Contract G.2.33		
PAHP Description of Process: NA		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
17. The notification must be provided in the following form: - Written notice by first-class mail to the individual at the last known address of the individual or, if the individual agrees to electronic notice and such agreement has not been withdrawn, by electronic mail. - If the PAHP knows the individual is deceased and has the address of the next of kin or personal representative of the individual, written notification by first-class mail to either the next of kin or personal representative of the individual. - The notification may be provided in one or more mailings as information is available. 45 CFR §164.404(d)(1) Contract G.2.33	HSAG Required Evidence: - Policies and procedures - Print fulfillment process (e.g., assurances of first-class mailing) Evidence as Submitted by the PAHP: - SIX_PRIV-PRIV01-ENT_Redacted Page 21 Section G - SIX_PRIV01.02-ENT-SOP-Iowa Medicaid Privacy Final Pages 1-5 - SIX_Notification Letter Template Pages 1-2 (Entire Document) - SIX_360 Privacy Incident and Inquiry Module Pages 1-4 (Entire Document) - SIX_INT04-INS-Outbound Correspondence (2) Page 1	☒ Met ☐ Not Met
PAHP Description of Process: NA		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Recommendations: HSAG recommends that the PAHP remove the acronym “PAHP” in Section G(3) of the <i>PRIV-ENT</i> policy.		
Required Actions: None.		

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Requirement	Supporting Documentation	Score
18. In the case in which there is insufficient or out-of-date contact information that precludes written notification to the individual, a substitute form of notice reasonably calculated to reach the individual must be provided. a. If there is insufficient or out-of-date contact information for fewer than 10 individuals, then such notice may be provided by an alternative form of written notice, telephone, or other means. b. If there is insufficient or out-of-date contact information for 10 or more individuals, then such substitute notice must: i. Be in the form of either a conspicuous posting for a period of 90 days on the home page of the PAHP’s website, or conspicuous notice in major print or broadcast media in geographic areas where the individuals affected by the breach likely reside. ii. Include a toll-free phone number that remains active for at least 90 days where an individual can learn whether the individual’s unsecured PHI may be included in the breach. c. Substitute notice need not be provided in the case in which there is insufficient or out-of-date contact information that precludes written notification to the next of kin or personal representative of the individual under 45 CFR §164.404(d)(1)(ii). 45 CFR §164.404(d)(1)(ii) 45 CFR §164.404(d)(2) Contract G.2.33	HSAG Required Evidence: • Policies and procedures • Substitute notice template/script for when there is insufficient or out-of-date contact information for fewer than 10 members • Substitute notice template/script for when there is insufficient or out-of-date contact information for 10 or more members Evidence as Submitted by the PAHP: • SIX_PRIV-PRIV01-ENT_Redacted Page 21-22 • SIX_PRIV01.02-ENT-SOP-Iowa Medicaid Privacy Final Pages 5	☒ Met ☐ Not Met
PAHP Description of Process: NA HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: HSAG strongly recommends that the PAHP implement the following:		

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Requirement	Supporting Documentation	Score
- Develop a tracking mechanism to ensure compliance with the 90-day substitute notice requirement as required by this element. - Remove the acronym “PAHP” in Section G(3) of the <i>PRIV-ENT</i> policy, renumber the bullet points starting after Section G(3)(d), and correct the indents of the bullet points in Section (G)(3) of the <i>PRIV-ENT</i> policy.		
Required Actions: None.		
19. In any case deemed by the PAHP to require urgency because of possible imminent misuse of unsecured PHI, the covered entity may provide information to individuals by telephone or other means, as appropriate, in addition to notice provided under 45 CFR §164.404(d)(1). 45 CFR §164.404(d)(1) 45 CFR §164.404(d)(3) Contract G.2.33	HSAG Required Evidence: - Policies and procedures Evidence as Submitted by the PAHP: - SIX_PRIV-PRIV01-ENT_Redacted- Page 21 Section G - SIX_PRIV01.02-ENT-SOP-Iowa Medicaid Privacy Final Pages 1-5	☒ Met ☐ Not Met
PAHP Description of Process: NA		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: HSAG recommends that the PAHP remove the acronym “PAHP” in Section G(3)(vi) of the <i>PRIV-ENT</i> policy.		
Required Actions: None.		
20. For a breach of unsecured PHI involving more than 500 residents of a State or jurisdiction, the PAHP must, following the discovery of the breach, notify prominent media outlets serving the State or jurisdiction, without unreasonable delay and in no case later than 60 calendar days after discovery of the breach. 45 CFR §164.404(c) 45 CFR §164.406(a-b) Contract G.2.33	HSAG Required Evidence: - Policies and procedures Evidence as Submitted by the PAHP: - SIX_PRIV-PRIV01-ENT_Redacted- Section G pages 20-21 - SIX_PRIV01-ENT- SOP Breach Investigation - SIX_PRIV01.02-ENT-SOP-Iowa Medicaid Privacy Final Pages 1-5	☒ Met ☐ Not Met
PAHP Description of Process: NA		

Standard IX—Confidentiality		
Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: HSAG strongly recommends that the PAHP develop a tracking and reporting mechanism to monitor adherence to the 60-day time frame standard. Required Actions: None.		
21. The PAHP must, following the discovery of a breach of unsecured PHI, notify the Secretary. a. For breaches of unsecured PHI involving 500 or more individuals, the PAHP must, except as provided in 45 CFR §164.412, provide the notification contemporaneously with the notice required by 45 CFR §164.404(a) and in the manner specified on the Department of Health and Human Services website. b. For breaches of unsecured PHI involving less than 500 individuals, the PAHP must maintain a log or other documentation of such breaches and, not later than 60 days after the end of each calendar year, provide the notification for breaches discovered during the preceding calendar year, in the manner specified on the U.S. Department of Health and Human Services website. 45 CFR §164.404(a) 45 CFR §164.408 45 CFR §164.412 Contract G.2.33	HSAG Required Evidence: • Policies and procedures • Mechanism for tracking breaches of unsecured PHI, including whether the breach involved 500 or more members or less than 500 members • Workflow for annual notification to the U.S. Department of Health and Human Services of breaches of unsecured PHI Evidence as Submitted by the PAHP: • SIX_PRIV-PRIV01-ENT- Redacted— Page 21, Section G. Breach Response 164.402–414 • SIX_PRIV01-ENT SOP 2025 Page 1 • SIX_Privacy Computer Information Security Training pages 19 and 20. • SIX_360 Privacy Incident and Inquiry Module Pages 1-4 (Entire Document) • SIX_PRIV01.02-ENT-SOP-Iowa Medicaid Privacy Final Pages 1-5	☒ Met ☐ Not Met
PAHP Description of Process: NA HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: HSAG recommends that the PAHP develop a tracking and reporting mechanism to monitor adherence to the 60-day time frame and annual reporting standards.		

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Requirement	Supporting Documentation	Score
Required Actions: None.		
22. The PAHP must require its business associates (i.e., subcontractors) to, following the discovery of a breach of unsecured PHI, notify the PAHP of such breach. a. A breach shall be treated as discovered by a business associate as of the first day on which such breach is known to the business associate or, by exercising reasonable diligence, would have been known to the business associate. A business associate shall be deemed to have knowledge of a breach if the breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the breach, who is an employee, officer, or other agent of the business associate. b. Except as provided in 45 CFR §164.412, the PAHP must require a business associate to provide the notification without unreasonable delay and in no case later than 60 calendar days after discovery of a breach. c. The notification must include, to the extent possible, the identification of each individual whose unsecured PHI has been, or is reasonably believed by the business associate to have been, accessed, acquired, used, or disclosed during the breach. d. The PAHP must require a business associate to provide the PAHP with any other available information that the PAHP is required to include in notification to the individual under 45 CFR §164.404(c) at the time of the notification or promptly thereafter as information becomes available. 45 CFR §164.404(c) 45 CFR §164.410 45 CFR §164.412	HSAG Required Evidence: • Policies and procedures • One example of executed delegation agreement with BAA • Mechanism for tracking breaches of unsecured PHI reported by delegated entities Evidence as Submitted by the PAHP: • SIX_PRIV01-ENT-_Redacted Section G Page 21 • SIX_Business Associate Agreement (BAA) Template - Pages 2–4 • SIX_PRIV01-ENT SOP Page 1 • SIX_2025 Privacy Computer Information Security Training-p. 19 -20.	☒ Met ☐ Not Met

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Requirement	Supporting Documentation	Score
Contract G.2.33		
PAHP Description of Process: NA		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: HSAG recommends that the PAHP develop a tracking and reporting mechanism to monitor business associates’ (i.e., subcontractors’) adherence to the 60-day time frame standard.		
Required Actions: None.		
Notice of Privacy Practices		
23. The PAHP’s members have a right to adequate notice of the uses and disclosures of PHI that may be made by the PAHP, and of the member’s rights and the PAHP’s legal duties with respect to PHI. a. The PAHP provides a notice that is written in plain language and that contains the elements required by 45 CFR §164.520(b)(1). b. The PAHP makes the notice available to its members on request as required by 45 CFR §164.520(c). 45 CFR §164.520 42 CFR §457.1110 Contract G.2.33	HSAG Required Evidence: • Policies and procedures • Process for disseminating Notice of Privacy Practices • Copy of draft or final Notice of Privacy Practices • Link to Notice of Privacy Practices on the PAHP’s website Evidence as Submitted by the PAHP: • SIX_PRIV01-ENT- Redacted Section D Page 14-15. • SIX_MKT04-Health Literacy Redacted Pages 2-3 • SIX_Notice of Privacy Practices (NOPP) Pages 1-3 • Company Website to Notice of Privacy Practices (NOPP) https://www.dentaquest.com/en/policies/notice-of-privacy-practices • SIX_360 Privacy Incident and Inquiry Module Pages 1-4 (Entire Document)	☒ Met ☐ Not Met
PAHP Description of Process: NA		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: The PAHP’s <i>NOPP</i> included a statement that member’s PHI is subject to redisclosure by the recipient of the PHI; however, this statement was located in the “Protect Substance Use Disorder (SUD) Treatment Records (42 C.F.R. Part 2)” section of the <i>NOPP</i>. As such, HSAG strongly		

Standard IX—Confidentiality		
Requirement	Supporting Documentation	Score
recommends that this statement be moved to a location that ensures members are aware that all PHI may be redisclosed by the recipient after receiving the PHI and may no longer be protected by HIPAA requirements.		
Required Actions: None.		

Standard IX—Confidentiality						
Met	=	23	X	1	=	23
Not Met	=	0	X	0	=	0
Total	=	23	Total Score	=		23
Total Score ÷ Total					=	100%

Standard X—Grievance and Appeal Systems

Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
Grievance System General Requirements		
1. The PAHP defines a grievance as an expression of dissatisfaction about any matter other than an ABD. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the PAHP to make an authorization decision. 42 CFR §438.228 42 CFR §438.400(b) 42 CFR §457.1260(a)(2)(ii) Contract Exhibit B: Glossary of Terms/Definitions	HSAG Required Evidence: • Policies and procedures • Member materials, such as the member handbook • Staff training materials Evidence as Submitted by the PAHP: • Policies and procedures ○ SX_CGA06-INS-Member Complaints and Grievances <Pg 2 Definitions> • Member materials, such as the member handbook ○ SX_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft_2.27.26 <pgs. 17-20> ○ SX_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <pgs. 13, 21, 22> • Staff training materials ○ SX_2026 CG Training Syllabus ○ SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA	☐ Met ☒ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG’s review identified the findings below: • The <i>CGA06-INS-Member Complaints and Grievances</i> policy defined a grievance as “an expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD)” and indicated that grievances may also be referred to as “complaints.” However, the <i>IA Provider ORM Draft Review v2 3.25.26</i> defined a grievance as “an expression of dissatisfaction about any matter other than an action” but identified complaints as “any oral or written expression of dissatisfaction by an enrollee submitted to DentaQuest or to a state agency and resolved by close of business the following day.” Additionally, the <i>CGA06-INS-Member Complaints and Grievances</i> policy indicated that an inquiry is “a written or verbal question or request for information posed to DentaQuest with regard to such issues as benefits, contracts, and organization rules,” whereas the <i>ORM</i> defined an inquiry as “the first contact with DentaQuest (verbal or written) expressing dissatisfaction from the Member or provider on behalf of the member, an attorney on		

Standard X—Grievance and Appeal Systems

Requirement	Supporting Documentation	Score
behalf of a Member, a government agency or an authorized representative acting on behalf of the Enrolled Member and with the Enrolled Member’s written consent.” - The <i>ORM</i> also indicated that complaints must be resolved by close of business the day following receipt or be moved into the grievance system. Additionally, during the review, PAHP staff members explained that if a member expresses dissatisfaction, but the member services representative can resolve the issue during the call, the grievance will not be tracked. PAHP staff members also indicated that the member services representative will ask the member if they want to file a grievance. In follow-up documentation, the PAHP provided the <i>IA Medicaid Appeals Grievances Delegated CRD Process Draft</i>, which outlined the process to only track grievances that could not be resolved during the first call. The <i>CGA06-INS-Member Complaints and Grievances</i> policy also indicated that if a grievance is not resolved during the first call, it is handled by a Complaint and Grievance Specialist (C&G Specialist). However, all expressions of dissatisfaction must be tracked, investigated, and resolved as grievances through the grievance process, regardless of whether the member wants to “file” a grievance or when the issue is resolved. Additionally, the <i>ORM</i> was in draft form. - While the three versions of the member handbooks (i.e., DWP Adult, DWP Kids, and Hawki) included an appropriate definition of grievances, the definition must also specifically indicate that a dispute of an extension of time proposed by the PAHP to make an authorization decision qualifies as a grievance. Additionally, the member handbooks were in draft form.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Update the definitions of inquiries, complaints, and grievances to ensure consistency across PAHP documents (i.e., policies and procedures, member handbooks, <i>ORM</i>, and staff training documents) and submit final versions of the member handbooks and <i>ORM</i> with HHS’ approval. - Revise processes to track, investigate, and resolve all expressions of dissatisfaction as grievances and provide updated process and staff training documents to HSAG.		
2. A member may file a grievance <i>only</i> with the PAHP at any time. a. With the written consent of the member, a provider or an authorized representative may file a grievance on behalf of a member. 42 CFR §438.228 42 CFR §438.402(c)(1)(ii) 42 CFR §438.402(c)(2)(i) 42 CFR §457.1260(b)(1) 42 CFR §457.1260(b)(3) Contract H.1.02 Contract H.4.03	HSAG Required Evidence: - Policies and procedures - Member materials, such as the member handbook - Member consent form template - Staff training materials - System screenshot of the field where the individual who filed the grievance is documented - System screenshot of the field where written consent of the member is documented - HSAG will also use the results of the system demonstration (i.e., mock grievance case examples)	☒ Met ☐ Not Met

Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
Contract H.10.01 Contract H.10.03	Evidence as Submitted by the PAHP: • Policies and procedures ○ SX_CGA06-INS-Member Complaints and Grievances <Pg 2 Procedure A • Member materials, such as the member handbook ○ SX_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft_2.27.26 <pg. 32> ○ SX_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <pg. 35> • Member consent form template ○ SX_Member AOR Form • Staff training materials ○ SX_2026 CG Training Syllabus ○ SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA • System screenshot of the field where the individual who filed the grievance is documented ○ SX_Member Grievance Screenshot • System screenshot of the field where written consent of the member is documented ○ SX_AOR_PHI System Screenshot 2026-03-04 091858.png	
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: The PAHP submitted the <i>hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA</i>, a training document for staff members. The training document was high level and only explained complaints, grievances, and appeals generally, and did not include any Medicaid or Iowa-specific information. During the review, staff members explained that the PAHP includes a Client Requirements Document (CRD) in the training for each client (i.e., HHS) that includes all the specific requirements for that state. After the review, the PAHP submitted the <i>IA Medicaid Appeals Grievances Delegated CRD Process Draft</i> document, which did not include how staff members would ensure the member provided written consent for a provider or		

Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
authorized representative to file a grievance on their behalf. HSAG recommends that the PAHP ensure training documentation includes how staff members will ensure member written consent is obtained for someone to submit a grievance on the member's behalf.		
Required Actions: None.		
3. The member may file a grievance either orally or in writing. 42 CFR §438.228 42 CFR §438.402(c)(3)(i) 42 CFR §457.1260(b)(1) Contract H.10.02	HSAG Required Evidence: • Policies and procedures • Member materials, such as the member handbook • Staff training materials • System screenshot of the field where the filing mode is documented (i.e., orally or in writing) • HSAG will also use the results of the system demonstration (i.e., mock grievance case examples) Evidence as Submitted by the PAHP: • Policies and procedures ○ SX_CGA06-INS-Member Complaints and Grievances <Pg 2 Procedure A 1, Pg. 3 Procedure B 2,3,4> • Member materials, such as the member handbook ○ SX_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft_2.27.26 <pg.19> ○ SX_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <pg. 22> • Staff training materials ○ SX_2026 CG Training Syllabus ○ SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA • System screenshot of the field where the filing mode is documented (i.e., orally or in writing) ○ SX_Member Grievance-Appeal Screenshot	☒ Met ☐ Not Met
PAHP Description of Process:		

Standard X—Grievance and Appeal Systems

Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: The member handbooks indicated members can file a grievance in writing by mailing it to Iowa Medicaid Complaints and Appeals, P.O. Box 2906, Milwaukee, WI 43201-2906. However, HHS noted that pursuant to DentaQuest’s RFP Response and incorporated by reference into the Contract with Iowa Medicaid, DentaQuest is required to have an Iowa mailing address for the purpose of meeting member and provider requirements in the contract and federal managed care regulations. HSAG recommends that the PAHP refer to the required actions in Standard II—Member Rights and Responsibilities for more information. Required Actions: None.		
Handling of Grievances		
4. The PAHP acknowledges receipt of each grievance <i>in writing within three business days</i>. 42 CFR §438.228 42 CFR §438.406(b)(1) 42 CFR §457.1260(d) Contract H.1.06	HSAG Required Evidence: • Policies and procedures • Grievance acknowledgment notice template • Tracking and reporting mechanisms to monitor timely acknowledgement (e.g., system tracking capabilities, mock timeliness report) • Staff training materials • System screenshot of the field where the date of written acknowledgement and the acknowledgement notice are documented • HSAG will also use the results of the system demonstration (i.e., mock grievance case examples) Evidence as Submitted by the PAHP: • Policies and procedures ○ SX_CGA06-INS-Member Complaints and Grievances < Pg 3 Procedure B 8 > <pg. 4 bullet 2> • Grievance acknowledgment notice template-N/A • Tracking and reporting mechanisms to monitor timely acknowledgement (e.g., system tracking capabilities, mock timeliness report)	☒ Met ☐ Not Met

Standard X—Grievance and Appeal Systems

Requirement	Supporting Documentation	Score
	○ SX_CGA05-INS-SOP-Monitoring Resolution Timeframes-No Exhibits 1.pdf • Staff training materials ○ SX_2026 CG Training Syllabus ○ SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA • System screenshot of the field where the date of written acknowledgement and the acknowledgement notice are documented ○ SX_Acknowledgement Tracking Screenshot 2026-03-04 082114	
PAHP Description of Process: The correspondence for Grievances and Appeals is currently in development. Drafts will be sent as soon as they are available.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: HSAG’s review identified the recommendations below: • The <i>CGA06-INS-Member Complaints and Grievances</i> policy indicated that the PAHP sends the acknowledgement letter to the member upon receipt of the grievance; however, the PAHP’s contract with HHS requires the acknowledgement notice to be sent to the member within three business days. During the review, staff members stated that if the C&G Specialist has all the information needed to send the letter, it is sent as soon as possible. HSAG recommends that the policy be revised to indicate the requirement of three business days, as during compliance reviews, HSAG must audit against the PAHP’s policies and procedures as well as federal and State requirements, and the most stringent time frame is used. • The <i>CGA06-INS-Member Complaints and Grievances</i> policy stated that “[t]he Acknowledgement Letter contains a statement to notify the Member of their right to submit documentation to support their Grievance. This statement will include the timeframe in which the Member may submit documentation for consideration in the resolution of the Grievance.” However, the <i>IA Medicaid Grievance Acknowledgement</i> notice template did not include this information. HSAG recommends that the PAHP ensure its <i>IA Medicaid Grievance Acknowledgement</i> notice template aligns with its policies and procedures while also not limiting the time frame during which the member can submit documentation (i.e., documentation can be sent throughout the grievance resolution time frame).		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
5. The PAHP ensures that the individuals who make decisions on grievances are individuals: a. Who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual. b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease: i. A grievance regarding denial of expedited resolution of an appeal. ii. A grievance that involves clinical issues. c. Who take into account all comments, documents, records, and other information submitted by the member or their representative. 42 CFR §438.228 42 CFR §438.406(b)(2) 42 CFR §457.1260(d) Contract H.1.07 Contract H.1.08(b-c) Contract H.1.09	HSAG Required Evidence: • Policies and procedures • Organizational chart of grievance staff members, including credentials • Staff training materials • System screenshot of the field where the decision-maker (name and credentials) on grievances is documented • System screenshot of the field where the results of the review are documented • HSAG will also use the results of the system demonstration (i.e., mock case examples of a standard and expedited grievance)	☐ Met ☒ Not Met
	Evidence as Submitted by the PAHP: • Policies and procedures ○ SX_CGA06-INS-Member Complaints and Grievances <Pg 3 Procedure C, 5 a > • Organizational chart of grievance staff members, including credentials ○ SX_RRQ_Attachment 16_Grievances Org Chart ○ SX_RRQ_Attachment 17_Appeals Org Chart • Staff training materials ○ SX_2026 CG Training Syllabus ○ SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA • System screenshot of the field where the decision-maker (name and credentials) on grievances is documented ○ SX_Decision Maker System Screenshots • System screenshot of the field where the results of the review are documented	

Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
	SX_Resolution Date_Time and Letters Sent Date Time	
PAHP Description of Process: N/A		
HSAG Findings: The PAHP’s policies and procedures and staff training documents did not indicate that individuals who make decisions on grievances are individuals who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual. Recommendations: Neither the <i>hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA</i> nor the <i>IA Medicaid Appeals Grievances Delegated CRD Process Draft</i> training documents explained how PAHP staff members will know who should resolve non-clinical grievances. The training documents also did not explain how staff members will take into account all comments, documents, records, and other information submitted by the member or their representative. HSAG recommends that the PAHP enhance its Iowa-specific training documents to ensure staff members have a strong understanding of not only the Iowa Medicaid requirements, but also how to track, investigate, and sufficiently resolve grievances.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Update and provide documentation to support that individuals who make decisions on grievances are individuals who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual. - Provide updated Iowa-specific staff training documents that detail how staff members will track, investigate, and sufficiently resolve grievances.		
Timely Resolution and Notification of Grievances		
6. The PAHP resolves each grievance, and provides <i>written</i> notice, as expeditiously as the member’s health condition requires, within HHS-established timeframes that do not exceed the timeframes specified in 42 CFR §438.408. a. The PAHP resolves the grievance and sends notice to the affected parties within <i>30 calendar days</i> from the day the PAHP receives the grievance. b. <i>The PAHP resolves 100 percent of grievances within 30 days of receipt, or within 72 hours of receipt for expedited grievances.</i> 42 CFR §438.228 42 CFR §438.408(a) 42 CFR §438.408(b)(1)	HSAG Required Evidence: - Policies and procedures - Grievance resolution notice template - Tracking and reporting mechanisms for timely grievance resolution (e.g., system tracking capabilities, mock timeliness report) - Staff training materials - System screenshot of the field where the date of receipt of the grievance is documented - System screenshot of the field where the date of written resolution and the resolution notice notes are documented - HSAG will also use the results of the system demonstration (i.e., mock case examples of a standard grievance)	☐ Met ☒ Not Met

Standard X—Grievance and Appeal Systems

Requirement	Supporting Documentation	Score
42 CFR §457.1260(e)(12) Contract H.10.04 Contract H.10.07 Contract H.11.04	Evidence as Submitted by the PAHP: • Policies and procedures ○ SX_CGA06-INS-Member Complaints and Grievances <Pg 5 Procedure D 1a-b> • Grievance resolution notice template -N/A • Tracking and reporting mechanisms for timely grievance resolution (e.g., system tracking capabilities, mock timeliness report) ○ SX_CGA05-INS-SOP-Monitoring Resolution Timeframes-No Exhibits 1.pdf • Staff training materials ○ SX_2026 CG Training Syllabus ○ SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA • System screenshot of the field where the date of receipt of the grievance is documented ○ SX_Member Grievance-Appeal Screenshot • System screenshot of the field where the date of written resolution and the resolution notice notes are documented ○ SX_Resolution Date_Time and Letters Sent Date_Time	
PAHP Description of Process: The correspondence for Grievances and Appeals is currently in development. Drafts will be sent as soon as they are available.		
HSAG Findings: HSAG’s review identified the findings below: • During the system demonstration, staff members confirmed that the date and time documented in the Salesforce system for when a resolution notice is sent to the member is the date and time the staff member generated the notice rather than when the notice is actually sent to the member. HSAG asked staff members when a resolution notice would be sent in the mail, and PAHP staff members indicated that once the letter is generated in Salesforce, it will route to the mail room for printing and mailing. The mail room staff member will print the letter and prepare it for pickup. However, mail will be picked up at 10:00 a.m. and 2:00 p.m. seven days a week except on holidays. Therefore, if the letter is sent to the mail room after 2:00 p.m., the letter would be sent the next day, which could impact the time frame.		

Standard X—Grievance and Appeal Systems

Requirement	Supporting Documentation	Score
- During the review, PAHP staff members indicated that the PAHP does not have a process to track time frames based on the mail date and will be developing that process. HSAG requested documentation that described the process of when mail is picked up and mailed the PAHP; however, this documentation was not provided after the review. Instead, the PAHP submitted the <i>INT-01-INS-GOV Inbound Mail–Government</i> policy and procedure, which outlined when incoming mail would be picked up and brought to the PAHP, but not when outgoing mail would be processed and mailed. Recommendations: The <i>CGA06-INS-Member Complaints and Grievances</i> policy indicated that grievances in which a delay would significantly increase risk to the member’s health will be resolved within one business day; however, the requirement is that these expedited grievances be resolved within 72 hours. Although the PAHP’s training documents included the correct time frame of 72 hours, HSAG recommends that the PAHP update its <i>CGA06-INS-Member Complaints and Grievances</i> policy to indicate expedited grievances will be resolved in 72 hours. One business day could be longer than 72 hours in the event that a holiday occurs consecutively with a weekend. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Implement a mechanism to use the date and time the PAHP received the grievance and the date and time the resolution notice entered the mailing stream (i.e., not the date and time the notice was sent to print and fulfillment) to calculate the TAT.		
7. The PAHP may extend the timeframe for resolving grievances by up to 14 calendar days if: - The member requests the extension; or - The PAHP shows (to the satisfaction of HHS, upon its request) that there is need for additional information and how the delay is in the member’s interest. 42 CFR §438.228 42 CFR §438.408(c)(1) 42 CFR §457.1260(e)(1) Contract H.10.05	HSAG Required Evidence: - Policies and procedures - Member materials, such as the member handbook - Tracking and reporting mechanisms for timely grievance resolution (e.g., system tracking capabilities, mock timeliness report) - Staff training materials - System screenshot of the field where the date and time of receipt of the grievance is documented - System screenshot of the field documenting that an extension was applied - System screenshot of the field where the date the extension was applied is documented - System screenshot of the field where the reason for the extension is documented - HSAG will also use the results of the system demonstration (i.e., mock case examples of a standard and expedited grievance)	☒ Met ☐ Not Met

Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
	Evidence as Submitted by the PAHP: • Policies and procedures ○ SX_CGA06-INS-Member Complaints and Grievances <Pg 5 Procedure D 3> • Member materials, such as the member handbook ○ SX_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft_2.27.26 ○ SX_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 • Tracking and reporting mechanisms for timely grievance resolution (e.g., system tracking capabilities, mock timeliness report) ○ SX_CGA05-INS-SOP-Monitoring Resolution Timeframes-No Exhibits 1.pdf • Staff training materials ○ SX_2026 CG Training Syllabus ○ SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA • System screenshot of the field where the date and time of receipt of the grievance is documented ○ SX_Member Grievance-Appeal Screenshot • System screenshot of the field documenting that an extension was applied ○ SX_Member Grievance-Appeal Screenshot • System screenshot of the field where the date the extension was applied is documented ○ SX_Member Grievance-Appeal Screenshot • System screenshot of the field where the reason for the extension is documented ○ SX_Member Grievance-Appeal Screenshot	

Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: Neither the <i>hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA</i> nor the <i>IA Medicaid Appeals Grievances Delegated CRD Process Draft</i> training documents explained how PAHP staff members would take an extension, the reasons for the extension, and what process to follow to ensure the member is notified of the extension. HSAG strongly recommends including this information in the staff training documents so staff members understand the appropriate processes to follow for extensions and where to document the information in the information system.		
Required Actions: None.		
8. If the PAHP extends the grievance resolution timeframe not at the request of the member, it completes all of the following: a. Makes reasonable efforts to give the member prompt oral notice of the delay. b. Within two calendar days gives the member written notice of the reason for the decision to extend the timeframe and informs the member of the right to file a grievance if he or she disagrees with that decision. 42 CFR §438.228 42 CFR §438.408(c)(2) 42 CFR §457.1260(e)(1) Contract H.10.06	HSAG Required Evidence: • Policies and procedures • Member materials, such as the member handbook • Grievance extension template letter • Staff training materials • System screenshot of field where oral notice of the extension is documented • System screenshot of field where written notice of the extension is documented, including the date of the notice • HSAG will also use the results of the system demonstration (i.e., mock grievance case examples) Evidence as Submitted by the PAHP: • Policies and procedures ○ SX_CGA06-INS-Member Complaints and Grievances <Pg 5 Procedure D 3> • Member materials, such as the member handbook ○ SX_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft_2.27.26 ○ SX_DQ4080 IA_Medicaid Child (7.26) HBEN Draft_2.26.26 • Grievance extension template letter-N/A	☐ Met ☒ Not Met

Standard X—Grievance and Appeal Systems

Requirement	Supporting Documentation	Score
	- Staff training materials - SX_2026 CG Training Syllabus - SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA - System screenshot of field where oral notice of the extension is documented-N/A - System screenshot of field where written notice of the extension is documented, including the date of the notice - SX_Grievance Extension Details	
PAHP Description of Process: DentaQuest does not have a field to document an oral notice of the extension. HSAG Findings: HSAG’s review identified the findings below: - The <i>CGA06-INS-Member Complaints and Grievances</i> policy indicated that the PAHP will give the provider prompt oral notice of the delay where the provider has agreed to be responsible for promptly notifying the member or authorized representative of the determination. However, this requirement is the PAHP’s responsibility and it cannot be delegated to the provider without appropriate delegation agreements and oversight in place; although this does not appear to be an appropriate function to delegate to providers. The policy must be updated to indicate that the PAHP staff members will provide the member or authorized representative prompt notification of the delay. - The PAHP submitted the <i>IA Medicaid Appeal Extension letter template</i>, which was specific to appeals and did not include language specific to grievances. Recommendations: HSAG’s review identified the recommendations below: - Neither the <i>hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA</i> nor the <i>IA Medicaid Appeals Grievances Delegated CRD Process Draft</i> training documents explained how PAHP staff members would take an extension, the reasons for the extension, and what process to follow to ensure the member is notified of the extension. HSAG strongly recommends including this information in the staff training documents so staff members understand the appropriate processes to follow for extensions and where to document the information in the information system. - The member handbooks indicated that the PAHP will notify the member by phone and in writing within two days; however, the requirement is that the PAHP <i>promptly</i> notify the member orally and provide notification in writing within two calendar days. HSAG recommends that the PAHP clarify this language in the member handbooks. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Update and submit its revised <i>CGA06-INS-Member Complaints and Grievances</i> policy to indicate that the PAHP staff members (rather than the provider) will provide the member or authorized representative prompt notification when the PAHP extends the grievance resolution time frame.		

Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
Develop and submit a grievance extension letter template.		
9. <i>The PAHP directs the following types of grievance requests to HHS:</i> a. <i>Enrolled member eligibility including termination of eligibility.</i> b. <i>Effective dates of coverage.</i> c. <i>Determinations of premium and copayment responsibilities.</i> Contract H.1.03(a-c)	HSAG Required Evidence: - Policies and procedures - Grievance referral template to HHS - Staff training materials Evidence as Submitted by the PAHP: - Policies and procedures - SX_CGA06-INS-Member Complaints and Grievances <Pg 7 Exhibit Q Procedure A 7 a,b,c> - Grievance referral template to HHS-N/A - Staff training materials - SX_2026 CG Training Syllabus - SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA	☐ Met ☒ Not Met
PAHP Description of Process: The Grievance referral process is currently under discussion with HHS.		
HSAG Findings: The <i>CGA06-INS-Member Complaints and Grievances</i> policy indicated that the grievance types in this element would be directed to HHS; however, during the review, PAHP staff members explained that the process is still in development with HHS. After the review, the PAHP provided the <i>IA Medicaid Appeals Grievances Delegated CRD Process Draft</i>, which indicated that C&G Specialists would attempt to resolve the issue, but if it could not be resolved, the disenrollment request would be directed to HHS. The document included a placeholder indicating that the PAHP is awaiting feedback from HHS regarding how the disenrollment request would be provided to HHS. However, the disenrollment request from a member is different than Medicaid eligibility and coverage grievances. The document provided did not address how grievances regarding member eligibility, effective dates of coverage, and determinations of premium copayment responsibilities would be handled.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Develop a process to ensure grievances related to enrolled member eligibility, including termination of eligibility, effective dates of coverage, and determinations of premium and copayment responsibilities, are directed to HHS. - Clearly outline the process for handling these types of grievances in process and training documents and submit to HSAG.		

Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
Appeals General Requirements		
10. The PAHP defines an appeal as a review by the PAHP of an ABD. 42 CFR §438.228 42 CFR §438.400(b) 42 CFR §457.1260(a)(2)(ii) Contract Exhibit B: Glossary of Terms/Definitions	HSAG Required Evidence: • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Staff training materials Evidence as Submitted by the PAHP: • Policies and procedures ○ SX_CGA01-INS-MCD-Member Appeals <Pg 2 Definitions> • Member materials, such as the member handbook ○ SX_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft_2.27.26 ○ SX_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 • Provider materials, such as the provider manual ○ SX_Provider Reference Manual <pg.11> • Staff training materials ○ SX_2026 CG Training Syllabus ○ SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: The <i>ORM</i> outlined several processes as they relate to appeals, including a “Provider Appeal (Internal Only)” process, and it noted that only a provider can file this type of appeal. However, it is unclear what this provider appeal process is. HSAG recommends that the PAHP review this process to ensure it applies to Iowa Medicaid and update the <i>ORM</i> as necessary, including ensuring that the process is clearly detailed.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
11. The PAHP has only one level of appeal for members. 42 CFR §438.228 42 CFR §438.402(b) 42 CFR §457.1260(b)(1) Contract H.1.04	HSAG Required Evidence: • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Staff training materials Evidence as Submitted by the PAHP: • Policies and procedures ○ SX_CGA01-INS-MCD-Member Appeals <Pg 4-5 Procedure B 5> • Member materials, such as the member handbook ○ SX_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft_2.27.26 ○ SX_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 • Provider materials, such as the provider manual ○ SX_Provider Reference Manual • Staff training materials ○ SX_2026 CG Training Syllabus ○ SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA	☒ Met ☐ Not Met
PAHP Description of Process: HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: The <i>CGA01-INS-MCD-Member Appeals</i> policy outlined a process for member external appeals. During the review, PAHP staff members explained that this is a Medicare process used only for members who have Medicare coverage. HSAG recommends that the PAHP either remove this section from the <i>CGA01-INS-MCD-Member Appeals</i> policy or include in its Iowa exhibit for this policy that the process does not apply to Iowa Medicaid. Required Actions: None.		

Standard X—Grievance and Appeal Systems

Requirement	Supporting Documentation	Score
12. The PAHP establishes and maintains an expedited review process for appeals, when the PAHP determines (for a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. a. The PAHP ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. 42 CFR §438.228 42 CFR §438.410(a-b) 42 CFR §457.1260(f) Contract H.6.09 Contract E.4.02	HSAG Required Evidence: • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Staff training materials • HSAG will also use the results of the system demonstration (i.e., mock case example of an expedited appeal) Evidence as Submitted by the PAHP: • Policies and procedures ○ SX_CGA01-INS-MCD-Member Appeals <Pg 4-5 Procedure B 5> • Member materials, such as the member handbook ○ SX_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft_2.27.26 ○ SX_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 • Provider materials, such as the provider manual ○ SX_Provider Reference Manual • Staff training materials ○ SX_2026 CG Training Syllabus ○ SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA	☒ Met ☐ Not Met
PAHP Description of Process: HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: HSAG's review identified the recommendations below: • While the PAHP provided an updated <i>ORM</i> after the review that described appeals and grievances processes at a high level, the <i>ORM</i> did not include that punitive action will not be taken against a provider who requests an expedited resolution or supports a member's appeal. HSAG recommends that the PAHP add this information to its <i>ORM</i>.		

Standard X—Grievance and Appeal Systems

Requirement	Supporting Documentation	Score
Neither the <i>hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA</i> nor the <i>IA Medicaid Appeals Grievances Delegated CRD Process Draft</i> training documents detailed the process Appeals Specialists will take to determine if a request meets the criteria for an expedited appeal. HSAG strongly recommends that the PAHP enhance its training documentation to clearly describe the processes used to determine if an appeal request meets the PAHP's criteria for an expedited resolution of the appeal.		
Required Actions: None.		
13. Following receipt of a notification of an ABD by a PAHP, the member has 60 calendar days from the date on the ABD notice in which to file a request for an appeal to the PAHP. 42 CFR §438.228 42 CFR §438.402(c)(2)(ii) 42 CFR §457.1260(b)(1) Contract H.5.03–H.5.04	HSAG Required Evidence: - Policies and procedures - Tracking mechanisms - Member materials, such as the member handbook - Provider materials, such as the provider manual - ABD notice template - Staff training materials - System screenshot of the field where the mailing date of the ABD is documented - System screenshot of the field where the date of receipt of the appeal is documented - HSAG will also use the results of the system demonstration (i.e., mock appeal case examples) Evidence as Submitted by the PAHP: - Policies and procedures - SX_CGA01-INS-MCD-Member Appeals <Pg 2 Procedure A1a> - Tracking mechanisms - SX_CGA05-INS-SOP-Monitoring Resolution Timeframes-No Exhibits 1.pdf - Member materials, such as the member handbook - SX_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft 2.27.26	☒ Met ☐ Not Met

Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
	○ SX_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 • Provider materials, such as the provider manual ○ SX_Provider Reference Manual • ABD notice template-N/A • Staff training materials ○ SX_2026 CG Training Syllabus ○ SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA • System screenshot of the field where the mailing date of the ABD is documented-N/A • System screenshot of the field where the date of receipt of the appeal is documented ○ SX_Member Grievance-Appeal Screenshot	
PAHP Description of Process: The correspondence for Grievances and Appeals is currently in development. Drafts will be sent as soon as they are available. The ABD date is documented on the letter itself. Please see policy SX_CGA01-INS-MCD-Member Appeals.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Recommendations: While all other PAHP documentation included that the member has 60 calendar days from the date on the ABD notice in which to file a request for an appeal, the <i>ORM</i> did not include this time frame or indicate that the provider may file the appeal on behalf of the member with the member's written consent. HSAG recommends that the PAHP include this information in the <i>ORM</i> .		
Required Actions: None.		
14. The member may file an appeal orally or in writing. a. With the written consent of the member, a provider or an authorized representative may request an appeal on behalf of the member. 42 CFR §438.228 42 CFR §438.402(c)(1)(ii)	HSAG Required Evidence: • Policies and procedures • Member materials, such as the member handbook • Member consent form template • Staff training materials • System screenshot of the field of where the individual who filed the appeal is documented	☒ Met ☐ Not Met

Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
42 CFR §438.402(c)(3)(ii) 42 CFR §457.1260(b)(1) 42 CFR §457.1260(b)(3) Contract H.4.03 Contract H.6.01–H.6.02	- System screenshot of the field where written consent of the member is documented - System screenshot of the field where the filing mode is documented (i.e., orally or in writing) - HSAG will also use the results of the system demonstration (i.e., mock appeal case examples) Evidence as Submitted by the PAHP: - Policies and procedures - SX_CGA01-INS-MCD-Member Appeals <Pg 2 Procedure A> - Member materials, such as the member handbook - SX_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft_2.27.26 - SX_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 - Member consent form template - SX_Member AOR Form - Staff training materials - SX_2026 CG Training Syllabus - SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA - System screenshot of the field of where the individual who filed the appeal is documented - SX_Member Grievance-Appeal Screenshot - System screenshot of the field where written consent of the member is documented - SX_AOR_PHI System Screenshot 2026-03-04 091858.png - System screenshot of the field where the filing mode is documented (i.e., orally or in writing)	

Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
	SX_Member Grievance-Appeal Screenshot	
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: Neither the <i>hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA</i> nor the <i>IA Medicaid Appeals Grievances Delegated CRD Process Draft</i> training documents included how staff members would ensure the member provided written consent for a provider or authorized representative to file an appeal on their behalf. HSAG recommends that the PAHP ensure training documentation includes how staff members will ensure member written consent is obtained for someone to submit an appeal on the member’s behalf. HSAG further recommends that the training specify that the member’s written consent must be specific to the appeal being filed.		
Required Actions: None.		
15. <i>The PAHP does not allow providers, acting on behalf of the member, to pursue an appeal with the PAHP or in any way suggest a contracted provider is entitled to a State fair hearing (SFH) when the sole issue in the claimed appeal is a payment dispute between the PAHP and the provider, such as whether a given claim is a “clean claim.” Such issues are to be addressed pursuant to the dispute resolution process outlined in the agreement between the PAHP and the provider.</i> a. <i>The PAHP must inform providers and subcontractors, at the time they enter into a contract, that providers and subcontractors do not have a right to request a SFH to address a payment dispute between the provider or subcontractor and PAHP after services have been rendered.</i> Contract H.4.04 Contract E.6.04	HSAG Required Evidence: - Policies and procedures - Provider materials, such as the provider manual and/or provider contract - Staff training materials Evidence as Submitted by the PAHP: - Policies and procedures - SX_CGA01-INS-MCD-Member Appeals <Pg 12 Exhibit T Procedure A 1 c > - Provider materials, such as the provider manual and/or provider contract - SX_Provider Reference Manual - Staff training materials - SX_2026 CG Training Syllabus - SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA	☒ Met ☐ Not Met
PAHP Description of Process: DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made.		

Standard X—Grievance and Appeal Systems

Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: Neither the <i>hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA</i> nor the <i>IA Medicaid Appeals Grievances Delegated CRD Process Draft</i> training documents included that provider appeals solely relating to claims payment after a service is rendered are not eligible for an SFH. HSAG recommends that the PAHP enhance its training documents so staff members receiving appeal and SFH requests from providers understand how to document and process these requests. Required Actions: None.		
Handling of Appeals		
16. If the PAHP denies a request for expedited resolution of an appeal, it: - Transfers the appeal to the timeframe for standard resolution in accordance with 42 CFR §438.408(b)(2). - Follows the requirements in 42 CFR §438.408(c)(2), including: - Makes reasonable efforts to give the member prompt oral notice of the delay. - Within two calendar days, gives the member written notice of the reason for the decision to deny the expedited appeal resolution timeframe and informs the member of the right to file a grievance if the member disagrees with that decision. 42 CFR §438.228 42 CFR §438.408(b)(2) 42 CFR §438.408(c)(2) 42 CFR §438.410(c) 42 CFR §457.1260(f) Contract H.6.11	HSAG Required Evidence: - Policies and procedures - Member materials, such as the member handbook - Denied expedited resolution letter template - Staff training materials - System screenshot of the field where the type of appeal request is documented (i.e., standard versus expedited) - System screenshot of the field where the denial of an expedited appeal resolution time frame is documented - System screenshot of the field where oral and written notice of the denied request for an expedited appeal resolution time frame is documented - HSAG will also use the results of the system demonstration (i.e., mock appeal case examples) Evidence as Submitted by the PAHP: - Policies and procedures - SX_CGA01-INS-MCD-Member Appeals <Pg 4-5 Procedure B, 5d-g; Pg 7 Procedure C 5d (i-vii)> - Member materials, such as the member handbook - SX_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft 2.27.26	☐ Met ☒ Not Met

Standard X—Grievance and Appeal Systems

Requirement	Supporting Documentation	Score
	○ SX_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 • Denied expedited resolution letter template-N/A • Staff training materials ○ SX_2026 CG Training Syllabus ○ SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA • System screenshot of the field where the type of appeal request is documented (i.e., standard versus expedited) ○ SX_Expedited Appeal System Screenshot • System screenshot of the field where the denial of an expedited appeal resolution time frame is documented ○ SX_Expedited Appeal System Screenshot • System screenshot of the field where oral and written notice of the denied request for an expedited appeal resolution time frame is documented ○ SX_Expedited Appeal System Screenshot	
PAHP Description of Process: The correspondence for Grievances and Appeals is currently in development. Drafts will be sent as soon as they are available.		
HSAG Findings: HSAG’s review identified the findings below: • The <i>CGA01-INS-MCD-Member Appeals</i> policy indicated that the PAHP will give the provider prompt oral notice of the delay where the provider has agreed to be responsible for promptly notifying the member or authorized representative of the determination. However, this requirement is the PAHP’s responsibility and it cannot be delegated to the provider without appropriate delegation agreements and oversight in place; although this does not appear to be an appropriate function to delegate to providers. The policy must be updated to indicate that the PAHP staff members will provide the member or authorized representative prompt notification of the delay. • The <i>CGA01-INS-MCD-Member Appeals</i> policy did not indicate that the written notice to the member will also include the member’s right to file a grievance if the member disagrees with the denial of an expedited appeal time frame. • During the review, HSAG requested that the PAHP provide the denied expedited resolution letter template. However, this document was not provided to HSAG as requested.		

Standard X—Grievance and Appeal Systems

Requirement	Supporting Documentation	Score
Recommendations: Neither the <i>hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA</i> nor the <i>IA Medicaid Appeals Grievances Delegated CRD Process Draft</i> training documents included the process for transferring an expedited request to the standard appeal time frame when the request does not meet the criteria for expedited review. HSAG recommends that the PAHP enhance its training documents so staff members understand how to document and process these requests. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Update its <i>CGA01-INS-MCD-Member Appeals</i> policy to indicate that the PAHP staff members (rather than the provider) will provide the member or authorized representative prompt notification when the PAHP denies the request to handle an appeal as expedited. - Update its <i>CGA01-INS-MCD-Member Appeals</i> policy to indicate that the written notice to the member will also include the member’s right to file a grievance if the member disagrees with the denial of an expedited appeal time frame. - Develop and submit a denied expedited resolution letter template that complies with these requirements.		
17. The PAHP acknowledges receipt of each appeal <i>in writing within three business days</i>. a. <i>The PAHP acknowledges 100 percent of appeals within three business days.</i> 42 CFR §438.228 42 CFR §438.406(b)(1) 42 CFR §457.1260(d) Contract H.1.06 Contract H.11.05	HSAG Required Evidence: - Policies and procedures - Member materials, such as the member handbook - Appeal acknowledgment template - Tracking and reporting mechanisms for timely acknowledgement (e.g., system tracking capabilities, mock timeliness report) - Staff training materials - System screenshot of the field where the date of receipt of the appeal is documented - System screenshot of the field where the date of acknowledgement and the acknowledgement notice are documented - HSAG will also use the results of the system demonstration (i.e., mock appeal case examples) Evidence as Submitted by the PAHP: - Policies and procedures - SX_CGA01-INS-MCD-Member Appeals <Pg 3-4 Procedure B 2; Pg 13 Exhibit T Procedure B 2 >	☒ Met ☐ Not Met

Standard X—Grievance and Appeal Systems

Requirement	Supporting Documentation	Score
	- Member materials, such as the member handbook - SX_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft 2.27.26 - SX_DQ4080 IA_Medicaid Child (7.26) HBEN Draft 2.26.26 - Appeal acknowledgment template-N/A - Tracking and reporting mechanisms for timely acknowledgement (e.g., system tracking capabilities, mock timeliness report) - SX_CGA05-INS-SOP-Monitoring Resolution Timeframes-No Exhibits 1.pdf - Staff training materials - SX_2026 CG Training Syllabus - SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA - System screenshot of the field where the date of receipt of the appeal is documented - SX_Member Grievance-Appeal Screenshot - System screenshot of the field where the date of acknowledgement and the acknowledgement notice are documented - SX_Member Grievance-Appeal Screenshot	
PAHP Description of Process: The correspondence for Grievances and Appeals is currently in development. Drafts will be sent as soon as they are available.		
HSAG Findings: Although the <i>CGA01-INS-MCD-Member Appeals</i> policy stipulated the requirements of this element, during the review, HSAG requested the acknowledgement notice template letter that the PAHP will use to acknowledge receipt of the member’s appeal request. After the review, the PAHP submitted the <i>IA Medicaid Grievance Acknowledgement</i> notice template, which was specific to grievances and did not include language specific to appeals. Recommendations: The <i>CGA01-INS-MCD-Member Appeals</i> policy noted that “[t]he Acknowledgement Letter contains a statement to notify the Member of their right to submit documentation to support their appeal request. This statement will include the timeframe in which the Member may submit documentation for consideration in the resolution of the appeal request.” The <i>CGA01-INS-MCD-Member Appeals</i> policy also indicated that “[t]he		

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Requirement	Supporting Documentation	Score
acknowledgement letter will include a copy of the appeal case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by DentaQuest, in connection with the appeal of the adverse benefit determination.” However, the document the PAHP submitted for this element, the <i>IA Medicaid Grievance Acknowledgement</i> notice template, did not include this information. HSAG recommends that the PAHP ensure its acknowledgement notice template aligns with its <i>CGA01-INS-MCD-Member Appeals</i> policy, while also not limiting the time frame during which the member can submit documentation (i.e., documentation can be sent throughout the appeal resolution time frame). Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Develop and submit an acknowledgement notice template letter.		
18. The PAHP ensures that the individuals who made decisions on appeals are individuals: - Who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual. - Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease: - An appeal of a denial that is based on lack of medical necessity. - An appeal that involves clinical issues. - Who take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial ABD. 42 CFR §438.228 42 CFR §438.406(b)(2) 42 CFR §457.1260(d) Contract H.1.07 Contract H.1.08(a) Contract H.1.08(c) Contract H.1.09	HSAG Required Evidence: - Policies and procedures - Organizational chart of appeal staff members, including credentials - List of delegates responsible for reviewing/making coverage decisions on appeals - Staff training materials - System screenshot of the field where the decision-maker (name and credentials) on appeals is documented - System screenshot of the field where the results of the review are documented - HSAG will also use the results of the system demonstration (i.e., mock appeal case examples) Evidence as Submitted by the PAHP: - Policies and procedures - SX_CGA01-INS-MCD-Member Appeals <Pg 3 Procedure B 6 a-e; Pg 13 Exhibit T Procedure B 1 > - Organizational chart of appeal staff members, including credentials - SX_RRQ_Attachment 17_Appeals Org Chart - List of delegates responsible for reviewing/making coverage decisions on appeals-N/A	☒ Met ☐ Not Met

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Requirement	Supporting Documentation	Score
	- Staff training materials - SX_2026 CG Training Syllabus - SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA - System screenshot of the field where the decision-maker (name and credentials) on appeals is documented - SX_Member Grievance-Appeal Screenshot - System screenshot of the field where the results of the review are documented - SX_Member Grievance-Appeal Screenshot	
PAHP Description of Process: The list of delegates that will be reviewing appeals is currently under development. A list will be provided once finalized.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: Neither the <i>hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA</i> nor the <i>IA Medicaid Appeals Grievances Delegated CRD Process Draft</i> training documents explained how staff members will know who should resolve appeals. The training documents also did not explain how staff members will take into account all comments, documents, records, and other information submitted by the member or the member's representative. HSAG recommends that the PAHP enhance its Iowa-specific training documents to ensure staff members have a strong understanding of not only the Iowa Medicaid requirements, but also how to track, investigate, and appropriately resolve appeals.		
Required Actions: None.		
19. The PAHP treats oral inquiries seeking to appeal an ABD as appeals. 42 CFR §438.228 42 CFR §438.406(b)(3) 42 CFR §457.1260(d) Contract H.6.04	HSAG Required Evidence: - Policies and procedures - Member materials, such as the member handbook - Staff training materials - HSAG will also use the results of the system demonstration (i.e., mock appeal case examples) Evidence as Submitted by the PAHP: - Policies and procedures - SX_CGA01-INS-MCD-Member Appeals <Pg 2 Procedure A>	☒ Met ☐ Not Met

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Requirement	Supporting Documentation	Score
	- Member materials, such as the member handbook - SX_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft_2.27.26 - SX_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 - Staff training materials - SX_2026 CG Training Syllabus - SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA	
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
20. The PAHP provides the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. a. The PAHP informs the member of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFR §438.408(b) and (c) in the case of expedited resolution. 42 CFR §438.228 42 CFR §438.406(b)(4) 42 CFR §438.408(b-c) 42 CFR §457.1260(d) Contract H.6.05 Contract H.6.10	HSAG Required Evidence: - Policies and procedures - Member communications, such as ABD notice template, member acknowledgment template, and/or call script - Staff training materials - HSAG will also use the results of the system demonstration (i.e., mock appeal case examples) Evidence as Submitted by the PAHP: - Policies and procedures - SX_CGA01-INS-MCD-Member Appeals <Pg 3 Section B 2 b> - Member communications, such as ABD notice template, member acknowledgment template, and/or call script-N/A - Staff training materials - SX_2026 CG Training Syllabus	☐ Met ☒ Not Met

Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
	○ SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA	
PAHP Description of Process: The correspondence for Grievances and Appeals is currently in development. Drafts will be sent as soon as they are available.		
HSAG Findings: HSAG’s review identified the findings below: • The <i>CGA01-INS-MCD-Member Appeals</i> policy indicated that members would be informed of their right to submit documentation to support their appeal request as part of the acknowledgement letter. However, the policy also indicated that if an appeal request was resolved before the acknowledgement letter was to be sent to the member, the acknowledgement letter would not be sent. During the review, HSAG recommended that the PAHP update its ABD notice to include this information as well as include it in the acknowledgement notice. After the review, the PAHP submitted the <i>IA Medicaid Grievance Acknowledgement</i> letter template, which was not specific to appeals and did not include the statement that members would have the right to submit documentation to support their appeal and the time frame in which to submit the documentation. • After the review, the PAHP submitted the updated ABD notice, which also did not include that the member would have a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments, or the limited time frame in which members could submit the information in the case of an expedited appeal.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: • Provide evidence of the process that the PAHP will use to provide the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments and notify the member of the limited time available for this sufficiently in advance of the resolution time frame for appeals as specified in 42 CFR §438.408(b) and (c) in the case of expedited resolution. • Update and submit written documentation (e.g., the ABD notice, appeal acknowledgement notice template, call script) that confirms the process and language used to inform members of this requirement.		
21. The PAHP provides the member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the PAHP (or at the direction of the PAHP) in connection with the appeal of the ABD. a. This information is provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFR §438.408(b) and (c).	HSAG Required Evidence: • Policies and procedures • Member communications, such as ABD notice template, member acknowledgment template, and/or call script • Staff training materials • HSAG will also use the results of the system demonstration (i.e., mock appeal case examples)	☐ Met ☒ Not Met
	Evidence as Submitted by the PAHP: • Policies and procedures	
42 CFR §438.228		

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Requirement	Supporting Documentation	Score
42 CFR §438.406(b)(5) 42 CFR §438.408(b-c) 42 CFR §457.1260(d) Contract H.6.06–H.6.07	○ SX_CGA01-INS-MCD-Member Appeals < Pg 3 Procedure B 2(c); Pg 8 Procedure C, 6c(viii)> • Member communications, such as ABD notice template, member acknowledgment template, and/or call script-N/A • Staff training materials ○ SX_2026 CG Training Syllabus ○ SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA	
PAHP Description of Process: The correspondence for Grievances and Appeals is currently in development. Drafts will be sent as soon as they are available.		
HSAG Findings: The <i>CGA01-INS-MCD-Member Appeals</i> policy indicated that the acknowledgement letter would include a copy of the appeal case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the PAHP, in connection with the appeal of the ABD. However, the <i>IA Medicaid Grievance Acknowledgement</i> notice template did not include this language. During the review, PAHP staff members indicated it would be included in the member handbooks; however, the updated member handbooks submitted after the review also did not include this information. Additionally, the information was not included in the updated ABD notice template submitted after the review.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: • Provide evidence of the process that the PAHP will use to provide the member and his or her representative the member’s case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the PAHP (or at the direction of the PAHP) in connection with the appeal of the ABD. This information must be provided free of charge and sufficiently in advance of the resolution time frame for appeals as specified in 42 CFR §438.408(b) and (c). • Update and submit written documentation (e.g., the ABD notice, appeal acknowledgement notice template, call script) that confirms the process and language used to inform members of this requirement.		
22. <i>The PAHP directs the appeals related to exceptions to policy regarding services outside of State Plan Benefits to HHS.</i> Note: Waivers of administrative rules are also referred to as exceptions to policy.	HSAG Required Evidence: • Policies and procedures • Process to assist members in requesting an exception to policy • Exception to policy referral template to HHS • Staff training materials	☐ Met ☒ Not Met

Standard X—Grievance and Appeal Systems

Requirement	Supporting Documentation	Score
Contract F.16.09 Contract H.1.03(d)	- Tracking and reporting mechanisms for exception to policy requests and HHS' decision Evidence as Submitted by the PAHP: - Policies and procedures - SX_CGA01-INS-MCD-Member Appeals < Pg 5 Procedure B 6 a-c > - Process to assist members in requesting an exception to policy - SX_CGA01-INS-MCD-Member Appeals < Pg 13 > - Exception to policy referral template to HHS-N/A - Staff training materials - SX_2026 CG Training Syllabus - SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA - Tracking and reporting mechanisms for exception to policy requests and HHS' decision - SX_CGA05-INS-SOP-Monitoring Resolution Timeframes-No Exhibits 1.pdf	
PAHP Description of Process: The Exception to policy referral process is currently in discussion with HHS.		
HSAG Findings: Although the PAHP's <i>CGA01-INS-MCD-Member Appeals</i> policy included this information, during the review, PAHP staff members stated that the process for directing appeals related to exceptions to policy regarding services outside of State Plan Benefits to HHS is still in process. After the review, the PAHP submitted no additional evidence, indicating that this process is still in development with HHS.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Submit its process to direct appeals related to exceptions to policy regarding services outside of State Plan Benefits to HHS.		
Resolution and Notification of Appeals		
23. The PAHP resolves standard appeals and sends notice to the affected parties as expeditiously as the member's health condition requires, but no later than 30 calendar days from the day the PAHP receives the appeal.	HSAG Required Evidence: - Policies and procedures - Tracking and reporting mechanisms (e.g., system tracking capabilities, mock timeliness report)	☐ Met ☒ Not Met

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Requirement	Supporting Documentation	Score
a. <i>The PAHP resolves 100 percent of appeals within 30 days of receipt for standard appeals.</i> 42 CFR §438.228 42 CFR §438.408(a) 42 CFR §438.408(b)(2) 42 CFR §457.1260(e)(1-2) Contract H.7.01 Contract H.11.05	- Staff training materials - System screenshot of the field where the type of appeal request is documented (i.e., standard appeal) - System screenshot of the field where the date of receipt of the appeal is documented - System screenshot of the field where the date of the mailing of the resolution notice is documented - HSAG will also use the results of the system demonstration (i.e., mock appeal case examples) Evidence as Submitted by the PAHP: - Policies and procedures - SX_CGA01-INS-MCD-Member Appeals <Pg 6 Procedure C 2> - Tracking and reporting mechanisms (e.g., system tracking capabilities, mock timeliness report) - SX_CGA05-INS-SOP-Monitoring Resolution Timeframes-No Exhibits 1.pdf - Staff training materials - SX_2026 CG Training Syllabus - SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA - System screenshot of the field where the type of appeal request is documented (i.e., standard appeal) - SX_Member Grievance-Appeal Screenshot - System screenshot of the field where the date of receipt of the appeal is documented - SX_Member Grievance-Appeal Screenshot - System screenshot of the field where the date of the mailing of the resolution notice is documented-N/A	
PAHP Description of Process: The date of the mailing is noted on the letter. Please see policy CGA01-INS-MCD-Member Appeals.		

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Requirement	Supporting Documentation	Score
HSAG Findings: HSAG’s review identified the findings below: - During the system demonstration, staff members confirmed that the date and time documented in the Salesforce system for when a resolution notice is sent to the member is the date and time the staff member generated the notice rather than when the notice is actually sent to the member. HSAG asked staff members when a resolution notice would be sent in the mail, and PAHP staff members indicated that once the letter is generated in Salesforce, it will route to the mail room for printing and mailing. The mail room staff member will print the letter and prepare it for pickup. However, mail will be picked up at 10:00 a.m. and 2:00 p.m. seven days a week except on holidays. Therefore, if the letter is sent to the mail room after 2:00 p.m., the letter would be sent the next day, which could impact the time frame. - During the review, PAHP staff members indicated that the PAHP does not have a process to track time frames based on the mail date and will be developing that process. HSAG requested documentation that described the process of when mail is picked up and mailed the PAHP; however, this documentation was not provided after the review. Instead, the PAHP submitted the <i>INT-01-INS-GOV Inbound Mail–Government</i> policy and procedure, which outlined when incoming mail would be picked up and brought to the PAHP, but not when outgoing mail would be processed and mailed. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Implement a mechanism to use the date the PAHP received the appeal and the date the resolution notice entered the mailing stream (i.e., not the date the notice was sent to print and fulfillment) to calculate the TAT.		
24. The PAHP resolves expedited appeals and sends notice to the affected parties no later than 72 hours after the PAHP receives the appeal. a. <i>The PAHP resolves 100 percent of appeals within 72 hours of receipt for expedited appeals.</i> 42 CFR §438.228 42 CFR §438.408(b)(3) 42 CFR §457.1260(e)(1) Contract H.7.04 Contract H.11.05	HSAG Required Evidence: - Policies and procedures - Tracking and reporting mechanisms (e.g., system tracking capabilities, mock timeliness report) - Staff training materials - System screenshot of the field where the type of appeal request is documented (i.e., expedited appeal) - System screenshot of the field where the date and time of receipt of the appeal is documented - System screenshot of the field where the date and time of the mailing of the resolution notice is documented - HSAG will also use the results of the system demonstration (i.e., mock appeal case examples) Evidence as Submitted by the PAHP: - Policies and procedures	☐ Met ☒ Not Met

Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
	○ SX_CGA01-INS-MCD-Member Appeals <Pg 6 Procedure C 1-2> • Tracking and reporting mechanisms (e.g., system tracking capabilities, mock timeliness report) ○ SX_CGA05-INS-SOP-Monitoring Resolution Timeframes-No Exhibits 1.pdf • Staff training materials ○ SX_2026 CG Training Syllabus ○ SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA • System screenshot of the field where the type of appeal request is documented (i.e., expedited appeal) ○ SX_Expedited Appeal System Screenshot • System screenshot of the field where the date and time of receipt of the appeal is documented ○ SX_Expedited Appeal System Screenshot • System screenshot of the field where the date and time of the mailing of the resolution notice is documented ○ SX_Resolution Date_Time and Letters Sent Date_Time	
PAHP Description of Process: N/A		
HSAG Findings: HSAG’s review identified the findings below: • During the system demonstration, staff members confirmed that the date and time documented in the Salesforce system for when a resolution notice is sent to the member is the date and time the staff member generated the notice rather than when the notice is actually sent to the member. HSAG asked staff members when a resolution notice would be sent in the mail, and PAHP staff members indicated that once the letter is generated in Salesforce, it will route to the mail room for printing and mailing. The mail room staff member will print the letter and prepare it for pickup. However, mail will be picked up at 10:00 a.m. and 2:00 p.m. seven days a week except on holidays. Therefore, if the letter is sent to the mail room after 2:00 p.m., the letter would be sent the next day, which could impact the time frame. • During the review, PAHP staff members indicated that the PAHP does not have a process to track time frames based on the mail date and will be developing that process. HSAG requested documentation that described the process of when mail is picked up and mailed the PAHP; however, this		

Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
documentation was not provided after the review. Instead, the PAHP submitted the <i>INT-01-INS-GOV Inbound Mail–Government</i> policy and procedure, which outlined when incoming mail would be picked up and brought to the PAHP, but not when outgoing mail would be processed and mailed.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Implement a mechanism to use the date and time the PAHP received the expedited appeal and the date and time the resolution notice entered the mailing stream (i.e., not the date and time the notice was sent to print and fulfillment) to calculate the TAT.		
25. The PAHP may extend the standard or expedited appeal resolution timeframes by up to 14 calendar days if: - The member requests the extension; or - The PAHP shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the member’s interest. 42 CFR §438.228 42 CFR §438.408(c)(1) 42 CFR §457.1260(e)(1) Contract H.7.02 Contract H.7.05	HSAG Required Evidence: - Policies and procedures - Tracking and reporting mechanisms (e.g., system tracking capabilities, mock timeliness report) - Staff training materials - System screenshot of the field where the date and time of receipt of the appeal is documented - System screenshot of the field documenting that an extension was applied - System screenshot of the field where the date the extension was applied is documented - System screenshot of the field where the reason for the extension is documented - HSAG will also use the results of the system demonstration (i.e., mock appeal case examples) Evidence as Submitted by the PAHP: - Policies and procedures - SX_CGA01-INS-MCD-Member Appeals <Pg 6 Procedure C 5 b> - Tracking and reporting mechanisms (e.g., system tracking capabilities, mock timeliness report) - SX_CGA05-INS-SOP-Monitoring Resolution Timeframes-No Exhibits 1.pdf - Staff training materials	☒ Met ☐ Not Met

Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
	○ SX_2026 CG Training Syllabus ○ SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA • System screenshot of the field where the date and time of receipt of the appeal is documented ○ SX_Expedited Appeal System Screenshot • System screenshot of the field documenting that an extension was applied ○ SX_Expedited Appeal System Screenshot • System screenshot of the field where the date the extension was applied is documented ○ SX_Expedited Appeal System Screenshot • System screenshot of the field where the reason for the extension is documented ○ SX_Expedited Appeal System Screenshot	
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: Neither the <i>hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA</i> nor the <i>IA Medicaid Appeals Grievances Delegated CRD Process Draft</i> training documents explained how the staff members would take an extension, the reasons for the extension, and what process to follow to ensure the member is notified of the extension. HSAG strongly recommends including this information in the staff training documents so staff members understand the appropriate processes to follow for extensions and where to document the information in the information system.		
Required Actions: None.		
26. If the PAHP extends the standard or expedited appeal resolution timeframes not at the request of the member, it completes all of the following: a. Makes reasonable efforts to give the member prompt oral notice of the delay.	HSAG Required Evidence: • Policies and procedures • Member materials, such as the member handbook • Appeal extension template letter • Staff training materials	☐ Met ☒ Not Met

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Requirement	Supporting Documentation	Score
b. Within two calendar days gives the member written notice of the reason for the decision to extend the timeframe and informs the member of the right to file a grievance if he or she disagrees with that decision. c. Resolves the appeal as expeditiously as the member’s health condition requires and no later than the date the extension expires. 42 CFR §438.228 42 CFR §438.408(c)(2) 42 CFR §457.1260(e)(1-2) Contract H.7.03 Contract H.7.06	- System screenshot of the field where oral notice of the extension is documented - System screenshot of the field where written notice of the extension is documented, including the date of the notice - HSAG will also use the results of the system demonstration (i.e., mock appeal case examples) Evidence as Submitted by the PAHP: - Policies and procedures - SX_CGA01-INS-MCD-Member Appeals <Pg 7 Procedure C 5d (i-vii)> - Member materials, such as the member handbook - SX_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft_2.27.26 - SX_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 - Appeal extension template letter-N/A - Staff training materials - SX_2026 CG Training Syllabus - SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA - System screenshot of the field where oral notice of the extension is documented-N/A - System screenshot of the field where written notice of the extension is documented, including the date of the notice - SX_Expedited Appeal System Screenshot	
PAHP Description of Process: The correspondence for Grievances and Appeals is currently in development. Drafts will be sent as soon as they are available.		
HSAG Findings: The <i>CGA01-INS-MCD-Member Appeals</i> policy indicated that the PAHP will give the provider prompt oral notice of the delay where the provider has agreed to be responsible for promptly notifying the member or authorized representative of the determination. However, this requirement is the PAHP’s responsibility and it cannot be delegated to the provider without appropriate delegation agreements and oversight in place; although this does		

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Requirement	Supporting Documentation	Score
not appear to be an appropriate function to delegate to providers. The policy must be updated to indicate that the PAHP staff members will provide the member or authorized representative prompt notification of the delay. Recommendations: HSAG’s review identified the recommendations below: - Neither the <i>hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA</i> nor the <i>IA Medicaid Appeals Grievances Delegated CRD Process Draft</i> training documents explained how the staff members would take an extension, the reasons for the extension, and what process to follow to ensure the member is notified of the extension. HSAG strongly recommends including this information in the staff training documents so staff members understand the appropriate processes to follow for extensions and where to document the information in the information system. - The three member handbooks indicated that the PAHP will notify the member by phone and in writing within two days; however, the requirement is that the PAHP <i>promptly</i> notify the member orally and provide notification in writing within two calendar days. HSAG recommends clarifying this language in the member handbooks. - The <i>IA Medicaid Appeal Extension letter template</i> implied that the member would be required to provide additional information to the PAHP; however, normally it is the provider who needs to submit the additional information. HSAG recommends that the PAHP revise its extension letter template to advise that the PAHP requested additional information from the provider. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Update its policy to indicate that the PAHP staff members (rather than the provider) will provide the member or authorized representative prompt notification of the delay.		
27. In the case that the PAHP fails to adhere to the appeal notice and timing requirements, the member is deemed to have exhausted the PAHP’s appeals process. The member may initiate a SFH. 42 CFR §438.228 42 CFR §438.408(c)(3) 42 CFR §438.408(f)(1)(i) 42 CFR §457.1260(e)(3) Contract H.5.01–H.5.02	HSAG Required Evidence: - Policies and procedures - Tracking and reporting mechanisms (e.g., system tracking capabilities, mock timeliness report) - Member materials, such as the member handbook - Appeal notice template for untimely appeal resolution - Staff training materials - System screenshot of the field to track denials for untimely appeals versus denials for medical necessity - One mock resolution notice due to the failure to complete an appeal timely - HSAG will also use the results of the system demonstration Evidence as Submitted by the PAHP:	☒ Met ☐ Not Met

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Requirement	Supporting Documentation	Score
	• Policies and procedures ○ SX_CGA01-INS-MCD-Member Appeals <Pg 10 Procedure E 4> • Tracking and reporting mechanisms (e.g., system tracking capabilities, mock timeliness report) ○ SX_CGA05-INS-SOP-Monitoring Resolution Timeframes-No Exhibits 1.pdf • Member materials, such as the member handbook ○ SX_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft_2.27.26 ○ SX_DQ4080 IA_Medicaid Child (7.26) HBEN Draft_2.26.26 • Appeal notice template for untimely appeal resolution-N/A • Staff training materials ○ SX_2026 CG Training Syllabus ○ SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA • System screenshot of the field to track denials for untimely appeals versus denials for medical necessity ○ SX_Medical Necessity and Untimely Appeals Screenshot • One mock resolution notice due to the failure to complete an appeal timely-N/A	
PAHP Description of Process: The correspondence for Grievances and Appeals is currently in development. Drafts will be sent as soon as they are available.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Recommendations: Neither the <i>hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA</i> nor the <i>IA Medicaid Appeals Grievances Delegated CRD Process Draft</i> training documents indicated that in the case that the PAHP fails to adhere to the appeal notice and timing requirements, the		

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Requirement	Supporting Documentation	Score
member is deemed to have exhausted the PAHP’s appeals process and may initiate an SFH. HSAG recommends enhancing its training documentation to ensure staff members understand when a member can request an SFH and how to determine whether or not the member’s request meets the requirements.		
Required Actions: None.		
28. For all appeals, the PAHP provides written notice of the appeal resolution that includes: - The results of the resolution process and the date it was completed. - For appeals not resolved wholly in favor of the member: - The right to request a SFH, and how to do so. - The right to request and receive benefits while the hearing is pending, and how to make the request. - That the member may be held liable for the cost of those benefits if the hearing decision upholds the PAHP's ABD related to the appeal. 42 CFR §438.228 42 CFR §438.408(e)(1-2) 42 CFR §457.1260(e)(1) 42 CFR §457.1260(e)(4) Contract H.8.01 Contract H.9.04	HSAG Required Evidence: - Policies and procedures - Appeal resolution notice template - Staff training materials - System screenshot of the field where the appeal resolution notice is maintained - HSAG will also use the results of the system demonstration (i.e., mock appeal case examples) Evidence as Submitted by the PAHP: - Policies and procedures - SX_CGA01-INS-MCD-Member Appeals <Pg 7-8 Procedure C, Item 6(c)(i-ix)> - Appeal resolution notice template-N/A - Staff training materials - SX_2026 CG Training Syllabus - SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA - System screenshot of the field where the appeal resolution notice is maintained - SX_Expedited Appeal System Screenshot	☐ Met ☒ Not Met
PAHP Description of Process: The correspondence for Grievances and Appeals is currently in development. Drafts will be sent as soon as they are available.		
HSAG Findings: HSAG’s review identified the findings below: The <i>CGA01-INS-MCD-Member Appeals</i> policy did not include that the resolution notice will indicate that the member may be held liable for the cost of continued benefits if the hearing decision upholds the PAHP’s ABD related to the appeal.		

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Requirement	Supporting Documentation	Score
- During the review, HSAG requested that the appeal resolution notice template be provided in follow-up documents; however, this template letter was not submitted as requested. - During the review, HSAG requested a policy or process document explaining how the appeal upheld reason (i.e., denial reason for appeals) would be generated in the appeal resolution notice; however, this evidence was not submitted as requested. Recommendations: The <i>CGA01-INS-MCD-Member Appeals</i> policy outlined a process for member external appeals and indicated that the resolution notice would include information related to this process. During the review, PAHP staff members explained that this is a Medicare process used only for members who have Medicare coverage. HSAG recommends that the PAHP remove this section from the <i>CGA01-INS-MCD-Member Appeals</i> policy or include in its Iowa exhibit for this policy that the process does not apply to Iowa Medicaid and that it would not be included in the resolution notice. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Develop and submit an appeal resolution notice template, including that the member may be held liable for the cost of continued benefits if the hearing decision upholds the PAHP's ABD related to the appeal. - Develop and submit a policy, process, or training document explaining how the appeal upheld reason (i.e., denial reason for appeals) will be generated in the appeal resolution notice.		
29. For notice of an expedited appeal resolution, the PAHP makes reasonable efforts to provide oral notice. 42 CFR §438.228 42 CFR §438.408(d)(2)(ii) 42 CFR §457.1260(e)(1) Contract H.8.02	HSAG Required Evidence: - Policies and procedures - Workflow for documenting oral notice to members - Staff training materials - System screenshot of the field where oral notice of an expedited appeal resolution is documented - HSAG will also use the results of the system demonstration (i.e., mock appeal case examples) Evidence as Submitted by the PAHP: - Policies and procedures - SX_CGA01-INS-MCD-Member Appeals < Pg 6 Procedure C, Item 1(a-e) > - Workflow for documenting oral notice to members - SX_CGA - Expedited Cases - Staff training materials - SX_2026 CG Training Syllabus	☒ Met ☐ Not Met

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Requirement	Supporting Documentation	Score
	○ SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA • System screenshot of the field where oral notice of an expedited appeal resolution is documented-N/A	
PAHP Description of Process: DentaQuest does not have a field to document an oral notice.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Recommendations: Neither the <i>hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA</i> nor the <i>IA Medicaid Appeals Grievances Delegated CRD Process Draft</i> training documents described the process staff members would use to notify the member orally of the resolution of an expedited appeal. HSAG recommends enhancing its training documentation to ensure staff members understand how to notify members of the resolution and where to document attempts to notify the member orally within the information system.		
Required Actions: None.		
State Fair Hearings and State External Review		
30. The member may request a SFH only after receiving notice that the PAHP is upholding the ABD related to the appeal. a. With the written consent of the member, a provider or an authorized representative may request a SFH on behalf of the member. 42 CFR §438.228 42 CFR §438.408(f)(1)(i) 42 CFR §457.1260(e)(5) Contract H.1.02 Contract H.4.01 Contract H.4.03	HSAG Required Evidence: • Policies and procedures • Appeal resolution notice template • Member materials, such as the member handbook and/or ABD notice • Staff training materials • System screenshot of the field indicating that a SFH was requested and documentation of the PAHP's participation • HSAG will also use the results of the system demonstration Evidence as Submitted by the PAHP: • Policies and procedures ○ SX_CGA01-INS-MCD-Member Appeals <Pg 9-10 Procedure E 2> • Appeal resolution notice template	☒ Met ☐ Not Met

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Requirement	Supporting Documentation	Score
	- Member materials, such as the member handbook and/or ABD notice - SX_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft_2.27.26 - SX_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 - Staff training materials - SX_2026 CG Training Syllabus - SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA - System screenshot of the field indicating that a SFH was requested and documentation of the PAHP's participation - SX_SFH Details Screenshot	
PAHP Description of Process: The correspondence for Grievances and Appeals is currently in development. Drafts will be sent as soon as they are available.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: Neither the <i>hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA</i> nor the <i>IA Medicaid Appeals Grievances Delegated CRD Process Draft</i> training documents described how staff members would ensure the member provided written consent for a provider or authorized representative to file an SFH on their behalf. HSAG recommends that the PAHP ensure training documentation includes how staff members will ensure member written consent is obtained for someone to submit an SFH request on the member's behalf. HSAG further recommends that the training specify that the member's written consent must be specific to the SFH being filed.		
Required Actions: None.		
31. The member has no more than <i>120 calendar days</i> from the date of the PAHP's notice of appeal resolution to request a SFH. 42 CFR §438.228 42 CFR §438.408(f)(2) 42 CFR §457.1260(e)(5) HHS.Iowa.Gov—How to Appeal	HSAG Required Evidence: - Policies and procedures - Appeal resolution notice template - Member materials, such as the member handbook and/or ABD notice - Staff training materials	☐ Met ☒ Not Met

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Requirement	Supporting Documentation	Score
IAC 441—7.4(b)	Evidence as Submitted by the PAHP: - Policies and procedures - SX_CGA01-INS-MCD-Member Appeals <Pg 9 Procedure E 1> - Appeal resolution notice template-N/A - Member materials, such as the member handbook and/or ABD notice - SX_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft 2.27.26 - SX_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft 2.26.26 - Staff training materials - SX_2026 CG Training Syllabus - SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA	
PAHP Description of Process: The correspondence for Grievances and Appeals is currently in development. Drafts will be sent as soon as they are available.		
HSAG Findings: Although the PAHP’s policies and procedures, training documentation, and member handbooks included that the member had 120 days to submit an SFH request after receipt of the appeal resolution notice, during the review, HSAG requested that the PAHP submit the appeal resolution notice template. However, this evidence was not submitted as requested.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Develop and submit an appeal resolution notice template, which must indicate that the member has no more than <i>120 calendar days</i> from the date of the PAHP’s notice of appeal resolution to request an SFH.		
Continuation of Benefits		
32. The PAHP continues the member’s benefits if all of the following occur: The member files the request for an appeal timely (within 60 calendar days from the date on the ABD notice).	HSAG Required Evidence: - Policies and procedures - ABD notice template - Appeal resolution notice template	☐ Met ☒ Not Met

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Requirement	Supporting Documentation	Score
b. The appeal involves the termination, suspension, or reduction of previously authorized services. c. The services were ordered by an authorized provider. d. The period covered by the original authorization has not expired. e. The member timely files for continuation of benefits. <i>Timely files</i> means on or before the later of the following: within 10 calendar days of the PAHP sending the notice of ABD, or the intended effective date of the PAHP's proposed ABD. 42 CFR §438.228 42 CFR §438.420(a-b) Contract H.9.01–H.9.02	- Staff training materials - Process to continue benefits when requested by a member - System screenshot of the field for where a member request to continue benefits is documented - HSAG will also use the results of the system demonstration Evidence as Submitted by the PAHP: - Policies and procedures - SX_CGA01-INS-MCD-Member Appeals <Pg 10-11 Procedure F 1-2> - ABD notice template-N/A - Appeal resolution notice template-N/A - Staff training materials - SX_2026 CG Training Syllabus - SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA - Process to continue benefits when requested by a member - SX_CGA01-INS-MCD-Member Appeals <Pg 10-11 Procedure F 1-2> - System screenshot of the field for where a member request to continue benefits is documented - SX_Member Grievance-Appeal Screenshot	
PAHP Description of Process: The correspondence for Grievances and Appeals is currently in development. Drafts will be sent as soon as they are available.		
HSAG Findings: Although the PAHP's <i>CGA01-INS-MCD-Member Appeals</i> policy included the information related to the continuation of benefits, during the review, HSAG requested that the PAHP submit the appeal resolution notice template. However, this evidence was not submitted as requested. Recommendations: HSAG's review identified the recommendations below: The <i>IA Medicaid NABD letter template with RGL</i> submitted by the PAHP indicated that members must ask for the benefits to be continued within 10 days of receiving the notice that the PAHP is reducing, ending, or denying previously authorized services; however, it did not notify the member that the period covered by the original authorization must not be expired for the services to continue during the appeal. HSAG recommends that the PAHP include this language in the ABD notice template.		

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Requirement	Supporting Documentation	Score
Neither the <i>hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA</i> nor the <i>IA Medicaid Appeals Grievances Delegated CRD Process Draft</i> training documents described how staff members would process the continuation of benefits, if requested, during the appeal or SFH. HSAG recommends that the PAHP ensure its training documentation includes how staff members will process the continuation of benefits and where to document information in the information system.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Develop an appeal resolution notice template, which must inform members of their right to continue benefits.		
33. If, at the member's request, the PAHP continues or reinstates the member's benefits while the appeal or SFH is pending, the benefits must be continued until one of following occurs: - The member withdraws the appeal or request for SFH. - The member fails to request a SFH and continuation of benefits within 10 calendar days after the PAHP sends the notice of an adverse resolution to the member's appeal. - A SFH office issues a hearing decision adverse to the member. 42 CFR §438.228 42 CFR §438.420(c) Contract H.9.01 Contract H.9.03	HSAG Required Evidence: - Policies and procedures - ABD notice template - Staff training materials - Process to continue benefits when requested by a member - System screenshot of the field for where a member request to continue benefits is documented - HSAG will also use the results of the system demonstration Evidence as Submitted by the PAHP: - Policies and procedures - SX_CGA01-INS-MCD-Member Appeals <Pg 11 Procedure F a-c> - ABD notice template-N/A - Staff training materials - SX_2026 CG Training Syllabus - SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA - Process to continue benefits when requested by a member - SX_CGA01-INS-MCD-Member Appeals <Pg 10-11 Procedure F 1-2> - System screenshot of the field for where a member request to continue benefits is documented - SX_Member Grievance-Appeal Screenshot	☒ Met ☐ Not Met

Standard X—Grievance and Appeal Systems

Requirement	Supporting Documentation	Score
PAHP Description of Process: The correspondence for Grievances and Appeals is currently in development. Drafts will be sent as soon as they are available.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: Neither the <i>hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA</i> nor the <i>IA Medicaid Appeals Grievances Delegated CRD Process Draft</i> training documents described how staff members would terminate the services in the event the member withdraws the request for an SFH or the SFH results in a decision that is adverse to the member. HSAG recommends that the PAHP ensure training documentation includes how staff members will process the continuation of benefits, when to terminate the benefits, and where to document information in the information system.		
Required Actions: None.		
34. <i>The PAHP may recover the cost of continued services furnished to the member while the appeal or SFH was pending if the final resolution of the appeal or SFH upholds the PAHP's ABD.</i> 42 CFR §438.228 42 CFR §438.420(d) Contract H.9.01 Contract H.9.04	HSAG Required Evidence: • Policies and procedures • ABD notice template • Appeal resolution notice template • Staff training materials • Workflow for recovering cost of continued services Evidence as Submitted by the PAHP: • Policies and procedures ○ SX_CGA01-INS-MCD-Member Appeals <Pg 11 Procedure F 3d> • ABD notice template-N/A • Appeal resolution notice template-N/A • Staff training materials ○ SX_2026 CG Training Syllabus ○ SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA • Workflow for recovering cost of continued services-N/A	☒ Met ☐ Not Met

Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
PAHP Description of Process: The correspondence for Grievances and Appeals is currently in development. Drafts will be sent as soon as they are available. The workflow is currently in discussion with HHS and will be documented once agreed upon.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
35. If the PAHP or the SFH officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, <i>the PAHP must pay for those services, unless State policy and regulations provide for the State to cover the cost of such services.</i> 42 CFR §438.228 42 CFR §438.424(b) Contract H.9.01 Contract H.9.06	HSAG Required Evidence: • Policies and procedures • Staff training materials Evidence as Submitted by the PAHP: • Policies and procedures ○ SX_CGA01-INS-MCD-Member Appeals <Pg 11 Procedure F 4> • Staff training materials ○ SX_2026 CG Training Syllabus ○ SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Recommendations: Although the <i>CGA01-INS-MCD-Member Appeals</i> policy indicated that if the SFH resulted in overturning the determination, the PAHP would pay for those services in accordance with State policy. However, HSAG recommends that the PAHP develop a procedural document that includes the processes used to ensure those services are paid for.		
Required Actions: None.		

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Requirement	Supporting Documentation	Score
Reinstatement of Services		
36. If the PAHP or the SFH officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the PAHP authorizes or provides the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. 42 CFR §438.228 42 CFR §438.424(a) 42 CFR §457.1260(i) Contract H.9.05	HSAG Required Evidence: • Policies and procedures • Workflow for authorizing or providing services within 72 hours of decision to reverse determination • Tracking and reporting mechanisms (e.g., system tracking capabilities, mock timeliness report) • Staff training materials Evidence as Submitted by the PAHP: • Policies and procedures ○ SX_CGA01-INS-MCD-Member Appeals <Pg 10 Procedure E 12> • Workflow for authorizing or providing services within 72 hours of decision to reverse determination ○ SX_CGA - Expedited Cases • Tracking and reporting mechanisms (e.g., system tracking capabilities, mock timeliness report) ○ SX_CGA05-INS-SOP-Monitoring Resolution Timeframes-No Exhibits 1.pdf • Staff training materials ○ SX_2026 CG Training Syllabus ○ SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA	☐ Met ☒ Not Met
PAHP Description of Process:		
HSAG Findings: The PAHP’s policy stipulated these requirements verbatim. However, during the review, the PAHP could not demonstrate systematically how the timeliness will be tracked. The PAHP explained that to reinstate services after an SFH reversal decision, the PAHP will use a ticketing system within Service Now to initiate the process and route the request to reinstate the services to the appropriate department (i.e., claims or UM). HSAG requested screenshots of this ticketing system to confirm how the PAHP will ensure the services are reinstated timely. However, after the review, the PAHP noted that this could not be demonstrated via screenshots.		

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Requirement	Supporting Documentation	Score
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Provide evidence (e.g., screenshots) for how it documents and tracks that it authorizes or provides the disputed services within 72 hours.		
Grievances, Appeals, and State Fair Hearings		
37. In handling grievances and appeals, the PAHP gives members any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. 42 CFR §438.228 42 CFR §438.406(a) 42 CFR §457.1260(d) Contract H.1.05	HSAG Required Evidence: - Policies and procedures - Member materials, such as the member handbook - Staff training materials Evidence as Submitted by the PAHP: - Policies and procedures - SX_CGA01-INS-MCD-Member Appeals <Pg 12 Exhibit T Procedure A 4 > - SX_CGA06-INS-Member Complaints and Grievances <Pg 7 Exhibit Q Procedure A 8> - Member materials, such as the member handbook - SX_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft_2.27.26 - SX_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 - Staff training materials - SX_2026 CG Training Syllabus - SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
38. <i>The PAHP is responsible for providing all support at all stages of the grievance and appeal processes, including but not limited to providing the necessary factual and expert testimony necessary to support the PAHP's position taken in relation to an enrolled member's claim, including providing any support required by the Attorney General's Office in relation to a judicial review proceeding arising out of the SFH process.</i> a. <i>The PAHP is responsible for any award of attorneys' fees and costs provided at any stage of SFH or judicial review of an PAHP decision.</i> Contract H.1.11	HSAG Required Evidence: • Policies and procedures • Staff training materials Evidence as Submitted by the PAHP: • Policies and procedures ○ SX_CGA01-INS-MCD-Member Appeals <Pg 13 Exhibit T Procedure E 13> ○ SX_CGA06-INS-Member Complaints and Grievances <Pg 8 Procedure C 6> • Staff training materials ○ SX_2026 CG Training Syllabus ○ SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA	☒ Met ☐ Not Met
PAHP Description of Process: HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: The language included in the <i>CGA01-INS-MCD-Member Appeals</i> policy met the requirements of this element; however, the information was under the heading of “Member Fair Hearing.” As this information relates to appeals and SFHs, this could be confusing to staff. Therefore, HSAG recommends that the PAHP move the section to be related to all appeals and SFHs.		
Required Actions: None.		
39. The PAHP provides written notice of the grievance and appeal resolution in a format and language that, at a minimum, meets the requirements in accordance with 42 CFR §438.10. 42 CFR §438.10 42 CFR §438.228 42 CFR §438.408(d)(1) 42 CFR §438.408(d)(2)(i)	HSAG Required Evidence: • Policies and procedures • Grievance and appeal resolution templates, including taglines • Staff training materials • Quality assurance process to monitor resolution notices (e.g., required content, easily understood, grammatical/typographical errors)	☐ Met ☒ Not Met

Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
42 CFR §457.1260(e)(1) Contract H.8.01(a) Contract H.10.07	- HSAG will also use the results of the system demonstration (i.e., mock case examples) Evidence as Submitted by the PAHP: - Policies and procedures - SX_CGA01-INS-MCD-Member Appeals < Pg 7-8 Procedure C 6(c)> - SX_CGA06-INS-Member Complaints and Grievances <Pg 5-6 Procedure D 5> - Grievance and appeal resolution templates, including taglines- N/A - Staff training materials - SX_2026 CG Training Syllabus - SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA - Quality assurance process to monitor resolution notices (e.g., required content, easily understood, grammatical/ typographical errors) - SX_QA10-INS-Complaints Grievances and Appeals Audit <Full Document>	
PAHP Description of Process: The correspondence for Grievances and Appeals is currently in development. Drafts will be sent as soon as they are available. HSAG Findings: While the requirements of this element were outlined in the PAHP’s policies and procedures, HSAG did not receive the appeal resolution notice template to confirm that the written notice will comply with 42 CFR §438.10. Although requested during the review, this evidence was not submitted. Recommendations: During the review, PAHP staff members indicated that the PAHP will audit each specialist every week and that part of the audit will include a review of the member notices that were sent. HSAG strongly recommends that the PAHP implement a quality assurance process to review member notices before they are mailed to the member to ensure accuracy and quality, at least for a specified period and when there are new staff members. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Develop and submit an appeal resolution notice template.		

Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
40. The PAHP provides information specified in 42 CFR §438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract. 42 CFR §438.10(g)(2)(xi) 42 CFR §438.228 42 CFR §438.414 42 CFR §457.1260(g) Contract E.6.01–E.6.03	HSAG Required Evidence: • Policies and procedures • Provider manual • Provider contract • Delegation agreement template • HSAG will also use the results of the delegation file review Evidence as Submitted by the PAHP: • Policies and procedures ○ SX_CGA06-INS-Member Complaints and Grievances • Provider manual ○ SX_Provider Reference Manual <Pg 31-33 Section 9.00> • Provider contract ○ SX_230206 IA MA MC HIX Provider Agreement • Delegation agreement template-N/A	☒ Met ☐ Not Met
PAHP Description of Process: DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
41. The PAHP includes as parties to the appeal and SFH: a. The member and his or her representative. b. The legal representative of a deceased member’s estate. c. For SFH, the PAHP. 42 CFR §438.228 42 CFR §438.406(b)(6) 42 CFR §438.408(f)(3) 42 CFR §457.1260(e)(5)	HSAG Required Evidence: • Policies and procedures • Member materials, such as the member handbook and/or notice templates • Staff training materials Evidence as Submitted by the PAHP: • Policies and procedures	☒ Met ☐ Not Met

Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
Contract H.6.08	○ SX_CGA01-INS-MCD-Member Appeals <Pg 2 Procedure A 1 b> • Member materials, such as the member handbook and/or notice templates ○ SX_DQ3197 IA Medicaid Adult (7.26) HBEN Draft_2.27.26<Pg 20, Requesting a Reconsideration> ○ SX_DQ4080 IA Medicaid Child (7.26) HBEN Draft_2.26.26<Pg 23 Requesting a Reconsideration> • Staff training materials ○ SX_2026 CG Training Syllabus ○ SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA	
PAHP Description of Process: DentaQuest will ensure authorized representatives are referenced in the Member Handbook by the date requested by HHS.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
Recordkeeping Requirements		
42. Grievance and appeal records are accurately maintained in a manner accessible to HHS and available upon request to CMS, and contain, at a minimum, all of the following information: - A general description of the reason for the appeal or grievance. - The date received. - The date of each review or, if applicable, review meeting. - Resolution at each level of the appeal or grievance, if applicable. - Date of resolution at each level, if applicable.	HSAG Required Evidence: • Policies and procedures • Staff training materials • HSAG will also use the results of the system demonstration Evidence as Submitted by the PAHP: • Policies and procedures ○ SX_CGA01-INS-MCD-Member Appeals <Pg 3 Procedure B 1> ○ SX_CGA06-INS-Member Complaints and Grievances <Pg 4 Procedure C 1(a)>	☒ Met ☐ Not Met

Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
f. Name of the member for whom the appeal or grievance was filed. 42 CFR §438.228 42 CFR § 438.416(b-c) 42 CFR §457.1260(h) Contract H.11.01–H.11.03	- Staff training materials - SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA<Full Document> - SX_2026 CG Training Syllabus<Full Document>	
PAHP Description of Process: HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: While the system demonstration included all of the requirements of this element, HSAG recommends that the PAHP update its <i>CGA01-INS-MCD-Member Appeals</i> and <i>CGA06-INS-Member Complaints and Grievances</i> policies to include that a general description of the appeal or grievance is documented in the information system. Required Actions: None.		

Standard X—Grievance and Appeal Systems						
Met	=	25	X	1	=	25
Not Met	=	17	X	0	=	0
Total	=	42	Total Score		=	25
Total Score ÷ Total					=	60%

Standard XI—Subcontractual Relationships and Delegation

Standard XI—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
General Rule		
1. Notwithstanding any relationship(s) that the PAHP may have with any delegate, PAHP maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with HHS. 42 CFR §438.230(b)(1) 42 CFR §457.1233(b) Contract J.3.02	HSAG Required Evidence: - Policies and procedures Evidence as Submitted by the PAHP: - SXI_COM11-ENT Delegation Oversight Policy <Page 1, Page 2>	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
Integrated Subcontracting		
2. Any subcontracting relationship provides for a seamless experience for members and providers. For example, any subcontracting of claims processing shall be invisible to the provider so as to not result in confusion about where to submit claims for payments. Contract J.3.01	HSAG Required Evidence: - Policies and procedures - Member materials, such as the member handbook - Provider materials, such as the provider manual Evidence as Submitted by the PAHP: - SXI_COM11-ENT Delegation Oversight Policy <Whole Document> - SXI_Member Handbook Prev Implementation DRAFT <Whole Document> - SXI_Iowa Provider Office Reference Manual <Whole Document>	☒ Met ☐ Not Met

Standard XI—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
Contract or Written Arrangement		
3. <i>The PAHP ensures that BAAs are in place as necessary.</i> Contract J.3.03	HSAG Required Evidence: • Policies and procedures • List of all delegated entities requiring a BAA and the date the agreement was executed • HSAG will use the results from the Delegation File Review Evidence as Submitted by the PAHP: • SXI_COM11-ENT Delegation Oversight Policy <Whole Document> • SXI_<DQ BAA's Folder Ansafone Contact Centers, LLC BANCTEC, Inc. (Exela Technologies Co.) Certified Languages International, LLC Columbia Translations, Inc. DBA Expert Translators Health Management Systems, Inc (HMS) (Gainwell) Ibex Global Solutions Optomi LLC dba ProValus Qualtrics, LLC SAGILITY, LLC (previously HGS HEALTHCARE, LLC) Sepire Smart Data Solutions Trachmar, LLC>	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		

Standard XI—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
4. Each contract or written arrangement with a delegate must specify: a. The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement. b. The delegate agrees to perform the delegated activities and reporting responsibilities specified in compliance with the PAHP’s contract obligations. c. The contract or written arrangement must either provide for revocation of the delegation of activities or obligations or specify other remedies in instances where HHS or the PAHP determine that the delegate has not performed satisfactorily. 42 CFR §438.230(b)(2) 42 CFR §438.230(c)(1) 42 CFR §457.1233(b) Contract J.3.04	HSAG Required Evidence: - Delegation agreement/contract template - HSAG will also use the results from the Delegation File Review Evidence as Submitted by the PAHP: - SXI_ Regulatory Compliance Addendum Template <Pg 3, 4, 9-10> - HSAG will also use the results from the Delegation File Review	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
5. The contract or written arrangement indicates that the delegate agrees to comply with all applicable <i>Children's Health Insurance Program (CHIP)</i>, Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions. 42 CFR §438.230(c)(2) 42 CFR §457.1233(b) Contract J.3.06	HSAG Required Evidence: - Delegation agreement/contract template - HSAG will also use the results from the Delegation File Review Evidence as Submitted by the PAHP: - SXI_ Regulatory Compliance Addendum Template <Pg 6-7>	☒ Met ☐ Not Met

Standard XI—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
6. The contract or written arrangement indicates, and the delegate agrees that: a. HHS, Centers for Medicare and Medicaid Services (CMS), the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the delegate, or of the delegate's subcontractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the PAHP's contract with the State. b. The delegate will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid members. c. The delegate agrees that the right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. d. The if HHS, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, HHS, CMS, or the HHS Inspector General may inspect, evaluate, and audit the delegate at any time. 42 CFR §438.230(c)(3) 42 CFR §457.1233(b) Contract J.1.03-J.1.05 Contract J.3.07-J.3.10	HSAG Required Evidence: • Delegation agreement/contract template • HSAG will also use the results from the Delegation File Review Evidence as Submitted by the PAHP: • SXI_Regulatory Compliance Addendum Template <Pg 6, Article IV Section 4.2-4.3; Pg 7, Article IV Sections 4.4–4.5>	☒ Met ☐ Not Met

Standard XI—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: While the PAHP’s <i>Regulatory Compliance Addendum</i> template included language that met the intent of the requirements for this element, as the PAHP executes new or amended contracts, HSAG recommends that the PAHP update its <i>Regulatory Compliance Addendum</i> to include the verbatim federal right to audit language stipulated in sub-elements (a)–(d) of this element.		
Required Actions: None.		
7. <i>The PAHP requires subcontractors providing direct services to have quality improvement goals and performance improvement activities specific to the types of services provided by the subcontractors.</i> Contract J.3.01	HSAG Required Evidence: - Delegation agreement/contract template - HSAG will use the results from the Delegation File Review	☒ Met ☐ Not Met
	Evidence as Submitted by the PAHP: SXI_Regulatory Compliance Addendum Template <Pg 4, Article III Section 3.1>	
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
Predelegation Activities		
8. <i>Prior to delegation, the PAHP evaluates the prospective subcontractor’s ability to perform the activities to be delegated, including firm and staff qualifications.</i> 42 CFR §438.230 42 CFR §457.1233(b) Contract J.3.03	HSAG Required Evidence: - Policies and procedures - Pre-delegation audit tool template - Staff training materials - HSAG will use the results from the Delegation File Review	☒ Met ☐ Not Met
	Evidence as Submitted by the PAHP: SXI_COM07-ENT Training & Education Policy <Pg 1–4>	

Standard XI—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
	- SXI_Regulatory Compliance Addendum Template <Pg 6, Article IV Section 4.3 – Pg 4-5, Article III Section 3.4-3.5> - SXI_Vendor Management Program <Pg 9> - SXI_2025 DQ Compliance Training Completion Status Report (sample) <Pg 1-1>	
PAHP Description of Process: HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: Although the delegated entity list provided by the PAHP included delegated entities previously contracted for other lines of business and the PAHP confirmed it is working with its delegates to serve Iowa Medicaid managed care populations, HSAG recommends that the PAHP ensure it has documented results of the assessments conducted with each delegate providing services for the Iowa Medicaid managed care program to ensure the delegate has the capacity to perform the delegated services and knowledge of Iowa-specific contract requirements.		
Required Actions: None.		
Monitoring and Auditing		
9. <i>The PAHP has policies and procedures to audit and monitor subcontractors' data, data submission and performance, and implements oversight mechanisms to monitor performance and compliance with Contract requirements.</i> 42 CFR §438.230 42 CFR §457.1233(b) Contract J.3.05	HSAG Required Evidence: - Policies and procedures - Staff training materials Evidence as Submitted by the PAHP: - SXI_Regulatory Compliance Addendum Template <Pg 6, Article IV Section 4.3 – Audit Pg 4, Article III Section 3.2 – Monitoring, reporting, data review, and corrective action expectations> - SXI_Vendor Management Program <Pg 14> - SXI_COM11-ENT Delegation Oversight <Pg 3, Procedure Section B> - SXI_COM07-ENT Training & Education Policy <Pg 1–4>	☒ Met ☐ Not Met
PAHP Description of Process:		

Standard XI—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
10. <i>The PAHP monitors the subcontractor’s performance on an ongoing basis.</i> a. <i>Formal reviews are conducted by the PAHP at least quarterly.</i> b. <i>Whenever deficiencies or areas of improvement are identified, the PAHP and subcontractor take corrective action.</i> c. <i>The PAHP provides to HHS the findings of all subcontractor performance monitoring and reviews upon request and notifies HHS any time a subcontractor is placed on corrective action.</i> 42 CFR §438.230 42 CFR §457.1233(b) Contract J.3.05	HSAG Required Evidence: • Policies and procedures • Staff training materials • HSAG will use the data from the Delegation Universe File • HSAG will use the results from the Delegation File Review Evidence as Submitted by the PAHP: • SXI_Regulatory Compliance Addendum Template <Pg 6, Article IV Section 4.3 Pg 4, Article III Section 3.2> • SXI_Vendor Management Program Page 14 – Vendor oversight, ongoing monitoring, data review, reporting evaluation, and escalation processes • SXI_COM11-ENT Delegation Oversight Policy <Pg 3, Section B> • SXI_COM07-ENT Training & Education Policy <Pg 1–4>	☐ Met ☒ Not Met
PAHP Description of Process:		
HSAG Findings: While the PAHP’s <i>COM11-ENT-SOP-Subcontractor Oversight</i> SOP included language about its standardized process for monitoring and oversight of its delegated entities, stating “the Delegation Oversight Subcommittee maintains the ultimate responsibility for monitoring subcontractor compliance with applicable contract requirements, rules and regulations,” this statement did not sufficiently address the requirements of sub-element (c). During the review, HSAG requested that the state-specific contract requirements be included in its policies and procedures to ensure PAHP staff were aware of and can adhere to the contract requirements, but evidence to support this requirement was not submitted.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must:		
• Update its procedure or other written documentation to include state-specific contract requirements outlined in sub-element (c), and provide confirmation that staff have been trained on state-specific contract requirements.		

Standard XI—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
Additional State Requirements		
11. <i>The PAHP notifies HHS in writing of all subcontracts relating to deliverables to be provided under its Contract prior to the time the subcontract(s) become effective.</i> 42 CFR §438.230 42 CFR §457.1233(b) Contract J.3.03	HSAG Required Evidence: • Policies and procedures • Copies of the notification to HHS of subcontractors responsible for deliverables Evidence as Submitted by the PAHP: • SXI_Regulatory Compliance Addendum Template <Pg 6, Article IV Section 4.3> • SXI_Vendor Management Program <Pg 3-4> • SXI_COM11-ENT Delegation Oversight <Pg 2-3> • SXI_IA Sub-Del Vendor List <Entire Document>	☐ Met ☒ Not Met
PAHP Description of Process: We have established processes to notify HHS of subcontractors responsible for deliverables. As we are still in the pre-go-live phase for 7/1/26, the required HHS notifications have not yet been triggered but will be submitted once subcontract agreements are finalized.		
HSAG Findings: Although the PAHP indicated in the <i>Description of Process</i> that the PAHP had established processes to notify HHS of subcontractors responsible for contract deliverables, the PAHP did not submit documentation to support this. Further, the PAHP indicated on the <i>Post-Site Review Tracker</i> that “DentaQuest will be developing a process with HHS to ensure the process is documented.”		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: • Submit a documented process (e.g., policy, procedure, SOP) that includes the process for how and when the PAHP notifies HHS in writing of all subcontracts relating to deliverables to be provided under its Contract prior to the time the subcontract(s) becomes effective.		
12. <i>The PAHP submits for HHS review and approval subcontractor agreements for any subcontractor whose payments are equal to or greater than five percent of capitation payments under the Contract.</i> a. <i>HHS reserves the right to review and approve any subcontracts, and all subcontracts are accessible to HHS and provided within three business days of request.</i> 42 CFR §438.230	HSAG Required Evidence: • Policies and procedures • List of delegates who will potentially meet the 5 percent or greater capitation payment threshold • Notification to HHS of subcontractors whose payments are equal to or greater than 5 percent of capitation Evidence as Submitted by the PAHP: • SXI_Regulatory Compliance Addendum Template <Pg 6>	☒ Met ☐ Not Met

Standard XI—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
42 CFR §457.1233(b) Contract J.3.03	- SXI_Vendor Management Program <Pg 4> - SXI_COM11-ENT Delegation Oversight <Pg 3> - SXI_IA Sub-Del Vendor List <Entire Document>	
PAHP Description of Process: IA has not yet gone live, so no capitation payments have been made and no subcontractors currently meet the 5% threshold. Policies and procedures are in place, and we will notify HHS once operations begin and any subcontractor reaches $\geq 5\%$.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		

Standard XI—Subcontractual Relationships and Delegation						
Met	=	10	X	1	=	10
Not Met	=	2	X	0	=	0
Total	=	12	Total Score	=		10
Total Score ÷ Total					=	83%

Standard XII—Practice Guidelines

Standard XII—Practice Guidelines		
Requirement	Supporting Documentation	Score
Adoption of Practice Guidelines		
1. The PAHP adopts practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in the particular field <i>and clinical practice guidelines required by HHS</i>. 42 CFR §438.236(b)(1) 42 CFR §457.1233(c) IAC 441-78.4 IAC 441-86.13(3) Contract G.4.01	HSAG Required Evidence: • Policies and procedures • List of adopted practice guidelines specific to Iowa, or list of practice guidelines the PAHP plans to adopt • Iowa-specific meeting minutes documenting committee review/approval, and/or planned meeting schedule and agenda • Staff training materials Evidence as Submitted by the PAHP: • SXII_UM01-INS-Clinical Algorithms <pages 1-4, Procedure A. Formulation/Establishment, B. Adoption, D. Ongoing and Annual Assessment>	☒ Met ☐ Not Met
PAHP Description of Process: Peer review committee meets annually, no minutes or schedules are available for Iowa. Staff Training materials are currently under development. They will be submitted by May 1, 2026.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: While the <i>UM01-INS-Clinical Algorithms</i> policy supported compliance with the requirements of this element, the policy focused on utilization review criteria and guidelines and not clinical practice guidelines (CPGs). The policy also supported that its clinical review criteria and guidelines are based on CPGs. However, the federal rule specifically requires the PAHP to adopt CPGs (e.g., American Dental Association [ADA]) for the Iowa Medicaid managed care program (i.e., adoption of the actual CPGs rather than the PAHP’s utilization review criteria and guidelines). Therefore, through the PAHP’s designated committee, the PAHP should identify and formally adopt the subset of CPGs (e.g., ADA—Topical Fluoride for Caries Prevention) that are applicable to the Iowa Medicaid managed care program. Additionally, while not specific to this element, but the entire standard, HSAG recommends that the PAHP educate its staff (e.g., UM and care management) on the CPGs that were adopted for the Iowa Medicaid managed care program. Further, HSAG recommends that the revised policy, at a minimum, clearly describes all federal and state-specific requirements under Standard XII.		
Required Actions: None.		

Standard XII—Practice Guidelines		
Requirement	Supporting Documentation	Score
2. The PAHP adopts practice guidelines that consider the needs of the PAHP’s members. 42 CFR §438.236(b)(2) 42 CFR §457.1233(c) Contract G.4.02	HSAG Required Evidence: • Policies and procedures • Analysis of the needs of the PAHP’s membership (i.e., using Iowa demographics and/or other published data) • List of adopted practice guidelines specific to Iowa, or list of practice guidelines the PAHP plans to adopt • Iowa-specific meeting minutes documenting committee review/approval, and/or planned meeting schedule and agenda • Staff training materials Evidence as Submitted by the PAHP: • SXII_UM01-INS-Clinical Algorithms <pages 1-4, Procedure A. Formulation/Establishment, B. Adoption, D. Ongoing and Annual Assessment> • SXII Member Handbook Prev Implementation DRAFT	☐ Met ☒ Not Met
PAHP Description of Process: Staff Training materials are currently under development. They will be submitted by May 1, 2026.		
HSAG Findings: HSAG’s review identified the findings below: • While the PAHP could speak to processes to consider member needs when adopting CPGs, this requirement and the PAHP’s process were not documented within its policy.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: • Update its policy to include how the PAHP adopts CPGs that consider the needs of its members.		
3. The PAHP adopts practice guidelines that are adopted in consultation with network providers. 42 CFR §438.236(b)(3) 42 CFR §457.1233(c) Contract G.4.03	HSAG Required Evidence: • Policies and procedures • List of adopted practice guidelines specific to Iowa, or list of practice guidelines the PAHP plans to adopt • Iowa-specific meeting minutes documenting committee review/approval, and/or planned meeting schedule and agenda • Evidence of consultation with network providers in Iowa, or plan/timeline to consult with network providers	☐ Met ☒ Not Met

Standard XII—Practice Guidelines		
Requirement	Supporting Documentation	Score
	Evidence as Submitted by the PAHP: SXII_UM01-INS-Clinical Algorithms <pages 1-4, Procedure A. Formulation/Establishment, B. Adoption, D. Ongoing and Annual Assessment>	
PAHP Description of Process: N/A		
HSAG Findings: While the PAHP’s <i>UM01-INS-Clinical Algorithms</i> policy indicated that its utilization criteria and guidelines are reviewed and adopted through the UM Committee and the Peer Review Committee, its policy did not specifically address how it consulted with contracted network providers for the Iowa Medicaid managed care program. Further, the PAHP provided attendees of the UM committee and Peer Review Committee; however, HSAG could not determine that any Iowa-contracted network providers were included on these committees. While PAHP staff members mentioned processes to solicit feedback from the provider community in Iowa and Iowa organizations, these processes were not documented to confirm that the PAHP had appropriate mechanisms to ensure network providers are included in the CPG adoption process.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Update its policy to describe the mechanisms to consult with Iowa network providers as part of the CPG adoption process. - Provide evidence (e.g., committee charter) to confirm that CPGs will be adopted by a local (i.e., Iowa) committee.		
4. The PAHP adopts practice guidelines that are reviewed and updated periodically as appropriate. 42 CFR §438.236(b)(4) 42 CFR §457.1233(c) Contract G.4.04	HSAG Required Evidence: - Policies and procedures - Plan for reviewing/updating practice guidelines, including the periodic schedule and forum/method for practitioner involvement - List of adopted practice guidelines specific to Iowa, or list of practice guidelines the PAHP plans to adopt - Iowa-specific meeting minutes documenting committee review/approval, and/or planned meeting schedule and agenda - Staff training materials Evidence as Submitted by the PAHP: - SXII_UM01-INS-Clinical Algorithms <pages 1-4, Procedure A. Formulation/Establishment, B. Adoption, D. Ongoing and Annual Assessment>	☒ Met ☐ Not Met

Standard XII—Practice Guidelines		
Requirement	Supporting Documentation	Score
PAHP Description of Process: Staff Training materials are currently under development. They will be submitted by May 1, 2026.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Recommendations: HSAG recommends that the PAHP ensure there is a process to review CPGs periodically and when any changes to CPGs are made (e.g., HHS mandates a new CPG).		
Required Actions: None.		
Dissemination of Guidelines		
5. The PAHP disseminates the guidelines to: a. All affected providers b. Members and potential members, upon request 42 CFR §438.236(c) 42 CFR §457.1233(c) Contract G.4.06	HSAG Required Evidence: • Policies and procedures • Staff training materials Evidence as Submitted by the PAHP: • SXII_Stakeholder Education Plan 2026 <Full document> • SXII_Sample Provider Newsletter <Full Document> • SXII_NET01-INS-Network Development Maintenance and Use <pages 2-4 Procedure A. Initial Network Development 5. Provider Training a) i-viii>	☒ Met ☐ Not Met
PAHP Description of Process: Staff Training materials are currently under development. They will be submitted by May 1, 2026.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
Application of Guidelines		
6. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.	HSAG Required Evidence: • Policies and procedures • Hierarchy of coverage criteria • Coverage guidelines/criteria	☐ Met ☒ Not Met

Standard XII—Practice Guidelines		
Requirement	Supporting Documentation	Score
42 CFR §438.236(d) 42 CFR §457.1233(c) Contract G.4.05	- Plan (including mechanisms) and timeline for monitoring the consistent application of clinical and practice guidelines for service authorization decisions - Plan to incorporate clinical and practice guidelines into member education materials (e.g., dental disease management materials, member newsletters) - Member materials (i.e., member handbook, member newsletters) - Staff training materials Evidence as Submitted by the PAHP: - SXII_UM01-INS-Clinical Algorithms <pages 1-4, Procedure A. Formulation/Establishment, B. Adoption, D. Ongoing and Annual Assessment> - SXII_Sample Provider Newsletter - SXII_Member Handbook Prev Implementation DRAFT	
PAHP Description of Process: Staff Training materials are currently under development. They will be submitted by May 1, 2026.		
HSAG Findings: HSAG’s review identified the findings below: Although the <i>UM01-INS-Clinical Algorithms</i> policy included its utilization review guidelines and criteria and their associated reference (e.g., ADA, American Academy of Pediatric Dentistry), it did not describe the PAHP’s mechanisms for ensuring member education aligns with its adopted CPGs for the Iowa Medicaid managed care program. While HSAG provided examples for how the PAHP could meet this requirement and requested additional evidence, no documentation was submitted in follow-up.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Update its policy and develop a process to describe how the PAHP ensures its member education is aligned with its adopted CPGs.		

Standard XII—Practice Guidelines						
Met	=	3	X	1	=	3
Not Met	=	3	X	0	=	0
Total	=	6	Total Score		=	3
Total Score ÷ Total					=	50%

Standard XIV—Quality Assessment and Performance Improvement Program

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	Supporting Documentation	Score
General Rules		
1. The PAHP establishes and implements an ongoing comprehensive quality assessment and performance improvement (QAPI) program (called the Quality Management/Quality Improvement [QM/QI] program in Iowa) for the services it furnishes to its members. 42 CFR §438.330(a)(1) 42 CFR §457.1240(b) Contract G.5.01 Contract G.5.06	HSAG Required Evidence: • Policies and procedures • QAPI program description • QAPI work plan • Staff training materials Evidence as Submitted by the PAHP: • SXIV_1_Quality Management_Quality Improvement Program_Iowa_FINAL <full document> • SXIV_1_QAPI Workplan_Iowa <full document> • SXIV_CGA - Quality of Care_Critical Incidents_Site visits <full document>	☒ Met ☐ Not Met
PAHP Description of Process: HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: HSAG strongly recommends that the PAHP proceed with its plan to update and finalize all policies and procedures supporting the quality assessment and performance improvement (QAPI) program. Additionally, HSAG recommends that the PAHP proceed with its plan to finalize and approve the QAPI program description and the QAPI program workplan.		
Required Actions: None.		
2. The QAPI program description, workplan, and program evaluation are exclusive to Iowa and do not contain documentation from other State Medicaid programs or product lines operated by the PAHP. Contract G.5.02	HSAG Required Evidence: • Policies and procedures • QAPI program description • QAPI workplan Evidence as Submitted by the PAHP:	☒ Met ☐ Not Met

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	Supporting Documentation	Score
	- SXIV_1_Quality Management_Quality Improvement Program_Iowa_FINAL <full document> - SXIV_1_QAPI Workplan_Iowa <full document>	
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
3. The QAPI program includes written policies and procedures for quality improvement including methods, timelines, and individuals responsible for completing each task. Contract G.5.02(f)	HSAG Required Evidence: - Policies and procedures - QAPI program description	☒ Met ☐ Not Met
	Evidence as Submitted by the PAHP: - SXIV_1_Quality Management_Quality Improvement Program_Iowa_FINAL <full document> - SXIV_1_QAPI Workplan_Iowa <full document>	
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
4. The PAHP makes all information about its QAPI program available to providers and members. Contract G.5.02	HSAG Required Evidence: - Policies and procedures - QAPI program description - QAPI workplan - Planned member and provider communications and/or website link	☒ Met ☐ Not Met
	Evidence as Submitted by the PAHP: SXIV_1_Quality Management_Quality Improvement Program_Iowa_FINAL <pg 25>	

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	Supporting Documentation	Score
	SXIV_1_QAPI Workplan_Iowa <full document>	
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
Basic Elements of QAPI Programs		
5. <i>The QAPI program includes an annual and prospective five-year QAPI workplan that sets measurable goals, establishes specific objectives, identifies the strategies and activities to be undertaken, monitors results, and assesses progress toward the goals.</i> Contract G.5.02(a)	HSAG Required Evidence: - Policies and procedures - QAPI workplan(s) Evidence as Submitted by the PAHP: - SXIV_1_Quality Management_Quality Improvement Program_Iowa_FINAL <full document> - SXIV_1_QAPI Workplan_Iowa <full document> - SXIV_QAPI Workplan_Iowa_5year <full document>	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Recommendations: HSAG recommends that the PAHP proceed with finalizing the prospective five-year QAPI program workplan, and as the program evolves and more data are available, the PAHP must revise this workplan as applicable. Additionally, the five-year workplan should be regularly updated to include all activities and associated objectives described in the QAPI program description. As the QAPI program progresses, the PAHP should update the annual and five-year workplans to include the SMART goals associated with its QAPI program activities.		
Required Actions: None.		
6. <i>The QAPI program includes dedicated resources (staffing, data sources, and analytical resources), including a quality committee that oversees the QAPI functions.</i> Contract G.5.02(b)	HSAG Required Evidence: - Policies and procedures - QAPI program description - Quality committee charter - Organizational chart	☒ Met ☐ Not Met

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	Supporting Documentation	Score
	Evidence as Submitted by the PAHP: - SXIV_1_Quality Management_Quality Improvement Program_Iowa_FINAL <pg 9> - SXIV_Quality Improvement Organizational Chart_Iowa	
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. However, please refer to additional findings related to staffing requirements in Element 28 of this standard. Recommendations: HSAG recommends that the PAHP proceed with its plan to hire the remaining staff members in the open roles indicated within its <i>IA Quality Oversight Committee Charter</i> prior to July 1, 2026.		
Required Actions: None.		
7. <i>The PAHP has a quality committee, which includes dental staff and network providers.</i> a. <i>This committee analyzes and evaluates the results of QAPI activities, recommends policy decisions, ensures that providers are involved in the QAPI program, institutes needed actions, and ensures that appropriate follow-up occurs.</i> b. <i>This committee also reviews and approves the QAPI program description, annual evaluation, and associated workplan prior to submission to HHS.</i> c. <i>The committee keeps written minutes of all meetings and a copy of the signed and dated written minutes for each meeting is available on-file and is made available for review upon request by HHS or its designee.</i> d. <i>The PAHP provides HHS with ten days advance notice of all regularly scheduled meetings of the QAPI committee.</i> Contract G.5.05	HSAG Required Evidence: - Policies and procedures - QAPI program description - Quality committee charter - List of quality committee members with credentials and position titles - All quality committee meeting minutes that have occurred - Quality committee meeting minutes showing approval of most recent QAPI program and workplan - Notice(s) to HHS of quality committee meetings Evidence as Submitted by the PAHP: - SXIV_1_Quality Management_Quality Improvement Program_Iowa_FINAL <pg 7-12> - SXIV_Quality Committee Members <full document>	☒ Met ☐ Not Met
PAHP Description of Process:		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
8. The QAPI program includes mechanisms to assess both underutilization and overutilization of services. 42 CFR §438.330(b)(3) 42 CFR §457.1240(b) Contract G.5.09	HSAG Required Evidence: • Policies and procedures • QAPI program description • QAPI workplan • Plan to assess underutilization of services • Plan to assess overutilization of services Evidence as Submitted by the PAHP: • SXIV_1_Quality Management_Quality Improvement Program_Iowa_FINAL <pg 21> • SXIV_1_QAPI Workplan_Iowa <full document> • SXIV_QAPI Workplan_Iowa_5year<full document>	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
9. <i>The QAPI program includes a process to monitor variation in practice patterns and identify outliers.</i> Contract G.5.02(c)	HSAG Required Evidence: • Policies and procedures • QAPI program description • QAPI workplan • Plan to monitor variation in practice patterns and identify outliers Evidence as Submitted by the PAHP: • SXIV_1_Quality Management_Quality Improvement Program_Iowa_FINAL <pg 21>	☒ Met ☐ Not Met

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	Supporting Documentation	Score
	- SXIV_1_QAPI Workplan_Iowa <full document> - SXIV_QAPI Workplan_Iowa_5year <full document> - SXIV_Utilization Management Program Description <pg 11> - SXIV_UM01-INS-Establishment and Adoption of Utilization Review Criteria and Clinical Guidelines <full document>	
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
10. <i>The QAPI program includes strategies designed to promote practice patterns that are consistent with evidence-based clinical practice guidelines through the use of education, technical support, and provider incentives.</i> Contract G.5.02(d)	HSAG Required Evidence: - Policies and procedures - QAPI program description - Plan to promote practice patterns (e.g., provider educational materials, technical supports, provider incentive program) Evidence as Submitted by the PAHP: - SXIV_Utilization Management Program Description <pg 11> - SXIV_UM01-INS-Establishment and Adoption of Utilization Review Criteria and Clinical Guidelines <full document>	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program

Requirement	Supporting Documentation	Score
11. The QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs, as identified by HHS in the Iowa HHS Medicaid Quality Strategy. 42 CFR §438.330(b)(4) 42 CFR §457.1240(b) Contract G.5.10	HSAG Required Evidence: • Policies and procedures • QAPI program description • QAPI work plan • Definition of members with special healthcare needs • Plan to assess members with special healthcare needs, including metrics/performance measures Evidence as Submitted by the PAHP: • SXIV_1_Quality Management_Quality Improvement Program_Iowa_FINAL <pg 15 and 18> • SXIV_1_QAPI Workplan_Iowa <full document>	☒ Met ☐ Not Met
PAHP Description of Process: HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: Although the PAHP’s policy included the definition of members with special healthcare needs, HSAG recommends that the PAHP also incorporate this definition within its QAPI program description. Required Actions: None.		
12. The QAPI program includes a system for monitoring services, including data collection and management for clinical studies, internal quality improvement activities, assessment of special needs populations, and other quality improvement activities found valuable by the PAHP or required by HHS. Contract G.5.02(g)	HSAG Required Evidence: • Policies and procedures • QAPI program description • QAPI workplan • Plan for monitoring services Evidence as Submitted by the PAHP: • SXIV_1_Quality Management_Quality Improvement Program_Iowa_FINAL <pg 12> • SXIV_1_QAPI Workplan_Iowa <full document>	☒ Met ☐ Not Met
PAHP Description of Process:		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
13. <i>The QAPI program incorporates clinical studies and use of HEDIS rate data, dental health care quality measures for Medicaid-eligible adults described in Section 1139B of the Social Security Act, using the survey tool identified by HHS, and data from other similar sources to periodically and regularly assess the quality and appropriateness of care provided to members.</i> Contract G.5.02(h)	HSAG Required Evidence: - Policies and procedures - QAPI program description - QAPI workplan - Plan to assess the quality and appropriateness of care provided to members Evidence as Submitted by the PAHP: - SXIV_1_Quality Management_Quality Improvement Program_Iowa_FINAL <pg 22> - SXIV_1_QAPI Workplan_Iowa <full document>	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
14. <i>The QAPI program includes procedures for a provider pay-for-performance program.</i> Contract G.5.02(l)	HSAG Required Evidence: - Policies and procedures - QAPI program description - Plan for provider pay-for-performance program Evidence as Submitted by the PAHP: - SXIV_1_Quality Management_Quality Improvement Program_Iowa_FINAL <full document> - SXIV_VBC04-INS-MCD-Value Based Care (1) <full document>	☒ Met ☐ Not Met
PAHP Description of Process:		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
15. <i>The QAPI program includes procedures for a member incentive program aligned with the Healthiest State Initiative and other quality outcomes to increase quality outcomes and encourage appropriate utilization of dental health services, oral hygiene practices, and education on office etiquette and what to expect at a dental visit.</i> Contract G.5.02(m) Contract G.5.03	HSAG Required Evidence: - Policies and procedures - QAPI program description - Plan for member incentive program documentation Evidence as Submitted by the PAHP: - SXIV_IA_DENTAL_CMPDT.01 <full document>	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
Performance Measurement		
16. The QAPI program includes the collection and submission of performance measurement data. The PAHP annually: - Measures and reports to HHS on its performance, using the standard measures required by HHS; - Submits to HHS data, specified by HHS, which enables HHS to calculate the PAHP's performance using the standard measures identified by HHS; or - Performs a combination of the activities described in subelements (a) and (b). 42 CFR §438.330(b)(2) 42 CFR §438.330(c) 42 CFR §457.1240(b) Contract G.5.08	HSAG Required Evidence: - Policies and procedures - QAPI program description - QAPI work plan - Deliverable grid/calendar Evidence as Submitted by the PAHP: - SXIV_1_Quality Management_Quality Improvement Program_Iowa_FINAL <full document> - SXIV_1_QAPI Workplan_Iowa <full document>	☒ Met ☐ Not Met

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	Supporting Documentation	Score
Contract G.5.18		
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: HSAG strongly recommends that the PAHP include all performance measure sets (e.g., Dental Quality Alliance [DQA], National Committee for Quality Assurance [NCQA]/Healthcare Effectiveness Data and Information Set [HEDIS®], ⁴ CMS Core Set) in its QAPI workplans to ensure adequate monitoring and oversight of performance metrics.		
Required Actions: None.		
17. <i>The QAPI program includes procedures for collecting and assuring accuracy, validity, and reliability of performance outcome rates that are consistent with best practice protocols developed in the public or private sector.</i> Contract G.5.02(k)	HSAG Required Evidence: • Policies and procedures • QAPI program description Evidence as Submitted by the PAHP: • SXIV_1_Quality Management_Quality Improvement Program_Iowa_FINAL <full document> • SXIV_1_QAPI Workplan_Iowa <full document>	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
Performance Improvement Projects		
18. The QAPI program includes performance improvement projects (PIPs). a. The PAHP conducts PIPs that focus on both clinical and nonclinical areas.	HSAG Required Evidence: • Policies and procedures • QAPI program description • QAPI work plan	☒ Met ☐ Not Met

⁴ HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	Supporting Documentation	Score
42 CFR §438.330(b)(1) 42 CFR §438.330(d)(1) 42 CFR §457.1240(b) Contract G.5.07	Project plan for developing clinical and nonclinical PIPs, including PIP topics, if known	
	Evidence as Submitted by the PAHP: - SXIV_1_Quality Management_Quality Improvement Program_Iowa_FINAL <pg 7> - SXIV_1_QAPI Workplan_Iowa <full document>	
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
19. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction, and includes the following elements: - Measurement of performance using objective quality indicators. - Implementation of interventions to achieve improvement in the access to and quality of care. - Evaluation of the effectiveness of the interventions based on the performance measures required by HHS. - Planning and initiation of activities for increasing or sustaining improvement.	HSAG Required Evidence: - Policies and procedures - QAPI program description - QAPI work plan - Project plan for developing clinical and nonclinical PIPs, including PIP topics, if known	☒ Met ☐ Not Met
42 CFR §438.330(d)(2) 42 CFR §457.1240(b) Contract G.5.19–G.5.23	Evidence as Submitted by the PAHP: - SXIV_1_Quality Management_Quality Improvement Program_Iowa_FINAL <pg 7> - SXIV_1_QAPI Workplan_Iowa <full document>	
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	Supporting Documentation	Score
20. The PAHP reports the status and results of each PIP to HHS as requested, but not less than once per year. 42 CFR §438.330(d)(3) 42 CFR §457.1240(b) Contract G.5.24	HSAG Required Evidence: • Policies and procedures • QAPI program description • QAPI work plan • Deliverable grid/calendar	☒ Met ☐ Not Met
	Evidence as Submitted by the PAHP: • SXIV_1_Quality Management_Quality Improvement Program_Iowa_FINAL<pg 7> • SXIV_1_QAPI Workplan_Iowa <full document>	
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Recommendations: HSAG strongly recommends that the PAHP include all PIPs implemented by the PAHP (e.g., PIPs required by HHS, PIPs conducted internally but not required by another entity) in its QAPI program description, workplans, and annual evaluation documents.		
Required Actions: None.		
Provider Preventable Conditions		
21. The PAHP does not make payment to a provider for provider-preventable conditions that meet the following criteria: a. Is identified in the State Plan; b. Has been found by the HHS, based upon a review of dental literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines; c. Has a negative consequence for the member; d. Is auditable; e. Includes, at a minimum: i. Wrong surgical or other invasive procedure performed on a patient;	HSAG Required Evidence: • Policies and procedures • QAPI program description • Provider materials, such as provider contract and/or provider manual • Claims processing guidelines	☒ Met ☐ Not Met
	Evidence as Submitted by the PAHP: • SXIV_1_Quality Management_Quality Improvement Program_Iowa_FINAL <full document> • SXIV_1_QAPI Workplan_Iowa <full document>	

Standard XIV—Quality Assessment and Performance Improvement Program

Requirement	Supporting Documentation	Score
ii. Surgical or other invasive procedure performed on the wrong body part; and iii. Surgical or other invasive procedure performed on the wrong patient. Pursuant to 42 CFR §447.26(c), no reduction in payment for a provider preventable condition is imposed when the condition defined as a provider preventable condition for a particular member existed prior to the initiation of treatment for that member by that provider. Reductions in provider payment may be limited to the extent that the identified provider-preventable conditions would otherwise result in an increase in payment; and the PAHP can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions. 42 CFR §438.3(g) 42 CFR § 447.26(b) Contract F.7.01		
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
22. The PAHP requires all providers to report provider-preventable conditions associated with claims for payment or member treatments for which payment would otherwise be made. 42 CFR 438.3(g) 42 CFR 434.6(a)(12) Contract F.7.02	HSAG Required Evidence: • Policies and procedures • QAPI program description • Provider materials, such as provider contract and/or provider manual Evidence as Submitted by the PAHP: • SXIV_2026.02.26 DRAFT Provider Agreement FQHC <pg 16> • SXIV_230206 IA MA MC HIX Provider Agreement pg 16	☒ Met ☐ Not Met

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	Supporting Documentation	Score
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
23. The PAHP reports all identified provider-preventable conditions in a form or frequency as specified by HHS. 42 CFR 438.3(g) Contract F.7.03	HSAG Required Evidence: • Policies and procedures • Deliverable grid/calendar Evidence as Submitted by the PAHP: • SXIV_2026.02.26 DRAFT Provider Agreement FQHC <pg 16> • SXIV_230206 IA MA MC HIX Provider Agreement <pg 16>	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Recommendations: HSAG strongly recommends that the PAHP prioritize its collaboration with HHS to finalize its procedure and the schedule for reporting all identified provider-preventable conditions prior to July 1, 2026.		
Required Actions: None.		
Member Experience		
24. The QAPI program includes procedures to assess member satisfaction. Contract G.5.02(n)	HSAG Required Evidence: • Policies and procedures • QAPI program description • QAPI workplan • Plan to assess member satisfaction Evidence as Submitted by the PAHP:	☒ Met ☐ Not Met

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	Supporting Documentation	Score
	- SXIV_1_Quality Management_Quality Improvement Program_Iowa_FINAL <pg 24> - SXIV_1_QAPI Workplan_Iowa <full document>	
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
Value-Based Purchasing Programs		
25. <i>The PAHP identifies the goals it has set to address its strategy for improving the delivery of dental health care benefits and services to its members via value-based purchasing (VBP) programs.</i> a. <i>The PAHP identifies the steps to be taken including a timeline with target dates and providing reporting on such timelines and targets consistent with the obligations in the Reporting Manual.</i> b. <i>The PAHP's VBP programs align with Iowa HHS Medicaid Quality Strategy, including specific detail for the value-based purchasing requirements described in Contract Section E.8 and C.6.02–C.6.05.</i> Contract C.6.02-C.6.05 Contract G.5.27	HSAG Required Evidence: - Policies and procedures - QAPI program description - QAPI workplan - Plan for VBP program(s) Evidence as Submitted by the PAHP: - SXIV_1_Quality Management_Quality Improvement Program_Iowa_FINAL <full document> - SXIV_1_QAPI Workplan_Iowa <full document> - SXIV_VBC04-INS-MCD-Value Based Care (1) <full document>	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program

Requirement	Supporting Documentation	Score
QAPI Program Reviews, Analysis, and Evaluation		
26. The PAHP develops a process to evaluate the impact and effectiveness of its QAPI Program. The QAPI program evaluation includes: - The performance on the measures on which it is required to report. - The outcomes and trended results of each PIP. 42 CFR §438.330(e) 42 CFR §457.1240(b) Contract G.5.26	HSAG Required Evidence: - Policies and procedures - QAPI program description - QAPI work plan - Plan/process to develop the QAPI evaluation - QAPI evaluation template Evidence as Submitted by the PAHP: - SXIV_1_Quality Management_Quality Improvement Program_Iowa_FINAL <pg 7> - SXIV_1_QAPI Workplan_Iowa <full document>	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
Organizational Structure and Staffing		
27. <i>The PAHP has in place an organizational and operational structure capable of fulfilling all Contract requirements. This structure supports collection and integration of data across the PAHP's delivery system and internal functional units to accurately report the PAHP's performance. The PAHP has in place sufficient administrative and clinical staff and organizational components to achieve compliance with all Contract requirements and performance standards. The PAHP manages the functional linkage of the following major operational areas:</i> <i>Administrative and fiscal management;</i> <i>Member services;</i>	HSAG Required Evidence: - Policies and procedures - Organizational chart(s) - Committee structure and charters - Implementation Plan (as requested via the Questionnaire) Evidence as Submitted by the PAHP: "SXIV_1_Quality Management_Quality Improvement Program_Iowa_FINAL <full document> - SXIV_1_QAPI Workplan_Iowa <full document>	☒ Met ☐ Not Met

Standard XIV—Quality Assessment and Performance Improvement Program

Requirement	Supporting Documentation	Score
c. <i>Provider services;</i> d. <i>Care Coordination;</i> e. <i>Marketing;</i> f. <i>Provider enrollment;</i> g. <i>Network development and management;</i> h. <i>Quality management and improvement;</i> i. <i>Utilization and care management;</i> j. <i>Member health and outcomes;</i> k. <i>Information systems;</i> l. <i>Performance data reporting and encounter claims submission;</i> m. <i>Claims payments; and</i> n. <i>Grievances and appeals.</i> Contract A.03	• SXIV_Quality Improvement Organizational Chart_Iowa <full document>	
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. However, please refer to additional findings related to staffing requirements in Element 28 of this standard. Of note, although the evidence submitted did not fully address all components of this element, HSAG used the PAHP’s updated <i>Iowa Personnel Organizational Structure</i> and HSAG’s interpretation of the departmental functions within this document to determine compliance.		
Required Actions: None.		
28. <i>The PAHP provides an initial operational staffing plan to HHS following the requirements in Section A of the Contract. In its staffing plan, the PAHP:</i> a. <i>Ensures that staff delivering in-person services are based in Iowa as appropriate.</i> b. <i>Includes no less than the staffing areas suggestion in Table 1 under Contract Section A.07.</i> c. <i>Encourages a local presence in Iowa, particularly in relation to the delivery of member and provider services.</i> d. <i>Includes key personnel positions included on the Staffing Checklist.</i>	HSAG Required Evidence: • Policies and procedures • Job descriptions for all personnel defined in the Staffing Checklist • Operational Staffing Plan (as requested via the Questionnaire) • Resume for all key personnel • HSAG will also use the results of the Staffing Checklist	☐ Met ☒ Not Met
	Evidence as Submitted by the PAHP:	

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	Supporting Documentation	Score
e. <i>Includes a resume for each key personnel member.</i> f. <i>Describes what functions are proposed to be conducted outside of Iowa and how out-of-State staff will be supervised to ensure compliance with Contract requirements.</i> g. <i>Has more than 50 percent of all work under the Contract in each functional area performed locally in Iowa, with less than 50 percent of all work performed under the Contract performed by PAHP's other corporate locations, unless otherwise approved by HHS.</i> h. <i>Onboards in excess of 50 percent of local staff in each functional area of contract performance within 120 days of contract execution.</i> Contract A.04-A.07 Contract A.11 Contract A.14	• SXIV_IA Staffing Plan <full document> • SXIV_Iowa Key Personnel Resumes <full document> • SXIV_DentaQuest Iowa Office <full document>	
PAHP Description of Process:		
HSAG Findings: HSAG's review identified the findings below: • The PAHP did not demonstrate adequate staffing to ensure a local presence in Iowa, including a sufficient percentage of staff in each functional area to meet the requirements under sub-element (g). For example, the updated staffing plan indicated a total of seven Contract Center Representatives who are responsible for both member and provider calls. Based on the expected call volume, it is not clear how the PAHP will effectively respond to member and provider calls. Additionally, as the management positions for member and provider services are separate positions (i.e., Member Services Manager and Provider Services Director) and both positions are not located in Iowa, it is unclear how the PAHP will effectively oversee staff members responsible for member and provider support. • The PAHP provided the <i>Iowa Key Personnel Resumes</i> and the <i>IA Staffing Plan</i> Microsoft Excel (Excel) workbook; however, the <i>IA Staffing Plan</i> Excel workbook only included the "Inclusions in Staffing Plan," listed verbatim from HHS' contract in column D, which did not provide clarity on the qualifications needed for the key personnel for the PAHP program. • The rows in the <i>IA Staffing Plan</i> Excel workbook that correlated with Requirements 16–24 of HSAG's <i>Staffing Checklist</i> did not align the positions with the required responsibilities (e.g., responds to member inquiries via a member services helpline as well as written and electronic correspondence; ensures timely and accurate processing of claims; responds to provider inquiries and disputes; and provides outreach on provider policies and procedures). • The PAHP did not provide job postings as requested to confirm that existing staff and staff to be hired have the appropriate qualifications to fulfill the role(s) for the key personnel positions.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	Supporting Documentation	Score
Please refer to HSAG Findings, Recommendations, and Required Actions (as applicable to staffing requirements) as noted within other Standard tools (e.g., refer to Standard VII regarding Requirements 3 and 8 of HSAG’s <i>Staffing Checklist</i>).		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must have an adequate staffing plan and sufficient documentation that: - Ensures that staff delivering in-person services are based in Iowa as appropriate. - Includes a sufficient number of staffing in each functional area to comply with Contract Section A.07. - Encourages a local presence in Iowa, particularly in relation to the delivery of member and provider services. - Includes a resume for each key personnel member that demonstrates appropriate qualifications for the filled roles. - Has more than 50 percent of all work under the Contract in each functional area performed locally in Iowa, with less than 50 percent of all work performed under the Contract performed by the PAHP’s other corporate locations, unless otherwise approved by HHS. - Onboards in excess of 50 percent of local staff in each functional area of contract performance within 120 days of contract execution.		
29. <i>The PAHP’s staffing plan includes a backup personnel plan, including a discussion of the staffing contingency plan for:</i> <i>The process for replacement of personnel in the event of a loss of key personnel or others before or after signing the Contract.</i> <i>Allocation of additional resources to the Contract in the event of an inability to meet a performance standard.</i> <i>Replacement of staff with key qualifications and experience and new staff with similar qualifications and experience.</i> <i>The time frame necessary for obtaining replacements.</i> <i>The method of bringing replacements or additions up to date regarding the Contract.</i> Contract A.07(d)	HSAG Required Evidence: - Policies and procedures - Operational Staffing Plan (as requested via the Questionnaire) Evidence as Submitted by the PAHP: - SXIV_IA Staffing Plan <full document>	☐ Met ☒ Not Met
PAHP Description of Process: In the event of a loss or vacancy of Key Personnel, DentaQuest will promptly assign a qualified internal employee to assume the responsibilities of the role on an interim basis, ensuring continuity of operations. The recruitment and replacement process may take up to eight weeks to allow sufficient time to identify and secure the most qualified candidate. Once onboarded, the new Key Staff member will receive comprehensive role-specific training from a designated Subject Matter Expert (SME) within the department to ensure full alignment with contract requirements, operational processes, and performance expectations.		

Standard XIV—Quality Assessment and Performance Improvement Program

Requirement	Supporting Documentation	Score
HSAG Findings: The PAHP provided the <i>IA Staffing Plan</i> Excel spreadsheet, which did not include information related to a backup personnel plan. While the PAHP did include a short description of its process within the <i>PAHP Description of Process</i> for this element, HSAG did not receive policies and procedures and/or a contingency plan. During the review, HSAG requested that the PAHP include a backup plan within a policy and procedure and/or a workplan; however, this was not provided as a follow-up item. Instead, the PAHP provided a <i>DentaQuest- Iowa Staffing Plan- 3.25.2026</i> spreadsheet and <i>DentaQuest- Iowa Personnel Organizational Structure- 03.25.2026 I</i>, which did not satisfy the intent of this element. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Provide a backup personnel plan that addresses all components under Contract A.07(d).		
30. <i>The PAHP provides initial and ongoing training and ensures all staff are trained in the areas listed in the Staff Training Checklist.</i> a. <i>The PAHP maintains documentation to confirm staff training, curriculum, schedules, and attendance.</i> Contract A.13	HSAG Required Evidence: - Policies and procedures - Staff training tracking mechanisms - Staff Training Plan (as requested via the Questionnaire) - HSAG will also use the results of the Staff Training Checklist Evidence as Submitted by the PAHP: - SXIV_COM07-ENT - Training and Education <Page 1> - SXIV_2025 DQ Compliance Training Completion Status Report (sample) <Pages 1-2>	☐ Met ☒ Not Met
PAHP Description of Process: HSAG Findings: While the PAHP provided some training materials and the <i>DentaQuest SOP_Iowa Medicaid CHIP Training Requirements_03.31.2026</i> SOP, these materials and the SOP did not provide specific details on the PAHP’s plan to ensure all applicable staff receive education and training to ensure compliance with all program-related requirements. The SOP only indicated that “[a]ll staff and subcontracted staff must complete training that includes, but not limited to:…Iowa Medicaid and CHIP Contract components [and] Iowa-specific providers and non-Medicaid Resources.” Additionally, HSAG noted the following deficiencies: Requirement #7 required the PAHP to provide “[t]raining regarding interpretation and application of UM guidelines for all UM staff”; however, the PAHP provided a <i>UM Initial and Ongoing Training Clinical Criteria</i> document that only contained two brief paragraphs on the “Inter-Rater Reliability Program” and “New Hire Training,” as well as a <i>Sample Clinical Training Materials</i> PowerPoint slide deck, which did not include Iowa-specific training for the UM staff. However, the PAHP confirmed that staff training materials will not be available until May 2026 as reported under Standard VII and the <i>Post-Site Review Tracker</i>.		

Standard XIV—Quality Assessment and Performance Improvement Program

Requirement	Supporting Documentation	Score
- Requirement #8 required the PAHP to provide “[t]raining and education to understand abuse, neglect, exploitation, and prevention including the detection, mandatory reporting, investigation, and remediation procedures and requirements.” While the <i>2025 Abuse-Neglect-Exploitation Training Final</i> PowerPoint deck included training and education to understand abuse, neglect, and exploitation, HSAG found a brief procedure list on page 20 that included: “1. Staff identifies a potential critical incident. This could be on a call, patient visit or any other type of interaction. 2. Staff notifies their Supervisor/Manager of the nature of the incident. 3. Supervisor/Manager will contact the appropriate Client Services Partner. Depending on the specific details of the incident, the Client, local authorities, etc., may be contacted. 4. If an immediate threat is made to DentaQuest and/or its employees, HR will be notified and potentially the appropriate authorities.” However, HSAG expected to see a workflow and/or procedure to document the steps that the staff member would take to report and investigate, and remediate abuse, neglect, and exploitation similar to what the PAHP provided for Requirement #2 (i.e., <i>Initial training - CGA – Quality of Care_Critical Incidents_Site visits</i> document), which outlined the process to create and investigate quality of care issues. During the review, HSAG requested the PAHP to provide a procedure document; however, the PAHP submitted the <i>DentaQuest SOP_Iowa Medicaid CHIP Training Requirements_03.31.2026</i> SOP, which only included “[a]buse, neglect, and exploitation prevention (including detection, mandatory reporting, investigation, and remediation)” with no additional details such as a procedure document. - Requirement #9 required the PAHP to provide “[t]raining specific to Iowa providers and non-Medicaid resources”; however, the PAHP provided the <i>NET03-INS-Provider Partner Staffing and Training-FINAL</i> policy and procedure, which was labeled as “All States” and “All lines of business” and did not include a specific Iowa Exhibit or Addendum. During the review, HSAG requested specific training and/or an Iowa Exhibit or Addendum for its Iowa providers; however, this was not provided after the review.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Provide an adequate training plan and documentation that addresses all operational program areas, including expected completion dates for department-specific trainings. - Refer to <i>HSAG Findings</i> within each Standard tool, as applicable, to address any program-related findings related to training. Of note, the PAHP will be required to attest that all training materials are Iowa-specific and will be provided to all hired staff prior to July 1, 2026, through a follow-up session that will occur with HSAG. Any failure to demonstrate sufficient training may result in a <i>Not Ready</i> status.		
Accreditation		
31. <i>The PAHP attains and maintains accreditation from the National Committee for Quality Assurance (NCQA).</i> a. <i>If not already accredited, the PAHP demonstrates it has initiated the accreditation process as of the Contract effective date.</i> b. <i>The PAHP achieves accreditation at the earliest date allowed by NCQA.</i>	HSAG Required Evidence: Proof of accreditation or plan/timeline for obtaining accreditation	☒ Met ☐ Not Met
	Evidence as Submitted by the PAHP: SXIV_NCQA Accreditations <full document>	

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	Supporting Documentation	Score
c. <i>Accreditation is maintained throughout the life of the Contract at no additional cost to HHS.</i> d. <i>When accreditation standards conflict with the standards set forth in the Contract, the Contract prevails unless the accreditation standard is more stringent.</i> Contract G.7.03		
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
Maintenance and Retention of Records		
32. <i>The PAHP maintains a medical records system that:</i> a. <i>Identifies each medical record by State identification (ID) number.</i> b. <i>Identifies the location of every medical record.</i> c. <i>Places medical records in a given order and location.</i> d. <i>Maintains the confidentiality of medical records information and releases the information only in accordance with applicable law.</i> e. <i>Maintains inactive medical records in a specific place.</i> f. <i>Permits effective professional review in medical audit processes.</i> g. <i>Facilitates an adequate system for follow-up treatment including monitoring and follow-up of off-site referrals and inpatient stays.</i> Contract G.2.32	HSAG Required Evidence: • Policies and procedures • Screenshot of where State ID number maintained • HSAG will use the results of the systems demonstration Evidence as Submitted by the PAHP: • SXIV_IA2024_PAHP_RR_Std_XIV_Subscriber Number <full document> • SXIV_ENR01-INS-Member Enrollment <full document>	☒ Met ☐ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program						
Met	=	29	X	1	=	29
Not Met	=	3	X	0	=	0
Total	=	32	Total Score		=	29
Total Score ÷ Total					=	91%

Standard XV—Program Integrity

Standard XV—Program Integrity		
Requirement	Supporting Documentation	Score
Certification		
1. Documentation or information the PAHP submits to HHS is certified by the PAHP’s Chief Executive Officer (CEO); Chief Financial Officer (CFO); or an individual who reports directly to the CEO or CFO with delegated authority to sign for the CEO or CFO so that the CEO or CFO is ultimately responsible for the certification. a. The certification provided by the individual must attest that, based on best information, knowledge, and belief, the data, documentation, and information specified in §438.604 is accurate, complete, and truthful. b. The PAHP submits the certification concurrently with the submission of the data, documentation, or information required in 42 CFR §438.604(a) and (b). 42 CFR §438.604(a-b) 42 CFR §438.606 42 CFR §457.1201(o) Contract I.2.11 Contract I.5.06	HSAG Required Evidence: • Policies and procedures to certify the data specified in 42 CFR §438.604, and under Sections I.2.01–I.2.09 and I.5.02–I.5.05 of the Contract • Position and job description of individual responsible for certification • Certification template(s) Evidence as Submitted by the PAHP: • SXV_COM08-ENT-Annual Attestation Policy (2) Page 3 Exhibit A • SXV_JD VP Dental Risk and Compliance 2026 Pages 1-4 • SXV_VP & CFO JD 2026 • SXV_CERTIFICATION TEMPLATE (Draft) Page 1	☒ Met ☐ Not Met
PAHP Description of Process: NA		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		

Standard XV—Program Integrity		
Requirement	Supporting Documentation	Score
Compliance Program/Program Integrity Plan		
2. The PAHP develops a compliance program that includes: - Written policies, procedures, and standards of conduct that articulate the PAHP or subcontractor’s commitment to comply with all applicable requirements and standards under the Contract, and all applicable Federal and State requirements. - The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Contract and who reports directly to the CEO and the board of directors. - The establishment of a Regulatory Compliance Committee on the board of directors and at the senior management level charged with overseeing the organization’s compliance program and its compliance with the requirements under the Contract. - A system for training and education for the Compliance Officer, the organization’s senior management, and the organization’s employees, for the Federal and State standards and requirements under the Contract. - Effective lines of communication between the Compliance Officer and the organization’s employees. - Enforcement of standards through well-publicized disciplinary guidelines. - Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of	HSAG Required Evidence: - Policies and procedures - Program Integrity Compliance Plan - Program Integrity Annual Work Plan - Compliance program description - Annual compliance work plan - Compliance Officer job description - Organizational chart - Regulatory Compliance Committee charter - Regulatory Compliance Committee description of responsibilities - Compliance training plan, including required attendees and timing of training - Compliance training materials - Training tracking mechanisms - Communication protocol and mechanisms for reporting Compliance issues (e.g., hotline) - Examples of planned forms of information exchange to maintain open lines of communication (e.g., emails, newsletters, suggestion boxes) - Code of Ethics - Employee attestation template - Potential employees and employee monitoring process (e.g., background checks, employee sanction checks) - Audit and monitoring plan - Corrective action plan (CAP) template - Auditor job description - Staffing plan	☒ Met ☐ Not Met

Standard XV—Program Integrity		
Requirement	Supporting Documentation	Score
suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the Contract. h. <i>Preparing an annual compliance plan on the date identified by HHS, including the information requested and identified in the most current “Program Integrity (PI) Compliance Plan” template.</i> i. <i>Preparing an annual workplan on the date identified by HHS, including the information requested and identified in the most current “PI Annual Work Plan” template.</i> j. <i>Complying with annual, quarterly, and monthly requirements outlined under Contract section I.5.02 – I.5.05.</i> 42 CFR §438.608(a)(1) Contract I.5.01(a-i) Contract I.5.02–I.5.05	• Risk assessment template • Questionnaire template for exiting employees • HSAG will also use findings from the Compliance Reporting/Tracking system demonstration Evidence as Submitted by the PAHP: • SXV_COM01-ENT-Policy Management and Control <Pages 1-3> • SXV_COM03-ENT Availability of Code of Conduct Standards <pages 1-2> • SXV_COM05-ENT-Compliance Officer; Corporate Compliance Committee <Pg 1.> • SXV_COM06-ENT Compliance Monitoring and Communication <Page 1-4> • SXV_COM07-ENT Training and Education <Page 2-4> • SXV_COM09-ENT Duty to Report Noncompliance, Non-Retaliation <Pages 1-4> • SXV_COM12-ENT- OIG-GSA <Pages 1-3> • SXV_COM13-ENT Compliance Investigation <Pages 1-6> • SXV_COM14-ENT Enforcement & Discipline <pages 1-2> • SXV_COM16-ENT-Corrective Action Plans <Page 2-3> • SXV_HRDQ1-ENT - Background Checks_Redacted <Pages 1-2> 2024 • SXV_2024 Code of Conduct Annual Training & Declaration<Pages 5, and 10-11> • SXV_Compliance Program Overview 2-8 • SXV_Program Integrity Compliance Plan (Template) • SXV_2026 Iowa Compliance Work Plan Template Pages 1-2 • SXV_JD VP Dental Risk and Compliance 2026 (Pages 1-4) • SXV_Compliance Org Chart 2026	

Standard XV—Program Integrity		
Requirement	Supporting Documentation	Score
	- SXV_Compliance Committee Charter Pages <1-4>(entire Document) - SXV_2025 General Compliance and FWA Training <PG 32> - SIX_2025 DQ Compliance Training Completion Status Report (sample) Page 1 - SXV_IA Staffing Plan - SXV_COM06-ENT-SOP-Risk Management, Auditing and Monitoring Pages 1-3 - SXV-CAP Form Template Page 1 - SXV_Internal Audit Specialist Pages 1-2 - SXV_Exit Questionnaire (1) (Template) Pages 1-3	
PAHP Description of Process: DentaQuest is currently in the planning phase of developing an annual Compliance Program Effectiveness Survey that will be administered to all employees. The survey will incorporate the same compliance-focused elements reflected in the attached questionnaire template, including awareness, reporting comfort, and risk identification. Although not yet implemented, this tool is being designed to meet HSAG expectations for assessing compliance program effectiveness across the organization. Information pertaining to Denta Quest’s Compliance training plan, including required attendees and timing of training can be found in COM07-ENT Training and Education.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: HSAG strongly recommends that the PAHP implement the following: - Review all documents for formatting and typographical errors (e.g., page numbers on the <i>Iowa Compliance Program Overview</i>). - After the PAHP receives program integrity training from HHS, as applicable, update and finalize the <i>Iowa Program Integrity (PI) Compliance Plan</i> and <i>PI Annual Work Plan</i>. - Revise the <i>Iowa Compliance Officer; Corporate Compliance Committee</i> policy, <i>COM05.01-ENT</i>, to differentiate between the Head of Risk Management, Ethics & Compliance and Iowa Chief Compliance and Privacy Officer as the policy indicates that both positions are the “Compliance Officer,” making it impossible for HSAG to distinguish the responsibilities of the Iowa-based Iowa Chief Compliance and Privacy Officer from those of the Head of Risk Management, Ethics & Compliance, or whether these are the same position. - Ensure that the Iowa Compliance Officer, and other Iowa designated staff members as appropriate (e.g., Chief Executive Officer, Chief Operations Officer), are included on all program integrity-related committees (e.g., Corporate Compliance Committee) to ensure Iowa-specific issues are discussed,		

Standard XV—Program Integrity		
Requirement	Supporting Documentation	Score
and that the Iowa-specific compliance officer is identified within Iowa-specific program integrity materials, including training documentation and within the compliance plan.		
Required Actions: None.		
Overpayments and Treatment of Recoveries		
3. The PAHP implements and maintains arrangements or procedures for the prompt reporting of all overpayments identified or recovered within 30 calendar days, specifying the overpayments due to potential fraud, to HHS. 42 CFR §438.608(a)(2) Contract I.5.02	HSAG Required Evidence: • Policies and procedures, including timeline for prompt reporting of overpayments • Provider notice workflow • Special investigations unit (SIU) workflows • Identification mechanisms • Reporting template/mechanism to ensure timeliness • Provider materials, such as the provider manual and provider contract • Staff training materials Evidence as Submitted by the PAHP: • Submitted: FPR02-INS-DENT -Extrapolation of Overpayment Pages 1-3 • SXV_CL02-INS-Claims Payment (2)_Redacted - Pages 4-6 Section D • SXV_IA Provider Agreement (Template)_Redacted Page 5 • SXV_2025 General Compliance and FWA Training (entire training)	☒ Met ☐ Not Met
PAHP Description of Process: DentaQuest has been informed that Program Integrity (PI) training with the state is scheduled to begin in May. At this time, DentaQuest does not have access to the reporting manual or the reporting templates for this section, as these materials are expected to be provided and discussed during the training.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		

Standard XV—Program Integrity		
Requirement	Supporting Documentation	Score
Recommendations: HSAG strongly recommends that the PAHP develop a tracking and reporting mechanism to monitor adherence to the 30-day time frame standard.		
Required Actions: None.		
4. The PAHP follows the retention policies for the treatment of recoveries of all overpayments from the PAHP to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse. a. The PAHP complies with the process, timeframes, and documentation required by HHS for reporting the recovery of all overpayments. b. The PAHP complies with the process, timeframes, and documentation HHS requires for payment of recoveries of overpayments to HHS in situations where the PAHP is not permitted to retain some or all of the recoveries of overpayments. c. This provision does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations. d. <i>The PAHP initiates administrative action and recovers improper payments or overpayments related to claims paid by the PAHP within 24 months from the date the claim was paid or the date any applicable reconciliation, whichever is later.</i> i. <i>Except for overpayments identified under a credible allegation of fraud, the PAHP confers with HHS before pursuing overpayment recoveries for claims where more than 24 months have passed since the claims were paid or adjudicated. The PAHP does not subject these claims to repayment or offset against future claim reimbursements without prior consent from HHS.</i> <i>For payment disputes and requesting HHS' review:</i>	HSAG Required Evidence: - Policies and procedures, including method and timeline for prompt reporting of overpayments - Recovery process workflow, including outreach procedures (e.g., process to obtain approval from HHS as applicable) - Overpayment reporting template(s) - Recovery template(s) - Annual PI Report template - Overpayment tracking mechanisms - Provider materials, such as the provider manual and provider contract - Template/mechanism for developing a report of recoveries of overpayments to State - Plan for collaborating with HHS in the creation of standard operation procedures for payment disputes and requesting HHS' review - Staff training materials Evidence as Submitted by the PAHP: - SXV_COM10-ENT-False Claims Act Information (1)_Redacted <Pages 1–4> - SXV_CL02-INS-Claims Payment (2)_Redacted <Pgs 4-6, Section D> - SXV_FPR01-INS-DENT-FPR Program-FINAL 2018_Redacted<Pages 1–8> - SXV_FPR04-INS Fraud Detection (redacted) <Pages 1–3> - SXV_PEC04-INS-Provider Maintenance and Ongoing Monitoring <Pages 3–6>	☒ Met ☐ Not Met

Standard XV—Program Integrity		
Requirement	Supporting Documentation	Score
– <i>Should a provider ask HHS to review the PAHP’s post-payment activity once the provider has exhausted the PAHP’s dispute or grievance process, the PAHP cooperates with HHS by providing information that supports the recovery activity. If HHS, in the review of information from the provider and the PAHP, finds evidence of erroneous findings by the PAHP, HHS will instruct the PAHP to amend or overturn the provider’s dispute and reimburse the provider any funds that have been recovered.</i> – <i>The PAHP collaborates with HHS in the creation of standard operation procedures for this process. If the PAHP’s decision is amended or overturned, HHS may require the PAHP to waive timely filing requirements and allow the provider to reprocess the claim for payment.</i> e. <i>Except as otherwise provided in the Contract, the PAHP may recoup and retain overpayments attributable to claims paid by the PAHP.</i> f. <i>Where a provider overpayment owed to the PAHP is recovered by the Recovery Audit Contractor (RAC), HHS, or the federal government, by any means, including, but not limited to false claims act lawsuits and investigations or any other State or federal action or investigation, the PAHP is not entitled to recoup, retain, or be reimbursed for any such overpayment. HHS determines, in its sole discretion, if any portion of the recovered payment over which HHS has authority will be returned to the PAHP.</i> 42 CFR §438.608(d)(1) 42 CFR §438.608(d)(3)	• SXV_COM12-ENT-OIG-GSA Exclusion Review <Pages 1–4> • SXV_CL02-INS-SOP Member Verification of Services (1) Redacted <Pages 1–2> • SXV_TIP FORM — Potential Provider Fraud or Abuse Referral Pages 1-2 • SXV_IA Provider Agreement 2-6 > • SXV_FPRU Current Org Chart_2026 <Page 1> • SXV_2025 General Compliance & FWA Training <Pages 2–7, 9–15, 30–33 and 36>	

Standard XV—Program Integrity		
Requirement	Supporting Documentation	Score
Contract I.8.01–I.8.05		
PAHP Description of Process: DentaQuest has been informed that Program Integrity (PI) training with the state is scheduled to begin in May. At this time, DentaQuest does not have access to the reporting manual or the reporting templates for this section, as these materials are expected to be provided and discussed during the training.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: HSAG strongly recommends that the PAHP include language verbatim within its <i>FPR01-INS-DENT</i> policy (e.g., under Exhibit S) to expand upon the requirement under sub-element (e).		
Required Actions: None.		
5. The PAHP requires and has a mechanism for a network provider to report to the PAHP when it has received an overpayment, to return the overpayment to the PAHP within 60 calendar days after the date on which the overpayment was identified, and to notify the PAHP in writing of the reason for the overpayment. 42 CFR §438.608(d)(2) Contract I.10.01	HSAG Required Evidence: • Policies and procedures • Overpayment and monitoring mechanisms • Provider materials, such as the provider manual and provider contract • Staff training materials Evidence as Submitted by the PAHP: • SXV_CL02-INS-Claims Payment (2)_Redacted – <Page 4-6 Section D> • SXV_FPR01-INS-DENT-FPR Program-FINAL 2018_Redacted Pages 1–8 • SXV_FPR04-INS Pages 1–3 • SXV_Iowa Provider Office Reference Manual Page 29 section 7.14	☒ Met ☐ Not Met
PAHP Description of Process: NA		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: HSAG strongly recommends that the PAHP establish a tracking and monitoring mechanism to demonstrate timeliness as related to the requirements of this element, such as when the overpayment was identified and when the overpayment was received by the PAHP.		

Standard XV—Program Integrity		
Requirement	Supporting Documentation	Score
Required Actions: None.		
Notification of Member and Provider Changes		
6. The PAHP (or subcontractor, to the extent that the subcontractor is delegated responsibility by the PAHP for coverage of services and payment of claims under the Contract between HHS and the PAHP) implements and maintains arrangements or procedures for prompt notification to HHS when it receives information about changes in a member’s circumstances that may affect the member’s eligibility, including all of the following: a. Changes in the member’s residence; b. The death of a member. 42 CFR §438.608(a)(3) Contract I.11.03	HSAG Required Evidence: • Policies and procedures • Reporting workflow • Reporting template(s) • Staff training materials Evidence as Submitted by the PAHP: • SXV_CS10.01-INS-SOP Change in Enrollee Circumstances Pages 1-2	☒ Met ☐ Not Met
PAHP Description of Process: NA		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: HSAG strongly recommends that the PAHP develop a tracking and reporting mechanism to monitor adherence to the “prompt notification” time frame standard. HSAG also recommends that the PAHP consult with HHS to determine the definition of “prompt” and revise the PAHP’s policies, procedures, and workflows, etc., where applicable.		
Required Actions: None.		
7. The PAHP (or subcontractor, to the extent that the subcontractor is delegated responsibility by the PAHP for coverage of services and payment of claims under the Contract between HHS and the PAHP) implements and maintains arrangements or procedures for notification to HHS when it receives information about a change in a network provider’s circumstances that may affect the network	HSAG Required Evidence: • Policies and procedures • Reporting workflow • Reporting template(s) • Staff training materials Evidence as Submitted by the PAHP:	☒ Met ☐ Not Met

Standard XV—Program Integrity		
Requirement	Supporting Documentation	Score
provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the PAHP. 42 CFR §438.608(a)(4) Contract I.11.04	- SXV_PEC05-INS-Provider Disciplinary Action CAP and Appeal Policy-FINAL_Redacted pages 1–4 - SXV_PEC04-INS-Provider Maintenance and Ongoing Monitoring pages 1–6	
PAHP Description of Process: DentaQuest has been informed that Program Integrity (PI) training with the state is scheduled to begin in May. At this time, DentaQuest does not have access to the reporting manual or the reporting templates for this section, as these materials are expected to be provided and discussed during the training.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: HSAG strongly recommends that the PAHP establish a tracking and monitoring mechanism when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the PAHP. HSAG also recommends that the PAHP consult with HHS regarding the timeliness expectation for this element and revise its policies, procedures, and workflows, etc., where applicable. HSAG further recommends that the PAHP ensure its tracking and monitoring mechanism can demonstrate adherence with HHS' timeliness expectation.		
Required Actions: None.		
Verification of Services Provided		
8. The PAHP (or subcontractor, to the extent that the subcontractor is delegated responsibility by the PAHP for coverage of services and payment of claims under the Contract between HHS and the PAHP) implements and maintains arrangements or procedures for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by members and the application of such verification processes on a regular basis. 42 CFR §438.608(a)(5) Contract I.12.01	HSAG Required Evidence: - Policies and procedures - Plan to initiate verification of services activities - Methodology for verification of services - Member explanation of benefits (EOB) template - SXV_DQ Sample EOB_Overpayment- Pages 1-5 - Tracking mechanism, including fraud allegations reported by members - Staff training materials Evidence as Submitted by the PAHP: - SXV_CL02-INS-SOP Member Verification of Services Pages 1–2	☒ Met ☐ Not Met

Standard XV—Program Integrity		
Requirement	Supporting Documentation	Score
	- SXV_FPR01-INS-DENT-FPR Program-FINAL 2018_Redacted Pages 1–8 - SXV_FPR04-INS – Fraud Detection Pages 1–3 - SXV-CORR-02-INS (EOB) 2025 General Compliance & FWA Training Pages 3, 12l 13-15, 30, 32, and 66-69	
PAHP Description of Process: DentaQuest has been informed that Program Integrity (PI) training with the state is scheduled to begin in May. At this time, DentaQuest does not have access to the reporting manual or the reporting templates for this section, as these materials are expected to be provided and discussed during the training.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
Whistleblower Protection		
9. In the case of PAHPs that make or receive annual payments under the contract of at least \$5,000,000, the PAHP (or subcontractor, to the extent that the subcontractor is delegated responsibility by the PAHP for coverage of services and payment of claims under the Contract between HHS and the PAHP) implements and maintains arrangements or procedures, written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers. 42 CFR §438.608(a)(6) Contract I.12.04	HSAG Required Evidence: - Policies and procedures - Program integrity/compliance plan - Fraud, waste, and abuse plan (if separate from compliance plan) - Annual compliance work plan - Employee handbook - Employee, provider, and subcontractor training/informational materials Evidence as Submitted by the PAHP: - SXV_COM10-ENT -False Claims Act Information Pages 1–4 - SXV_COM07-ENT -Training and Education Pages 2-4 - SXV_2024 Code of Conduct Annual Training & Declaration 6 & 18	☒ Met ☐ Not Met

Standard XV—Program Integrity		
Requirement	Supporting Documentation	Score
	- SXV_2026 General Compliance & FWA Training Pages 30–33 - SXV_Compliance Program Overview Pages 2-5 and 8 - SXV_Program Integrity / Compliance Plan Pages 1-4 and 7-9 - SXV_2026 Fraud and Abuse Compliance Plan Pages 1-15 (Entire Document) - SXV_2026 Iowa Compliance Work Plan Template Pages 1-2 - SXV_Iowa Program Integrity Annual Work Plan (Template) - SXV_SL_US_Employee Handbook Page 49 - SXV_2025 General Compliance Training FWA Training Final Pages 3, 12l 13-15, 30, 32, and 66-69	
PAHP Description of Process: NA		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: HSAG strongly recommends that the PAHP develop a tracking and reporting mechanism ensuring that all employees of the PAHP, and of any contractor or agent, comply with this requirement. An example of a reporting mechanism may be an annual attestation from the provider(s), subcontractor(s), or vendor(s), who make or receive annual payments of at least \$5,000,000 under the contract, confirming the development, implementation, and maintenance of procedures, such as trainings, and written policies for all employees that include detailed information about the False Claims Act and other federal and State laws described in Section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers.		
Required Actions: None.		
Fraud, Waste, and Abuse		
10. The PAHP (or subcontractor, to the extent that the subcontractor is delegated responsibility by the PAHP for coverage of services and payment of claims under the Contract between HHS and the PAHP) implements and maintains arrangements or procedures: a. That are designed to detect and prevent fraud, waste, and abuse.	HSAG Required Evidence: - Policies and procedures - Fraud, waste, and abuse plan - SIU workflow, including referral steps to Iowa Medicaid - Reporting mechanisms - Staff training materials	☒ Met ☐ Not Met

Standard XV—Program Integrity		
Requirement	Supporting Documentation	Score
b. For the prompt referral of any potential fraud, waste, or abuse that the PAHP identifies, <i>including provider activity which would incur a sanction under 441 Iowa Administrative Code §79.2</i>, to HHS’ program integrity unit or any potential fraud directly to the Iowa Medicaid Fraud Control Unit (MFCU). 42 CFR §438.608(a) 42 CFR §438.608(a)(7) 441 Iowa Administrative Code §79.2 Contract I.5.01 Contract I.12.07–I.12.08	Evidence as Submitted by the PAHP: - SXV_FPR01-INS-DENT-FPR Program-FINAL 2018_Redacted- Pages 1–2, 3–4 and 6 - SXV_SFY 2026 Fraud Waste and Abuse Compliance Plan Pages 1-15 - SXV_2025 General Compliance & FWA Training Pages 3, 121 13-15, 30, 32, and 66-69	
PAHP Description of Process: DentaQuest has been informed that Program Integrity (PI) training with the state is scheduled to begin in May. At this time, DentaQuest does not have access to the reporting manual or the reporting templates for this section, as these materials are expected to be provided and discussed during the training.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Recommendations: HSAG strongly recommends that the PAHP develop a tracking and reporting mechanism to monitor adherence to the “prompt referral” time frame standard. HSAG also recommends that the PAHP consult with HHS to determine the definition of “prompt” and revise its policies, procedures, and workflows, etc., where applicable.		
Required Actions: None.		
11. <i>The PAHP assesses and strengthens internal controls to ensure claims are submitted and paid properly.</i> a. <i>The PAHP educates employees, providers, and members about fraud and abuse and how to report it.</i> b. <i>The PAHP ensures sufficient organizational resources to effectively respond to complaints of fraud and abuse and effectively and efficiently responds to complaints of fraud and abuse.</i>	HSAG Required Evidence: - Policies and procedures, including SIU referral process(es) - Fraud, waste, and abuse educational materials (employee-, provider-, and member-specific) - Internal controls for claims payment (including claims coding guidelines) - SIU organizational chart (for Iowa complaints) - Fraud and abuse complaint reporting and communication mechanisms/plans - Fraud and abuse data mining mechanisms	☒ Met ☐ Not Met

Standard XV—Program Integrity		
Requirement	Supporting Documentation	Score
c. <i>The PAHP develops data mining techniques and conducts on-site audits when potential fraud or abuse is identified.</i> 42 CFR §438.608(a) Contract I.12.03 Contract I.12.05–I.12.06	- Staff training materials - HSAG also will use findings from the Fraud, Waste, and Abuse Reporting/Tracking system demonstration and Claims edits system demonstration Evidence as Submitted by the PAHP: - SXV_FPR04-INS-DENT - Fraud Detection Pages 1–3 - SXV_FPRU Org Chart 2026 – Page 1 - SXV_TIPS FORM – Potential Provider Fraud or Abuse Referral to FPR – Pages 1–2 - SXV_COM09-ENT – Duty to Report Noncompliance; Non-retaliation – Pages 1–4 - SXV_2025 General Compliance & FWA Training – Pages 3, 12, 13–15, 30, 32, 35, 66–69	
PAHP Description of Process: NA		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
Suspension of Payments		
12. The PAHP, and all applicable subcontractors, implements and maintains arrangements or procedures for the suspension of payments to a network provider for which HHS determines there is a credible allegation of fraud in accordance with 42 CFR §455.23. 42 CFR §438.608(a)(8) 42 CFR §455.23 Contract I.13.01	HSAG Required Evidence: - Policies and procedures - Fraud, waste, and abuse program description - Credible allegation of fraud reporting workflow - Reporting template(s) - Payment suspension workflow, including timeliness expectations (i.e., suspension placed within 24 hours) - Staff training materials Evidence as Submitted by the PAHP:	☒ Met ☐ Not Met

Standard XV—Program Integrity		
Requirement	Supporting Documentation	Score
	- SXV_FPR05-INS-MCD-Credible Allegation of Fraud Hold-FINAL 2018_Redacted– Pages 1–4 - SXV_FPR01-INS-DENT-FPR Program-FINAL 2018_Redacted – Pages 1–2, 5	
PAHP Description of Process:		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: HSAG strongly recommends that the PAHP develop tracking and monitoring mechanisms to ensure payment suspensions are timely, and that suspensions are lifted and payments are returned to the provider, if applicable. HSAG also recommends that the PAHP consult with HHS to determine the timeliness expectations for issuing notices of payment suspension to providers and revise its policies, procedures, and workflows, etc., where applicable.		
Required Actions: None.		
13. The PAHP, and all applicable subcontractors, issues a notice of payment suspension that comports with 42 CFR §455.23(b) and retains the suspension in accordance with 42 CFR §455.23(c). a. <i>The PAHP will not suspend payments without consulting first with the MFCU and second with the HHS.</i> b. <i>The PAHP provides a grievance process for providers whose payments have been suspended under 42 CFR §455.23.</i> c. <i>When notified that the HHS suspension has been lifted, the PAHP, and all applicable subcontractors, lifts its suspension of payments and return the suspended payments to the provider unless the PAHP has other authority to continue to withhold those payments.</i> d. <i>The PAHP maintains all materials related to payments suspension for five years as required by and in accordance with 42 CFR §455.23(g).</i> 42 CFR §438.608(a)(8) 42 CFR §455.23	HSAG Required Evidence: - Policies and procedures - Payment suspension workflow, including applicable timeframes - Notice of payment suspension letter template - Monthly reporting template of suspended funds - Staff training materials - HSAG also will use findings from the provider payment suspensions tracking system demonstration Evidence as Submitted by the PAHP: - SXV_FPR05-INS-MCD-Credible Allegation of Fraud Hold-FINAL 2018_Redacted– Pages 1–4 - SXV_FPR01-INS-DENT-FPR Program-FINAL 2018_Redacted– Pages 1–2 and 5 and 8	☒ Met ☐ Not Met

Standard XV—Program Integrity		
Requirement	Supporting Documentation	Score
Contract I.13.02–I.13.03		
PAHP Description of Process: DentaQuest has been informed that Program Integrity (PI) training with the state is scheduled to begin in May. At this time, DentaQuest does not have access to the reporting manual or the reporting templates for this section, as these materials are expected to be provided and discussed during the training.		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: HSAG strongly recommends that the PAHP develop tracking and monitoring mechanisms to ensure payment suspensions are timely and that suspensions are lifted and payments are returned to the provider, if applicable. HSAG also recommends that the PAHP consult with HHS to determine the timeliness expectations for issuing notices of payment suspension, as well as issuing notices if suspensions are lifted, to providers and revise its policies, procedures, and workflows, etc., where applicable.		
Required Actions: None.		
Provider Screening and Enrollment Requirements		
14. The PAHP ensures that all network providers are enrolled with HHS as Medicaid providers consistent with the provider disclosure, screening, and enrollment requirements of Part 455, Subparts B and E. 42 CFR §438.608(b) 42 CFR §457.990 42 CFR Part 455, Subparts B and E Contract I.2.17	HSAG Required Evidence: • Policies and procedures • Medicaid enrollment verification workflow (e.g., use of HHS’ provider master file, out of state provider verification process) • Two examples of documented Medicaid enrollment verifications • Staff training materials Evidence as Submitted by the PAHP: • SXV_PEC01-INS-Credentialing Guidelines_Redacted – Pages 3–6 • SXV_PEC04-INS – Provider Maintenance and Ongoing Monitoring – Pages 3–6	☒ Met ☐ Not Met
PAHP Description of Process: DentaQuest does not currently have any Iowa contracted providers; therefore, examples of documented Medicaid enrollment verifications are not yet available. These materials will be available once provider contracts begin and verification activities can be performed in accordance with Medicaid requirements.		

Standard XV—Program Integrity		
Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
15. The PAHP may execute network provider agreements pending the outcome of screening, enrollment, and revalidation processes of up to 120 days. a. The PAHP terminates a network provider immediately upon notification from HHS that the network provider cannot be enrolled, or the expiration of the 120-day period without enrollment of the provider, and notify affected members. 42 CFR §438.602(b)(2) Contract I.11.02	HSAG Required Evidence: • Policies and procedures • Medicaid enrollment timeliness tracking mechanisms • Staff training materials Evidence as Submitted by the PAHP: • SXV_PEC04-INS-Provider Maintenance and Ongoing Monitoring – Page 4 (Section F) & 6	☒ Met ☐ Not Met
PAHP Description of Process: NA		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Recommendations: HSAG strongly recommends that the PAHP develop tracking and monitoring mechanisms to ensure network provider agreements are terminated immediately upon notification from HHS that the network provider cannot be enrolled, or the expiration of the 120-day period without enrollment of the provider, and timely notification to affected members.		
Required Actions: None.		
Disclosures and Prohibited Affiliations		
16. The PAHP, and any subcontractors: a. Provides written disclosure of any prohibited affiliation under 42 CFR §438.610. b. Provides written disclosures of information on ownership and control required under 42 CFR §455.104.	HSAG Required Evidence: • Policies and procedures that apply to provider/contracted entities and the PAHP • Provider materials, such as a contract template or provider manual (requiring disclosures within 35 days after any change in ownership)	☒ Met ☐ Not Met

Standard XV—Program Integrity		
Requirement	Supporting Documentation	Score
c. Reports to HHS within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the Contract. 42 CFR §455.104 42 CFR §438.608(c) 42 CFR §438.610 Contract I.2.07 Contract I.2.12–I.2.15 Contract I.2.18	- Disclosure of ownership and control notice template (required for completion by contracted entities) - Confirmation PAHP disclosures were provided to HHS upon contract execution - Staff training materials Evidence as Submitted by the PAHP: - SXV_COM12-ENT – OIG/GSA Exclusion Review – Pages 1–4 - SXV_PEC01-INS-Credentialing Guidelines _Redacted– Page 4 - SXV_Disclosure of Ownership – Instructions (2022) – Pages 1–5 (Entire Document) - SXV_Disclosure of Ownership and Conflict of Interest Form – Pages 1–5 (Entire Document) - SXV_CL01-INS – Claims Processing – Pages 4–6, 27, 30	
PAHP Description of Process: NA		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: HSAG strongly recommends that the PAHP develop a tracking and reporting mechanism to monitor adherence to the 60-day time frame standard. HSAG also recommends that the PAHP revise the <i>Fraud Prevention and Recovery Program – Dental</i> policy to include sub-element (c) in its entirety in accordance with 42 CFR §438.608(c)(3) and Contract provision I.2.18 for staff awareness.		
Required Actions: None.		
Provider Disclosures/Provider Applications for Program Integrity Reasons		
17. <i>The PAHP implements in its provider enrollment processes the obligation of providers to disclose the identity of any person described in 42 CFR §1001.1001(a)(1) as well as other</i>	HSAG Required Evidence: - Policies and procedures - Provider contract template - Disclosure of ownership and control notice template - Reporting mechanisms	☐ Met ☒ Not Met

Standard XV—Program Integrity		
Requirement	Supporting Documentation	Score
<i>permissible exclusions that would impact the integrity of the provider enrollment.</i> a. <i>The PAHP forwards such disclosures to HHS.</i> b. <i>The PAHP abides by any direction provided by HHS on whether or not to permit the applicant to be a provider in the program.</i> i. <i>Specifically, the PAHP does not permit the provider to become a network provider if HHS or the PAHP determines that any person who has ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the Title XX Services program, or if HHS or the PAHP determines that the provider did not fully and accurately make any disclosure pursuant to 42 CFR §1001.1001(a)(1).</i> 42 CFR §1001.1001(a)(1) Contract I.11.06	- Staff training materials Evidence as Submitted by the PAHP: - SXV_PEC01-INS-Credentialing Guidelines Redacted 5–6 - SXV_COM12-ENT – OIG/GSA Exclusion Review – Pages 1–4 - SXV_Disclosure of Ownership & Control Form Pages 1–5 (Entire Document) - SXV_Disclosure of Ownership – Instructions – Pages 1–5 (Entire Document)	
PAHP Description of Process: NA		
HSAG Findings: The documents submitted did not include the requirements of this element. HSAG requested that the PAHP include the Iowa-specific requirements in its appropriate program integrity policy and/or procedure. However, the PAHP did not provide a revised policy inclusive of the Iowa-specific requirements as requested.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Revise its appropriate policy(ies), procedure(s), templates, etc., to include the Iowa-specific requirements of this element.		

Standard XV—Program Integrity		
Requirement	Supporting Documentation	Score
Medicaid Excluded Providers		
18. <i>The PAHP may not employ or contract with providers excluded from participation in Federal and State health care programs under either section 1128 or section 1128A of the Social Security Act.</i> a. <i>The PAHP checks employees and subcontractors every month against the Office of Inspector General’s (OIG’s) List of Excluded Individuals/Entities (LEIE), the General Services Administration (GSA) System of Aware Management (SAM; formerly known as the GSA Excluded Parties List System [EPLS]), the Social Security Administration Death Master File (SSDMF), the National Plan and Provider Enumeration System (NPPES), and the Iowa Medicaid exclusion list to ensure that no employee or subcontractor has been excluded.</i> b. <i>The PAHP checks the lists of providers currently excluded by the State and the federal government every 30 days. In addition, the PAHP checks the SSDMF, the NPPES, the SAM, the Medicare Exclusion Database (MED) and any such other databases as the Secretary of DHHS may prescribe.</i> 42 CFR §438.214(d)(1) 42 CFR §457.1233(a) Contract E.3.03 Contract I.1.01–I.1.02 Contract I.1.07 Contract I.2.16	HSAG Required Evidence: • Policies and procedures • Three consecutive examples of documentation supporting the monthly screening of employees for sanctions/exclusions (proof of sources must be included) • Three consecutive examples of documentation supporting the monthly screening of providers for sanctions/exclusions (proof of sources must be included) • Plan for ongoing monitoring of sanctions/exclusions • Written agreement with the delegated entity if ongoing monitoring of sanctions/exclusions will be completed by the delegated entity • Staff training materials Evidence as Submitted by the PAHP: • SXV_COM12-ENT-OIG-GSA Exclusion Review Pages 1–4 • SXV_PEC01-INS-Credentialing Guidelines_Redacted Pages 5–6 • SXV_PEC04-INS-Provider Maintenance and Ongoing Monitoring Page 3-6 • SXV_PEC05-INS-Provider Disciplinary Action CAP and Appeal Policy-FINAL_Redacted Pages 2–4 • SXV_HRDQ1-ENT - Background Checks_Redacted 1–3	☐ Met ☒ Not Met
PAHP Description of Process: NA		
HSAG Findings: The PAHP did not provide documentation to demonstrate it will conduct monthly checks against the Social Security Administration Death Master File (SSDMF) and National Plan and Provider Enumeration System (NPPES) for PAHP employees. HSAG requested that the PAHP include the Iowa-specific requirements in its appropriate program integrity policy and/or procedure. However, although the PAHP provided additional supporting		

Standard XV—Program Integrity		
Requirement	Supporting Documentation	Score
evidence under Standard VIII—Provider Selection, the PAHP did not provide additional evidence that confirmed the process for monitoring employees monthly.		
Recommendations: HSAG strongly recommends that the PAHP develop a monitoring mechanism to demonstrate compliance with monthly checks.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must:		
Revise the appropriate policy(ies) to include the SSDMF and NPPES monthly checks for PAHP employees (e.g., licensed dental staff).		
Reporting Obligations for Adverse Actions Taken on a Provider		
19. <i>The PAHP notifies HHS and the Office of the Inspector General (OIG) of provider decredentialing for program integrity reasons and in compliance with 42 CFR Part 1001.</i> 42 CFR Part 1001 Contract I.11.05	HSAG Required Evidence: - Policies and procedures - Provider termination workflow (for program integrity reasons) - Program integrity/fraud, waste, abuse plan - Identification and reporting mechanisms - Staff training materials Evidence as Submitted by the PAHP: - SXV_PEC05-INS-Provider Disciplinary Action CAP and Appeal Policy-FINAL_Redacted Pages 2–4 - SXV_Program Integrity Compliance Plan – Pages 4 and 7 - SXV_FPR01-INS-DENT-FPR Program-FINAL 2018_Redacted 1–4	☐ Met ☒ Not Met
PAHP Description of Process: DentaQuest has been informed that Program Integrity (PI) training with the state is scheduled to begin in May. At this time, DentaQuest does not have access to the reporting manual or the reporting templates for this section, as these materials are expected to be provided and discussed during the training.		
HSAG Findings: The PAHP did not submit documentation to demonstrate that it will report to HHS and OIG after the decredentialing of a provider due to program integrity reasons. During the review, HSAG requested that the PAHP include the Iowa-specific requirements in its appropriate program integrity policy and/or procedure. However, a revised policy was not submitted as requested.		
Recommendations: HSAG strongly recommends that the PAHP develop a tracking and reporting mechanism to demonstrate compliance with the requirements of this element.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must:		

Standard XV—Program Integrity		
Requirement	Supporting Documentation	Score
Revise and submit written documentation (e.g., policy, procedure, program integrity plan) that outlines the steps that occur after the decredentialing of a provider due to program integrity reasons, including the entities that require notification.		

Standard XV—Program Integrity						
Met	=	16	X	1	=	16
Not Met	=	3	X	0	=	0
Total	=	19	Total Score		=	16
Total Score ÷ Total					=	84%

Checklists

Standard II—Member Rights Checklist

Standard II—Member Rights Checklist		
Reference	Required Components	
A member enrolled with the PAHP has the following rights:		
42 CFR §438.10 42 CFR §438.100(b)(2)(i) 42 CFR §457.1220 Contract C.2.12(a) Contract F.16.01	1. Receive information in accordance with 42 CFR §438.10. Evidence as submitted by the PAHP: • MKT01-INS-Marketing Safeguards, Exhibit A, Enrollees’ rights and responsibilities, page 4	Y ☒ N ☐
42 CFR §438.100(b)(2)(ii) 42 CFR §457.1220 Contract C.2.12(b) Contract F.16.02	2. Be treated with respect and with due consideration for his or her dignity and privacy. Evidence as submitted by the PAHP: • MKT01-INS-Marketing Safeguards, Exhibit A, Enrollees’ rights and responsibilities, page 4	Y ☒ N ☐
42 CFR §438.100(b)(2)(iii) 42 CFR §457.1220 Contract C.2.12(c) Contract F.16.04	3. Receive information on available treatment options and alternatives, presented in a manner appropriate to the member’s condition and ability to understand. Evidence as submitted by the PAHP: • MKT01-INS-Marketing Safeguards, Exhibit A, Enrollees’ rights and responsibilities, page 4	Y ☒ N ☐
42 CFR §438.100(b)(2)(iv) 42 CFR §457.1220 Contract C.2.12(d) Contract F.16.05	4. Participate in decisions regarding his or her health care, including the right to refuse treatment. Evidence as submitted by the PAHP: • MKT01-INS-Marketing Safeguards, Exhibit A, Enrollees’ rights and responsibilities, page 4	Y ☒ N ☐
42 CFR §438.100(b)(2)(v) 42 CFR §457.1220 Contract C.2.12(e) Contract F.16.06	5. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulations on the use of restraints and seclusion. Evidence as submitted by the PAHP: • MKT01-INS-Marketing Safeguards, Exhibit A, Enrollees’ rights and responsibilities, page 4	Y ☒ N ☐

Standard II—Member Rights Checklist		
Reference	Required Components	
42 CFR §438.100(b)(2)(vi) 42 CFR §457.1220 45 CFR Part 160 45 CFR Part 164, Subparts A and E 45 CFR §164.524 45 CFR §164.526 Contract C.2.12(f) Contract F.16.07	6. If the privacy rule (as set forth in 45 CFR parts 160 and 164 subparts A and E) applies, request and receive a copy of his or her <i>dental</i> records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and §164.526. Evidence as submitted by the PAHP: MKT01-INS-Marketing Safeguards, Exhibit A, Enrollees’ rights and responsibilities, page 4	Y ☒ N ☐
42 CFR §438.100(b)(3) 42 CFR §438.206 through §438.210 42 CFR §457.1220 Contract C.2.13	7. Be furnished health care services in accordance with 42 CFR §438.206 through §438.210. Evidence as submitted by the PAHP: MKT01-INS-Marketing Safeguards, Exhibit A, Enrollees’ rights and responsibilities, page 4	Y ☒ N ☐
42 CFR §438.100(c) 42 CFR §457.1220 Contract F.16.08	8. Exercise his or her rights, and that the exercise of those rights does not adversely affect the way the PAHP and its network providers or HHS treat the member. Evidence as submitted by the PAHP: MKT01-INS-Marketing Safeguards, Exhibit A, Enrollees’ rights and responsibilities, page 4	Y ☒ N ☐
42 CFR §438.100(d) 42 CFR §438.3(d)(3)(4) 42 CFR §457.1220 45 CFR Part 80 45 CFR Part 91 Rehabilitation Act of 1973 Education Amendments of 1972, Title IX ADA, Titles II and III ACA, Section 1557 Contract J.2.01-J.2.02	9. The PAHP shall comply with any other applicable federal and State laws (including Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80, the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91, the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972 (regarding education programs and activities), Titles II and III of the Americans with Disabilities Act (ADA), and section 1557 of the Patient Protection and Affordable Care Act (ACA). Evidence as submitted by the PAHP: - MKT01-INS-Marketing Safeguards, Exhibit A, Enrollees’ rights and responsibilities, page 4 - SII_Checklist_Member Rights_COM15-ENT-Nondiscrimination Compliance Program	Y ☒ N ☐

Standard II—Member Rights Checklist		
Reference	Required Components	
Contract F.16.03	10. <i>In recognizing each member’s dignity and privacy, the PAHP does not in any way restrict the member’s right to fully participate in the community and to work, live, and learn to the fullest extent possible.</i>	Y ☐ N ☒
	Evidence as submitted by the PAHP: MKT01-INS-Marketing Safeguards, Exhibit A, Enrollees’ rights and responsibilities, page 4	

Standard II—Member Handbook Checklist

Standard II—Member Handbook Checklist		
Reference	Required Components	
The content of the member handbook includes information that enables the member to understand how to effectively use the managed care program. This information includes at a minimum:		
42 CFR §438.10(g)(2)(i) 42 CFR §457.1207 Contract C.2.02 Contract C.2.03 Contract C.2.04(a)	1. Benefits provided by the PAHP, <i>including information about Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits and how to access component services if individuals under age 21 entitled to the EPSDT benefit are enrolled with the PAHP.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_Member Handbook_IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <Pg. 11 of handbook>	
42 CFR §438.10(g)(2)(ii) 42 CFR §457.1207 Contract C.2.03 Contract C.2.04(b)	2. How and where to access any benefits provided by HHS, <i>including EPSDT benefits delivered by the PAHP, if any.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_Member Handbook_IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <Pg. 4 – 8 of handbook>	
42 CFR §438.10(g)(2)(ii) 42 CFR §457.1207 Contract C.2.03 Contract C.2.04(d)	3. How transportation is provided <i>for any benefits carved out of the PAHP's Contract and provided by HHS.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_Member Handbook_IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <Pg. 2 & Pg. 26>	
42 CFR §438.10(g)(2)(ii)(A) 42 CFR §457.1207 Contract C.2.03 Contract C.2.05(a) Contract C.8.06	4. In the case of a counseling or referral service that the PAHP does not cover because of moral or religious objections, the PAHP informs members that the service is not covered by the PAHP. a. <i>The PAHP notifies members when it adopts a policy to discontinue coverage of a counseling or referral service based on moral or religious objections at least 30 days prior to the effective date of the policy for any particular service.</i>	Y ☐ N ☐ NA ☒
	Evidence as submitted by the PAHP: SII_Checklist_Member Handbook_IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <Pg. 16>	

Standard II—Member Handbook Checklist		
Reference	Required Components	
42 CFR §438.10(g)(2)(ii)(A-B) 42 CFR §457.1207 Contract C.2.03 Contract C.2.05(b)	5. The PAHP informs members how they can obtain information from HHS about how to access the services not provided by the PAHP because of moral or religious objections.	Y ☐ N ☐ NA ☒
	Evidence as submitted by the PAHP: SII_Checklist_Member Handbook_IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <Pg 17 second paragraph>	
42 CFR §438.10(g)(2)(iii) 42 CFR §457.1207 Contract C.2.03 Contract C.2.06(a)	6. The amount, duration, and scope of benefits available under the Contract in sufficient detail to ensure that members understand the benefits to which they are entitled.	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_Member Handbook_IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <Pg. 4 – 8>	
42 CFR §438.10(g)(2)(iv) 42 CFR §457.1207 Contract C.2.03 Contract C.2.06(b)	7. Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the member's primary care provider (PCP).	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_Member Handbook_IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <Pg. 10, 11, 13>	
42 CFR §438.10(g)(2)(v) 42 CFR §457.1207 Contract C.2.03 Contract C.2.07	8. The extent to which, and how, after-hours care is provided.	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_Member Handbook_IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <Pg. 2>	
Contract C.2.03 Contract C.2.08(a)	9. <i>How emergency care is provided.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_Member Handbook_IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <P. 2>	
42 CFR §438.10(g)(2)(v)(A) 42 CFR §457.1207 Contract C.2.03 Contract C.2.08(b-c)	10. What constitutes an emergency <i>dental</i> /medical condition and emergency services.	Y ☒ N ☐
	Evidence as submitted by the PAHP: The handbook is in the development phase. We have noted this gap as an edit for the next round.	

Standard II—Member Handbook Checklist		
Reference	Required Components	
42 CFR §438.10(g)(2)(v)(B) 42 CFR §457.1207 Contract C.2.03 Contract C.2.08(d)	11. The fact that prior authorization is not required for emergency services.	Y ☒ N ☐
	Evidence as submitted by the PAHP: The handbook is in the development phase. We have noted this gap as an edit for the next round.	
42 CFR §438.10(g)(2)(v)(C) 42 CFR §457.1207 Contract C.2.03 Contract C.2.08(e)	12. The fact that the member has a right to use any <i>dentist</i> for emergency care.	Y ☒ N ☐
	Evidence as submitted by the PAHP: The handbook is in the development phase. We have noted this gap as an edit for the next round.	
42 CFR §438.10(g)(2)(vi) 42 CFR §457.1207 Contract C.2.03 Contract C.2.09(a)	13. Any restrictions on the member’s freedom of choice among network providers.	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_Member Handbook_IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <Pg. 14?	
42 CFR §438.10(g)(2)(viii) 42 CFR §457.1207 Contract C.2.03 Contract C.2.04(c) Contract C.2.11	14. Cost sharing <i>on any benefits carved out of the PAHP’s Contract and provided by HHS.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_Member Handbook_IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <P. 17>	
42 CFR §438.10(g)(2)(ix) 42 CFR §438.100 42 CFR §457.1207 Contract C.2.03 Contract C.2.12 Contract C.2.13	15. Member rights and responsibilities, including the elements specified in 42 CFR §438.100.	Y ☐ N ☒
	Evidence as submitted by the PAHP: SII_Checklist_Member Handbook_IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <P. 17 – 18>	
42 CFR §438.10(g)(2)(x) 42 CFR §457.1207 Contract C.2.03 Contract C.2.14	16. The process of selecting and changing the member’s PCP.	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_Member Handbook_IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <P. 14>	

Standard II—Member Handbook Checklist		
Reference	Required Components	
42 CFR §438.10(g)(2)(xi)(A) 42 CFR §457.1207 Contract C.2.03 Contract C.2.15 Contract C.2.16(a)	17. The right to file grievances and appeals.	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_Member Handbook_IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <P. 19 – 22>	
42 CFR §438.10(g)(2)(xi)(B) 42 CFR §457.1207 Contract C.2.03 Contract C.2.15 Contract C.2.16(b)	18. The requirements and timeframes for filing a grievance or appeal.	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_Member Handbook_IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <P. 19 – 22>	
42 CFR §438.10(g)(2)(xi)(C) 42 CFR §457.1207 Contract C.2.03 Contract C.2.15 Contract C.2.16(c-d)	19. The availability of assistance in the filing process for grievances and appeals.	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_Member Handbook_IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <P. 19 – 22>	
42 CFR §438.10(g)(2)(xi)(D) 42 CFR §457.1207 Contract C.2.03 Contract C.2.15 Contract C.2.16(e)	20. The right to request a state fair hearing (SFH) (or a State external review for the Children’s Health Insurance Program [CHIP]) after the PAHP has made a determination on a member's appeal which is adverse to the member.	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_Member Handbook_IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <P. 21>	
42 CFR §438.10(g)(2)(xi)(E) Contract C.2.03 Contract C.2.15 Contract C.2.16(f)	21. The fact that, when requested by the member, benefits that the PAHP seeks to reduce or terminate will continue if the member files an appeal or a request for the SFH within the timeframes specified for filing, and that the member may, consistent with HHS policy, be required to pay the cost of services furnished while the appeal or the SFH is pending if the final decision is adverse to the member.	Y ☐ N ☒
	Evidence as submitted by the PAHP: SII_Checklist_Member Handbook_IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <P. 19 – 22>	

Standard II—Member Handbook Checklist		
Reference	Required Components	
42 CFR §438.10(g)(2)(xiii) 42 CFR §457.1207 Contract C.2.03 Contract C.2.18(a)	22. How to access auxiliary aids and services, including additional information in alternative formats or languages.	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_Member Handbook_IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 < P. 2 & 29>	
42 CFR §438.10(g)(2)(xiv) 42 CFR §457.1207 Contract C.2.03 Contract C.2.18(b-d)	23. The toll-free telephone number for member services, <i>oral health</i> management, and any other unit providing services directly to members.	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_Member Handbook_IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <P. 1>	
42 CFR §438.10(g)(2)(xv) 42 CFR §457.1207 Contract C.2.03 Contract C.2.18(e)	24. Information on how to report suspected fraud or abuse.	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_Member Handbook_IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <P. 22 – 23>	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 Contract C.2.03 Contract C.2.18(f) Contract C.2.21	25. <i>Description of the transition of care policies for members and potential enrolled members.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: The handbook is in the development phase. We have noted this gap as an edit for the next round.	

Standard II—Provider Directory Checklist

Standard II—Provider Directory Checklist		
Reference	Required Components	
<i>The PAHP makes available in paper form upon request and electronic form, the following information about its network providers:</i>		
42 CFR §438.10(h)(1)(i) 42 CFR §457.1207 Contract C.4.01(a)	1. The provider's name as well as any group affiliation.	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_2c_Checklist_DQ3180 IA State Medicaid_Geo coded Directory_bw (2.26)_DRAFT_2-26-26	
42 CFR §438.10(h)(1)(ii) 42 CFR §457.1207 Contract C.4.01(b)	2. Street address(es).	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_2c_Checklist_DQ3180 IA State Medicaid_Geo coded Directory_bw (2.26)_DRAFT_2-26-26	
42 CFR §438.10(h)(1)(iii) 42 CFR §457.1207 Contract C.4.01(c)	3. Telephone number(s).	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_2c_Checklist_DQ3180 IA State Medicaid_Geo coded Directory_bw (2.26)_DRAFT_2-26-26	
42 CFR §438.10(h)(1)(iv) 42 CFR §457.1207 Contract C.4.01(d)	4. Website Uniform Resource Locator (URL), as appropriate.	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_2c_Checklist_DQ3180 IA State Medicaid_Geo coded Directory_bw (2.26)_DRAFT_2-26-26	
42 CFR §438.10(h)(1)(v) 42 CFR §457.1207 Contract C.4.01(e)	5. Specialty, as appropriate.	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_2c_Checklist_DQ3180 IA State Medicaid_Geo coded Directory_bw (2.26)_DRAFT_2-26-26	
42 CFR §438.10(h)(1)(vi) 42 CFR §457.1207 Contract C.4.01(f)	6. Whether the provider will accept new members.	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_2c_Checklist_DQ3180 IA State Medicaid_Geo coded Directory_bw (2.26)_DRAFT_2-26-26	

Standard II—Provider Directory Checklist		
Reference	Required Components	
Contract C.4.01(g)	7. <i>Whether the provider has any limitations on members they accept (i.e., children only, or adults only).</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_2c_Checklist_DQ3180 IA State Medicaid_Geo coded Directory_bw (2.26)_DRAFT_2-26-26	
42 CFR §438.10(h)(1)(vii) 42 CFR §457.1207 Contract C.4.01(h)	8. The provider’s cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider’s office.	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_2c_Checklist_DQ3180 IA State Medicaid_Geo coded Directory_bw (2.26)_DRAFT_2-26-26	
42 CFR §438.10(h)(1)(viii) 42 CFR §457.1207 Contract C.4.01(i)	9. Whether the provider’s office/facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment, including but not limited to wide entries, wheelchair access, accessible exam tables and rooms, lifts, scales, bathrooms, grab bars, or other equipment.	Y ☐ N ☒
	Evidence as submitted by the PAHP: SII_2c_Checklist_DQ3180 IA State Medicaid_Geo coded Directory_bw (2.26)_DRAFT_2-26-26	

Standard II—New Member Communications Checklist

Standard II—New Member Communications Checklist		
Reference	Required Components	
<i>The PAHP distributes enrollment materials to each member and their authorized representative. The enrollment materials include the following information:</i>		
Contract C.1.03(a)	1. <i>The PAHP's contact information, including address, telephone number, website.</i>	Y ☐ N ☒
	Evidence as submitted by the PAHP: SII_Checklist_Member Communications_IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <Pg 1 Mailing Address>	
Contract C.1.03(b)	2. <i>The PAHP's office hours/days, including the availability of the helplines.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_Member Communications_IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <Pg 1 Hours>	
Contract C.1.03(c)	3. <i>Description of how to complete an oral health risk assessment.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_Member Communications_IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <Pg 32>	
Contract C.1.03(d)	4. <i>If applicable, any cost-sharing information, and contact information where the member can ask questions regarding their cost-sharing obligations.</i>	Y ☐ N ☒
	Evidence as submitted by the PAHP: SII_Checklist_Member Communications_IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <Pg 17>	
Contract C.1.03(e)	5. <i>Procedures for obtaining out-of-network services and any special benefit provisions (for example, co-payments, limits or rejections of claims) that may apply to services obtained outside the PAHP's network.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_Member Communications_IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <Pg 17>	
Contract C.1.03(f)	6. <i>Standards and expectations for receiving preventive dental services.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_Member Communications_IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <Pg 11>	

Standard II—New Member Communications Checklist		
Reference	Required Components	
Contract C.1.03(g)	7. <i>Procedures for changing PAHPs and circumstances under which this is possible, as described in Contract Section B.5.</i>	Y ☐ N ☒
	Evidence as submitted by the PAHP: The Member Handbook is in development. This element has been noted as an edit needed for the next phase.	
Contract C.1.03(h)	8. <i>Procedures for making complaints and recommending changes in policies and services.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_Member Communications_IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <Pg 22 Reporting Problems>	
Contract C.1.03(i)	9. <i>Information on how to contact the Iowa Medicaid Enrollment Broker.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_Member Communications_IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <Pg 1>	
Contract C.1.03(j)	10. <i>Information on alternative methods or formats of communication for visually and hearing-impaired and non-English speaking members and how members can access those methods or formats at no expense.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_Member Communications_IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <Pg 2 Auxiliary Aids>	
Contract C.1.03(k)	11. <i>Information and procedures on how to report suspected abuse and neglect, including the phone numbers to call to report suspected abuse and neglect.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_Member Communications_IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <Pg 25>	
Contract C.1.03(l)	12. <i>Contact information and description of the role of the Ombudsman.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_Member Communications_IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <Pg 24>	

Standard II—Member Services Helpline Checklist

Standard II—Member Services Helpline Checklist		
Reference	Required Components	
Contract C.1.10	1. <i>The PAHP does not have separate numbers for members to call regarding separate covered services plans (i.e., DWP vs. Hawki).</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_MSHelpline_CS02-INS-Customer Service Standards-FINAL • During the contract review and implementation, it was agreed that DentaQuest would implement 2 toll-free incoming lines for members to call: • DWP/Medicaid: 866-629-6074 • Hawki/CHIP: 866-552-7944	
Contract C.1.10	2. <i>The PAHP either routes the call to another entity or conducts a “warm transfer” to another entity, but the PAHP does not require a member to call a separate number regarding separate services or plans (i.e., DWP vs. Hawki).</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: - SII_Checklist_MSHelpline_CS03-INS-DENT-Customer Service Incoming Phone Lines-Dental-FINAL - SII_Checklist_MSHelpline_CS11-INS-CS Representative Training-FINAL	
Contract C.1.11	3. <i>The PAHP maintains a dedicated toll-free Member Services Helpline staffed with trained personnel knowledgeable about the program.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_MSHelpline_CS11-INS-CS Representative Training-FINAL	
Contract C.1.11	4. <i>Helpline staff are equipped to handle a variety of member inquiries.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_MSHelpline_CS11-INS-CS Representative Training-FINAL	

Standard II—Member Services Helpline Checklist		
Reference	Required Components	
Contract C.1.11	5. <i>The telephone line is staffed with live-voice coverage during normal working days (Monday through Friday), excluding State holidays, and is accessible, at minimum, during working hours of 7:30 a.m.–6:00 p.m. Central Time (CT). The State holidays are:</i> a. <i>New Year’s Day.</i> b. <i>Martin Luther King, Jr. ’s Birthday.</i> c. <i>Memorial Day.</i> d. <i>July 4th.</i> e. <i>Labor Day.</i> f. <i>Veterans Day.</i> g. <i>Thanksgiving.</i> h. <i>Day after Thanksgiving.</i> i. <i>Christmas Day.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_MSHelpline_CS03-INS-DENT-Customer Service Incoming Phone Lines-Dental-FINAL	
Contract C.1.11	6. <i>The PAHP provides a voice message system that informs callers of the PAHP’s business hours and offers an opportunity to leave a message after business hours.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_MSHelpline_CS03-INS-DENT-Customer Service Incoming Phone Lines-Dental-FINAL	
Contract C.1.11	7. <i>Calls received in the voice message system are returned within one business day.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_MSHelpline_CS03-INS-DENT-Customer Service Incoming Phone Lines-Dental-FINAL	
Contract C.1.11	8. <i>The PAHP has the ability to “warm transfer” members to outside entities, such as provider offices, enrollment broker, and internal PAHP departments, such as to care coordinators, to facilitate the provision of high-quality customer service.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_MSHelpline_CS11-INS-CS Representative Training-FINAL	

Standard II—Member Services Helpline Checklist		
Reference	Required Components	
Contract C.1.11	9. <i>The PAHP ensures all calls are answered by live operators who identify themselves by name to each caller.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_MSHelpline_CS11-INS-CS Representative Training-FINAL	
Contract C.1.11	10. <i>The PAHP may utilize an Interactive Voice Response (IVR) system but ensures a caller is connected to a live person within one minute if the caller chooses that option.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_MSHelpline_CS02-INS-Customer Service Standards-FINAL	
Contract C.1.12	11. <i>The PAHP's Member Services Helpline complies at all times with the performance metrics set forth in Contract Section A.27.</i>	Y ☐ N ☒
	Evidence as submitted by the PAHP: SII_Checklist_MSHelpline_CS02-INS-Customer Service Standards-FINAL	
Contract C.1.13	12. <i>The Member Services Helpline is available for all callers.</i> a. <i>The PAHP maintains an operates telecommunication device for the deaf (TDD) services for hearing impaired members.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_MSHelpline_CS09-INS-CS Member Access with LEP	
Contract C.1.13	13. <i>The PAHP ensures communication between the PAHP and the member is in a language the member understands.</i> a. <i>In cases where a member's language is other than English, the PAHP offers and, if accepted by the member, supplies interpretive services at no charge to the member.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_MSHelpline_CS09-INS-CS Member Access with LEP	

Standard II—Member Services Helpline Checklist		
Reference	Required Components	
Contract C.1.13	14. <i>Automated telephone menu options are made available in English and Spanish.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_MSHelpline_CS09-INS-CS Member Access with LEP	
Contract C.1.14	15. <i>The PAHP’s Member Services Helpline staff are prepared to efficiently respond to member concerns or issues, including but not limited to:</i> <i>How to access dental health care services and dentists accepting new members who provide those services.</i> <i>Identification or explanation of covered services.</i> <i>Procedures for submitting a grievance or appeal.</i> <i>Reporting fraud or abuse.</i> <i>Locating a provider.</i> <i>Dental health crises.</i> <i>Balance billing issues.</i> <i>Cost-sharing.</i> <i>Primary care provider (PCP) change and/or initial attribution.</i> <i>Incentive programs.</i>	Y ☐ N ☒
	Evidence as submitted by the PAHP: SII_Checklist_MSHelpline_CS05-INS-SOP-CS Service Interruption Communications-FINAL	
Contract C.1.15	16. <i>The PAHP maintains a backup plan and system to ensure that, in the event of a power failure or outage, the following are in place and functioning:</i> <i>A back-up system capable of operating the telephone system, at full capacity, with no interruption of data collection.</i> <i>A notification plan that ensures HHS is notified when the PAHP’s phone system is inoperative or a back-up system is being utilized.</i> <i>Manual back-up procedure to allow requests to continue being processed if the system is down.</i>	Y ☐ N ☒
	Evidence as submitted by the PAHP: SII_Checklist_MSHelpline_CS05-INS-SOP-CS Service Interruption Communications-FINAL	

Standard II—Member Services Helpline Checklist		
Reference	Required Components	
Contract C.1.16	17. <i>The PAHP maintains a system for tracking and reporting the number and type of member calls and inquiries it receives during business and non-business hours.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_MSHelpline_CS08-INS-DENT-Customer Service-Call Metric Reporting-Dental-FINAL	

Standard II—Marketing Checklist

Standard II—Marketing Checklist		
Reference	Required Components	
42 CFR §438.104(b)(1)(i) Contract C.7.01(a)	1. The PAHP does not distribute marketing materials without first obtaining HHS approval.	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_MKT03-INS-COMM-Member Communications Distribution	
42 CFR §438.104(b)(1)(ii) Contract C.7.01(b)	2. The PAHP distributes marketing materials to its entire service area as indicated in the Contract.	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_MKT03-INS-COMM-Member Communications Distribution	
42 CFR §438.104(b)(1)(iv) Contract C.7.01(c)	3. The PAHP does not seek to influence enrollment in conjunction with the sale or offering of any private insurance.	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_MKT03-INS-COMM-Member Communications Distribution	
42 CFR §438.104(b)(1)(v) Contract C.7.01(d)	4. The PAHP does not directly or indirectly engage in door-to-door, telephone, email, texting, or other cold-call marketing activities.	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_MKT03-INS-COMM-Member Communications Distribution	
Contract C.7.02	5. <i>The PAHP is encouraged to market its products to the general community and potential members.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_MKT03-INS-COMM-Member Communications Distribution	
Contract C.7.02	6. <i>All marketing activities are provided at no additional cost to HHS.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_MKT03-INS-COMM-Member Communications Distribution	

Standard II—Marketing Checklist		
Reference	Required Components	
Contract C.7.02	7. <i>The PAHP complies with all applicable laws and regulations regarding marketing by health insurance issuers.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_MKT03-INS-COMM-Member Communications Distribution	
Contract C.7.02	8. <i>The PAHP obtains HHS approval for all marketing materials at least 30 days or within the timeframe requested by HHS, prior to distribution.</i>	Y ☐ N ☒
	Evidence as submitted by the PAHP: SII_Checklist_MKT02-INS-COM-Member Communications Development-FINAL	
Contract C.7.03	9. <i>PAHP permissible marketing activities include the following:</i> a. <i>The PAHP may market via mail and mass media advertising such as radio, television, and billboards.</i> b. <i>Participation in community-oriented marketing such as participation in community health fairs is encouraged.</i> c. <i>Tokens or gifts of nominal value may be distributed to potential members, so long as the PAHP acts in compliance with all law and policy guidance regarding inducements in the Medicaid Program, including marketing provisions provided for in 42 CFR §438.104.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_MKT03-INS-COMM-Member Communications Distribution	
42 CFR §438.104(b)(2) Contract C.7.04	10. The PAHP’s marketing, including plans and materials, are accurate and do not mislead, confuse, or defraud members or HHS.	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_MKT03-INS-COMM-Member Communications Distribution	
42 CFR §438.104(b)(2)(i) Contract C.7.04	11. The PAHP’s materials do not contain any assertion or statement (whether written or oral) that the recipient must enroll in the PAHP to obtain benefits or to not lose benefits.	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_MKT03-INS-COMM-Member Communications Distribution	

Standard II—Marketing Checklist		
Reference	Required Components	
42 CFR §438.104(b)(2)(ii) Contract C.7.04	12. The PAHP’s materials do not contain any assertion or statement (whether written or oral) that the PAHP is endorsed by CMS, the Federal or State government, or a similar entity.	Y ☒ N ☐
	Evidence as submitted by the PAHP: SII_Checklist_MKT03-INS-COMM-Member Communications Distribution	

Standard IV—Appointment Times Checklist

Standard IV—Appointment Times Checklist		
Reference	Required Components	
Dentist Access Standards		
42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) Contract Exhibit C: General Access Standards	1. <i>Dentist appointments are available as follows:</i> <i>a. Routine: not to exceed six to eight weeks from the date of a member’s request.</i> <i>b. Persistent symptoms: within 48 hours.</i> <i>c. Urgent: within one day.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: • SIV_IA DWP and HAWKI Exhibit_Access and Availability <full document>	
Specialty Care Access Standards		
42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) Contract Exhibit C: General Access Standards	2. <i>For specialty referrals for oral surgery, orthodontia, prosthodontia, periodontia, endodontia, and pediatric specialties:</i> <i>a. Routine: not to exceed 30 days; or</i> <i>b. Urgent: not to exceed one day.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: • SIV_IA DWP and HAWKI Exhibit_Access and Availability <full document>	
Emergency and Poststabilization Services Access Standards		
42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) Contract Exhibit C: General Access Standards	3. <i>For emergency and poststabilization of services, the PAHP provides appointments in accordance with the following:</i> <i>a. Emergency Care: All emergency care is immediate, at the nearest facility, regardless of whether the facility or provider is under contract with the PAHP.</i> <i>b. Poststabilization Services: Available in a timely manner to prevent rehospitalization or presenting at the emergency room and coordinated by the PAHP, for the member, upon notification from the member, MCO, hospital, physician, or dentist who referred the member.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: • SIV_IA DWP and HAWKI Exhibit_Access and Availability <full document> • SIV_NET07-INS-Access to Dental Services for Members<Page 2, Procedure A>	

Standard V—Network Adequacy Checklist

Standard V—Network Adequacy Checklist		
Reference	Required Components	
Dentist Access Standards		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract E.5.03 Contract Exhibit C: General Access Standards	1. <i>Within 30 minutes or 30 miles from the personal residences of members.</i> Evidence as submitted by the PAHP: - SV_IA DWP and HAWKI Exhibit_Access and Availability <Entire Document> - SV_SAMPLE Network Analysis - GEO Report <Entire Document> - We are still actively building the network ahead of the 7/1 go-live. Please refer to the Access and Availability Exhibit as evidence of our focus on ensuring member access. The Iowa GEO Report will not be available until after go-live; therefore, a sample GEO Report is included to illustrate the process we will use moving forward to monitor and maintain network adequacy.	Y ☒ N ☐
Specialty Care Access Standards		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract E.5.03 Contract Exhibit C: General Access Standards	2. Oral surgery is within: a. <i>Sixty minutes or 60 miles from the personal residence for at least 75 percent of members.</i> b. <i>Ninety minutes or 90 miles from the personal residence for all members.</i> Evidence as submitted by the PAHP: - SV_IA DWP and HAWKI Exhibit_Access and Availability <Entire Document> - SV_SAMPLE Network Analysis - GEO Report <Entire Document> - We are still actively building the network ahead of the 7/1 go-live. Please refer to the Access and Availability Exhibit as evidence of our focus on ensuring member access. The Iowa GEO Report will not be available until after go-live; therefore, a sample GEO Report is included to illustrate the process we will use moving forward to monitor and maintain network adequacy.	Y ☒ N ☐

Standard V—Network Adequacy Checklist		
Reference	Required Components	
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract E.5.03 Contract Exhibit C: General Access Standards	3. Orthodontia is within: a. <i>Sixty minutes or 60 miles from the personal residence for at least 75 percent of members.</i> b. <i>Ninety minutes or 90 miles from the personal residence for all members.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: - SV_IA DWP and HAWKI Exhibit_Access and Availability <Entire Document> - SV_SAMPLE Network Analysis - GEO Report <Entire Document> - We are still actively building the network ahead of the 7/1 go-live. Please refer to the Access and Availability Exhibit as evidence of our focus on ensuring member access. The Iowa GEO Report will not be available until after go-live; therefore, a sample GEO Report is included to illustrate the process we will use moving forward to monitor and maintain network adequacy.	
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract E.5.03 Contract Exhibit C: General Access Standards	4. Prosthodontia is within: a. <i>Sixty minutes or 60 miles from the personal residence for at least 75 percent of members.</i> b. <i>Ninety minutes or 90 miles from the personal residence for all members.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: - SV_IA DWP and HAWKI Exhibit_Access and Availability <Entire Document> - SV_SAMPLE Network Analysis - GEO Report <Entire Document> - We are still actively building the network ahead of the 7/1 go-live. Please refer to the Access and Availability Exhibit as evidence of our focus on ensuring member access. The Iowa GEO Report will not be available until after go-live; therefore, a sample GEO Report is included to illustrate the process we will use moving forward to monitor and maintain network adequacy.	
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract E.5.03 Contract Exhibit C: General Access Standards	5. Periodontia is within: a. <i>Sixty minutes or 60 miles from the personal residence for at least 75 percent of members.</i> b. <i>Ninety minutes or 90 miles from the personal residence for all members.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SV_IA DWP and HAWKI Exhibit_Access and Availability <Entire Document>	

Standard V—Network Adequacy Checklist		
Reference	Required Components	
	- SV_SAMPLE Network Analysis - GEO Report <Entire Document> - We are still actively building the network ahead of the 7/1 go-live. Please refer to the Access and Availability Exhibit as evidence of our focus on ensuring member access. The Iowa GEO Report will not be available until after go-live; therefore, a sample GEO Report is included to illustrate the process we will use moving forward to monitor and maintain network adequacy.	
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract E.5.03 Contract Exhibit C: General Access Standards	6. <i>Endodontia</i> is within: a. <i>Sixty minutes or 60 miles from the personal residence for at least 75 percent of members.</i> b. <i>Ninety minutes or 90 miles from the personal residence for all members.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: - SV_IA DWP and HAWKI Exhibit_Access and Availability <Entire Document> - SV_SAMPLE Network Analysis - GEO Report <Entire Document> - We are still actively building the network ahead of the 7/1 go-live. Please refer to the Access and Availability Exhibit as evidence of our focus on ensuring member access. The Iowa GEO Report will not be available until after go-live; therefore, a sample GEO Report is included to illustrate the process we will use moving forward to monitor and maintain network adequacy.	
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract E.5.03 Contract Exhibit C: General Access Standards	7. <i>Pediatric specialties</i> are within: a. <i>Sixty minutes or 60 miles from the personal residence for at least 75 percent of members.</i> b. <i>Ninety minutes or 90 miles from the personal residence for all members.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: - SV_IA DWP and HAWKI Exhibit_Access and Availability <Entire Document> - SV_SAMPLE Network Analysis - GEO Report <Entire Document> - We are still actively building the network ahead of the 7/1 go-live. Please refer to the Access and Availability Exhibit as evidence of our focus on ensuring member access. The Iowa GEO Report will not be available until after go-live; therefore, a sample GEO Report is included to illustrate the process we will use moving forward to monitor and maintain network adequacy.	

Standard VI—Clinical Records Checklist

Standard VI—Clinical Records Checklist		
Reference	Required Components	
<i>The PAHP maintains in its information system (IS) the information necessary to assist in authorizing and monitoring services as well as providing data necessary for quality assessment and other evaluative activities, including but not limited to:</i>		
Contract K.30(a)	1. <i>Diagnosis: documentation of the diagnoses.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SVI_UM Program Description <Pg. 8 EPSDT>	
Contract K.30(b)	2. <i>Services Authorized: documentation of clinical services requested, services authorized, services substituted, services provided; documentation reflects the application of UM criteria.</i>	Y ☐ N ☒
	Evidence as submitted by the PAHP: SVI_UM Program Description <Pg 5-6 Authorizations and Clinical Review>	
Contract K.30(c)	3. <i>Services Denied: documentation of services not authorized, reasons for the non-authorization based on Iowa Administrative Code citations and substitutions offered.</i>	Y ☐ N ☒
	Evidence as submitted by the PAHP: SVI_UM Program Description <Pg 5-6 Authorizations and Clinical Review>	
Contract K.30(d)	4. <i>Missed Appointments: documentation of missed appointments and subsequent attempts to follow up with the member.</i>	Y ☐ N ☒
	Evidence as submitted by the PAHP: SVI_IA_DENTAL_CMPDT.01	
Contract K.30(e)	5. <i>Treatment Planning: documentation of joint treatment planning, clinical consultation, or other interaction with the member or providers and/or funders providing or seeking to provide services to the member.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SVI_IA_DENTAL_CMPDT.01 <Pg 15-16 Assistance and Desired Outcomes>	

Standard VI—Clinical Records Checklist		
Reference	Required Components	
Contract K.30(f)	6. <i>Joint Treatment Planning: name(s) of persons key to the treatment planning of members who access multiple services.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SVI_IA_DENTAL_CMPDT.01 <Pg 4 Key Staff>	

Standard VIII—Provider Manual Checklist

Standard VIII—Provider Manual Checklist		
Reference	Required Components	
The provider manual includes, at a minimum, the following topics:		
Contract E.1.03(a)	1. <i>Program benefits and limitations.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SVIII_Provider Reference Manual page 74-154, Appendix C – Covered Benefits>	
Contract E.1.03(b)	2. <i>Claims filing instructions.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SVIII_Provider Reference Manual <page 26-27, 7.00 Review & Claim Submission Procedures (Claim Filing Options) and Encounter Data>	
Contract E.1.03(c)	3. <i>Criteria and process to use when requesting prior authorizations.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SVIII_Provider Reference Manual <page 28-29, section 7.02 Submitting E-Rays for Prio Auth & 7.03 Electronic Prio Auth or Claim Submissions>	
Contract E.1.03(d)	4. <i>Cost sharing requirements.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SVIII_Provider Reference Manual <page 23, section 5.02 Indian Health Care Providers>	
Contract E.1.03(e)	5. <i>Definition and requirements pertaining to urgent and emergent care.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SVIII_Provider Reference Manual <page 14 & 16, section Emergency/Urgent Definitions>	
Contract E.1.03(f)	6. <i>Members’ rights.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SVIII_Provider Reference Manual <page 6, section The Iowa Patient’s Bill of Rights and Responsibilities>	

Standard VIII—Provider Manual Checklist		
Reference	Required Components	
Contract E.1.03(g)	7. <i>Providers' rights for advising and advocating on behalf of his or her patient.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SVIII_Provider Reference Manual <page 7, section Statement of Provider Rights and Responsibilities>	
Contract E.1.03(h)	8. <i>Provider non-discrimination information.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SVIII_Provider Reference Manual <page 8, section NONDISCRIMINATION NOTICE>	
Contract E.1.03(i)	9. <i>Policies and procedures for grievances and appeals in accordance with 42 CFR §438.414 and consistent with Section E.6 of the contract.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SVIII_Provider Reference Manual <page 36, section B. Complaints/Grievance Staff>	
Contract E.1.03(j)	10. <i>PAHP and HHS contact information such as addresses and phone numbers.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SVIII_Provider Reference Manual <page 4, section Contact Info>	
Contract E.1.03(k)	11. <i>Policies and procedures for third party liability (TPL) and other collections.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SVIII_Provider Reference Manual <Page 32, Section 7.08 Coordination of Benefits >	

Standard VIII—Provider Contract Checklist

Standard VIII—Provider Contract Checklist		
Reference	Required Components	
<i>Provider contracts include, at a minimum, the following requirements:</i>		
Contract E.1.06	1. <i>The applicable terms of the PAHP's Contract with HHS and any incorporated documents and all applicable State and Federal laws, as amended, govern the duties and responsibilities of the provider with regard to the provision of services to members.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: - Provider Agreement, page 1, paragraph under Addendum list – see below - By signing below, Participating Practice acknowledges that it has received and reviewed each Addendum attached hereto and applicable to the product types selected on the first page of this Agreement (“Applicable Addendum” and, collectively, “Applicable Addenda”) and agrees to comply with all rules, regulations, and obligations set forth in this Dental Participating Practice Agreement and all Applicable Addenda (collectively, with all attachments and amendments, the “Agreement”). To the extent that the terms herein conflict with the terms set forth in any Applicable Addendum, the terms of the Addendum shall control. - Provider Agreement, <page 5, #7 Additional Requirements> - Provider Agreement, <page 8, Addendum A>	
Contract E.1.06	2. <i>Provisions to ensure continuation of benefits.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: - Provider Agreement, <page 5, (g.) Continuation of care> - Provider Agreement, <page 11, 1.4.3 Participating Practice Responsibilities>	
Contract E.1.06	3. <i>A signed Business Associates Agreement (BAA) when required.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: - Provider Agreement, <page 17, Addendum C, #11> <u>Addendum C is Iowa Medicaid</u>	

Standard VIII—Provider Contract Checklist		
Reference	Required Components	
Contract E.1.06	4. <i>The provider's responsibility regarding third party liability (TPL), including the provider's obligations to identify TPL coverage, including Medicare as applicable, and except as otherwise required, seek such TPL payment before submitting claims to the PAHP.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: - Provider Agreement < page 4, 5 (d), Coordination of benefits > - Provider Agreement < page 18, 6.01 Provider Reimbursement >	
Contract E.1.06	5. <i>Submission of claims that do not involve a third-party payer within 180 days of the date of service.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: Provider Agreement < page 16, Addendum C, #9 >	
Contract E.8.03	6. <i>For any providers who are paid on a capitated basis, the submission of encounter data within 90 days of the date of service.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: Provider Agreement	
Contract D.6.03	7. <i>Alternative payment schedule as provided in 42 CFR §447.46(c)(2), as applicable.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: Provider Agreement	

Standard XIV—Staffing Checklist

Standard XIV—Staffing Checklist		
Reference	Required Components	
<i>The PAHP's staffing includes the following key personnel positions:</i>		
Contract A.07(f)	1. <i>Chief Executive Officer (CEO): Responsible for overseeing the entire healthcare plan of the PAHP. Has full and final responsibility for Contract compliance.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SXIV_IA Staffing Plan <Row 6>	
Contract A.07(g)	2. <i>Chief Operating Officer (COO): Responsible for oversight of all day-to-day operations of the healthcare plan operations. Has oversight of all functional operational areas within the healthcare plan. Reports directly to the CEO.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SXIV_IA Staffing Plan <Row 7>	
Contract A.07(h)	3. <i>Dental Director: Shall be an Iowa-licensed dentist in good standing. Ensures oversight of all clinical functions. Ensures for the coordination and implementation of the quality assessment and performance improvement (QAPI) program. Attends and actively participates in any scheduled Quality committee meetings as directed by HHS. Directs the PAHP's internal UM committee.</i>	Y ☐ N ☒
	Evidence as submitted by the PAHP: SXIV_IA Staffing Plan <Row 8>	
Contract A.07(i)	4. <i>Chief Financial Officer: Oversees the PAHP's budget, accounting systems, and financial reporting for the Contract.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SXIV_IA Staffing Plan <Row 9>	

Standard XIV—Staffing Checklist		
Reference	Required Components	
Contract A.07(j)	5. <i>Compliance Officer: Accountable to the PAHP’s executive leadership and dedicated full-time to the Contract with the requirements of Section I.5 of the Contract. This individual is the primary liaison with HHS (or its Designees) to facilitate communications between HHS, HHS’ contractors, and the PAHP’s executive leadership and staff. This individual maintains a current knowledge of federal and State legislation, legislative initiatives, and regulations that may impact the Contract. It is the responsibility of the Compliance Officer to comply with all HIPAA and privacy regulations as well as coordinate reporting to HHS and to review the timeliness, accuracy, and completeness of reports and data submissions to HHS. The Compliance Officer, in close coordination with other key personnel, has primary responsibility for ensuring all PAHP functions are in compliance with the terms of the Contract.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SXIV_IA Staffing Plan <Row 10>	
Contract A.07(k)	6. <i>Grievance and Appeals Manager: Manages the PAHP’s grievance and appeals process, ensuring compliance with processing timelines and policy and procedure adherence.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SXIV_IA Staffing Plan <Row 11>	
Contract A.07(l)	7. <i>Quality Management Manager: Oversees the PAHP’s QAPI program and ensure compliance with quality management requirements and quality improvement initiatives.</i>	Y ☐ N ☒
	Evidence as submitted by the PAHP: SXIV_IA Staffing Plan <Row 12>	
Contract A.07(m)	8. <i>UM Manager: Manages all elements of the PAHP’s UM program and staff under the supervision of the Dental Director. This includes but is not limited to functions related to prior authorization, medical necessity determinations, concurrent and retrospective reviews, and other programs as described in the Contract.</i>	Y ☐ N ☒
	Evidence as submitted by the PAHP: SXIV_IA Staffing Plan <Row 13>	

Standard XIV—Staffing Checklist		
Reference	Required Components	
Contract A.07(n)	9. <i>Member Services Manager: Provides oversight of the member services functions of the Contract, including, but not limited to, member helpline telephone performance, member email communications, member education, the member website, member outreach programs, development, and approval and distribution of member materials. The Member Services Manager oversees the interface with HHS or its subcontractors regarding such issues as member enrollment and disenrollment.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SXIV_IA Staffing Plan <Row 14>	
Contract A.07(o)	10. <i>Provider Services Manager: Provides oversight of the provider services function of the Contract. This includes, but is not limited to, the provider services helpline, provider recruitment, contracting and credentialing, facilitating the provider claims dispute process, developing and distributing the provider manual and education materials, and developing provider outreach programs. The Provider Services Manager, in close coordination with other key personnel, ensures that all of the PAHP's provider services operations are in compliance with the terms of the Contract.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SXIV_IA Staffing Plan <Row 15>	
Contract A.07(p)	11. <i>Information Systems Manager: Serves as a liaison between the PAHP and HHS, or its designee, regarding member encounter data submissions, capitation payment, member eligibility, enrollment, and other data transmission interface and management issues. The Information Systems Manager, in close coordination with other key personnel, ensures all information system security and controls, program data transactions, data exchanges, and other information system requirements are in compliance with the terms of the Contract and all data submissions required for federal reporting. The Information Systems Manager oversees all systems testing, including during the readiness review.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SXIV_IA Staffing Plan <Row 16>	

Standard XIV—Staffing Checklist		
Reference	Required Components	
Contract A.07(q)	12. <i>Claims Administrator: Ensures prompt and accurate provider claims processing in accordance with the terms of the Contract.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SXIV_IA Staffing Plan <Row 17>	
Contract A.07(r)	13. <i>Care Coordination Manager: Ensures oversight of the PAHP's care coordination program.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: SXIV_IA Staffing Plan <Row 18>	
Contract A.07(s)	14. <i>Program Integrity Manager and Special Investigations Unit Staffing: Ensures oversight of the PAHP's Special Investigations Unit (SIU) activity. The PAHP ensures that their Program Integrity Manager has demonstrated experience in providing leadership, oversight and direction in the development and implementation of Medicaid Managed Care program integrity programs. The Program Integrity Manager leads the implementation of strategic direction from State of Iowa Medicaid managed care program administrators and leadership. The Program Integrity Manager leads collaboration of managed care plan's program integrity efforts with CMS and federal/state law enforcement partners, including supporting all efforts by Iowa Medicaid to hold providers and suppliers responsible for fraud, waste, and abuse (FWA). Specifically, the Program Integrity Manager meets the following requirements:</i> <i>Demonstrated knowledge and experience in managing health care delivery, program integrity, UM, or public health program functions within a large-scale health plan or programs.</i> <i>Comprehensive knowledge of laws, policies, and regulations that apply to the administration of Medicaid Managed Care program health care delivery and program integrity. Demonstrated ability to use this knowledge and associated metrics to assess and improve program effectiveness, management processes, and systems to achieve program integrity priorities and results.</i> <i>Demonstrated experience, in a senior leadership position working with government agencies and programs, law enforcement organizations, and/or public and private organizations on complex and controversial issues relating to program administration and the protection of the integrity of the Medicaid programs.</i> <i>Qualification Requirements:</i> <i>Graduation from an accredited four-year college or university with a degree in any field (e.g., public or business administration, social work, public health, law, education, engineering), and experience equal to five years of full-time professional-level work in program administration, program development, program operations, or management; or</i>	Y ☐ N ☒

Standard XIV—Staffing Checklist		
Reference	Required Components	
	ii. <i>A total of nine years of combined education and/or full-time experience in any field and profession experience as defined above.</i> e. <i>The Program Integrity Manager serves as the liaison between the PAHP and State agencies, law enforcement, and federal agencies. The Program Integrity Manager is informed of current trends in FWA as well as mechanisms to detect such activity. The Program Integrity Manager is located in the Iowa offices. The position is dedicated at least 100 percent of the time to the oversight and management of the program integrity efforts required under the Contract. The Program Integrity Manager has open and immediate access to all claims, claims processing data and any other electronic or paper information sufficient to meet the requirements of the Agency. The duties shall include, but not be limited to:</i> i. <i>Oversight of the program integrity function under the Contract.</i> ii. <i>Liaison with HHS in all matters regarding program integrity.</i> iii. <i>Development and operations of a fraud control program within the PAHP's claims payment system.</i> iv. <i>Liaison with Iowa's Medicaid Fraud Control Unit (MFCU) and/or the Office of the Attorney General.</i> v. <i>Assures coordination of efforts with HHS and other agencies with regards to program integrity issues.</i> Evidence as submitted by the PAHP: SXIV_IA Staffing Plan <Row 19>	
Contract A.07(t)	15. <i>Primary Point of Contact: In addition to all other key personnel and management positions, the PAHP designates a primary point of contact with HHS for delivery system reform activities, including managing a specific project plan and reporting on activity and progress towards identified goals. The point person will also serve as the liaison between the PAHP and various state agencies, leaders from the healthcare delivery system, other payers, stakeholders, and federal agencies. The point person also is informed of current trends in delivery system reports and have the specific experience within the healthcare delivery system in Iowa. The point person is located in the Iowa offices.</i> Evidence as submitted by the PAHP: SXIV_IA Staffing Plan <Row 20>	Y ☒ N ☐

Standard XIV—Staffing Checklist		
Reference	Required Components	
The PAHP also includes the following staffing:		
Contract A.07(b)	16. <i>Prior Authorization: Authorizes requests for services.</i>	Y ☐ N ☒
	Evidence as submitted by the PAHP: SXIV_IA Staffing Plan <Row 13>	
Contract A.07(b)	17. <i>Member Services Staff: Responds to member inquiries via a member services helpline, as well as written and electronic correspondence.</i>	Y ☐ N ☒
	Evidence as submitted by the PAHP: SXIV_IA Staffing Plan <Row 31>	
Contract A.07(b)	18. <i>Provider Services Staff: Responds to provider inquiries and disputes and provides outreach on provider policies and procedures.</i>	Y ☐ N ☒
	Evidence as submitted by the PAHP: SXIV_IA Staffing Plan <Row 22>	
Contract A.07(b)	19. <i>Claims Processing Staff: Ensures timely and accurate processing of claims.</i>	Y ☐ N ☒
	Evidence as submitted by the PAHP: SXIV_IA Staffing Plan <Row 36>	
Contract A.07(b)	20. <i>Reporting and Analytics Staff: Ensures timely and accurate reporting and analytics needed to meet the requirements of the Contract.</i>	Y ☐ N ☒
	Evidence as submitted by the PAHP: SXIV_IA Staffing Plan <Row 33>	
Contract A.07(b)	21. <i>Quality Management Staff: Performs quality management and improvement activities.</i>	Y ☐ N ☒
	Evidence as submitted by the PAHP: SXIV_IA Staffing Plan <Row 28>	

Standard XIV—Staffing Checklist		
Reference	Required Components	
Contract A.07(b)	22. <i>Marketing and Outreach Staff: Manages marketing and outreach efforts.</i>	Y ☐ N ☒
	Evidence as submitted by the PAHP: SXIV_IA Staffing Plan <Row 21, 23>	
Contract A.07(b)	23. <i>Compliance Staff: Supports the Compliance Officer and ensures compliance with laws and regulations, internal policies and procedures, and terms of the Contract.</i>	Y ☐ N ☒
	Evidence as submitted by the PAHP: SXIV_IA Staffing Plan <Row 29>	
Contract A.07(b)	24. <i>SIU Staffing (one full-time Iowa-dedicated SIU staff member for each 100,000 members assigned to the PAHP and a majority of SIU staff members located in Iowa): Reviews, investigates, and audits the PAHP's providers and members to identify FWA.</i>	Y ☐ N ☒
	Evidence as submitted by the PAHP: SXIV_IA Staffing Plan <Row 40>	

Standard XIV—Staff Training Checklist

Standard XIV—Staff Training Checklist		
Reference	Required Components	
<i>The PAHP provides initial and ongoing training and ensures all staff are trained in the major components of the Contract, including:</i>		
Contract A.13(i)	1. <i>Contract requirements and State and Federal requirements specific to job functions.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: • SXV_Iowa Key Personnel Resumes • SXIV_Additional Iowa Key Personnel Resumes	
Contract A.13(ii)	2. <i>Initial and ongoing training on identifying and handling quality of care concerns, including access to dental services as outlined in the Contract.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: • SXIV_Initial training - CGA - Quality of Care_Critical Incidents_Site visits	
Contract A.13(iii)	3. <i>Cultural sensitivity training.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: • SXIV_2025 Cultural Competency and NonDiscrimination Training	
Contract A.13(iv)	4. <i>Training on fraud and abuse and the False Claims Act as further described in Section I of the Contract.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: • SXIV_2025 Abuse-Neglect-Exploitation Training Final	
Contract A.13(v)	5. <i>Health Information Portability and Accountability Act (HIPAA) training.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: • SXIV_CDW_HITRUST Interim Certification Letter - 2025 SOC2 will be emailed to IA HHS	
Contract A.13(vi)	6. <i>Clinical protocol training for all clinical staff.</i>	Y ☒ N ☐
	Evidence as submitted by the PAHP: • SXIV_UM Initial and Ongoing Training Clinical Criteria • SXIV_Sample Clinical Training Materials	

Standard XIV—Staff Training Checklist		
Reference	Required Components	
Contract A.13(vii)	7. <i>Training regarding interpretation and application of UM guidelines for all UM staff.</i>	Y ☐ N ☒
	Evidence as submitted by the PAHP: - SXIV_UM Initial and Ongoing Training Clinical Criteria - SXIV_Sample Clinical Training Materials	
Contract A.13(viii)	8. <i>Training and education to understand abuse, neglect, exploitation, and prevention including the detection, mandatory reporting, investigation, and remediation procedures and requirements.</i>	Y ☐ N ☒
	Evidence as submitted by the PAHP: SXIV_2025 Abuse-Neglect-Exploitation Training Final	
Contract A.13(ix)	9. <i>Training specific to Iowa providers and non-Medicaid resources.</i>	Y ☐ N ☒
	Evidence as submitted by the PAHP: SXIV_NET03-INS-Provider Partner Staffing and Training-FINAL	

Appendix B. Operational Readiness Review Remediation Plan

Standard II—Member Rights and Member Information

Operational Readiness Review Standards Remediation Plan		
Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
Specific Rights		
3. The PAHP complies with the requirements listed in the Member Rights Checklist. 42 CFR §438.100(b-d) 42 CFR §457.1220 Contract C.2.12- C.2.13 Contract F.16	HSAG Required Evidence: • Policies and Procedures • Member materials, such as the member handbook • Section 1557 Language Access Provisions • HSAG will use the results of the Member Rights Checklist Evidence as Submitted by the PAHP: • SII_DQ3197 IA_Medicaid Adult (7.26) HBEN • SII_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26	☐ Met ☒ Not Met
PAHP Description of Process: HSAG Findings: The PAHP’s <i>Marketing Safeguards</i> policy included information related to members’ right to “privacy and to be treated with respect and recognition of their dignity when receiving dental care,” and its member handbooks (i.e., DWP Adults, DWP Kids, and Hawki) informed members they have the right to be treated with respect and have their information kept private; however, the PAHP’s policies and member handbooks did not specify that the PAHP will not in any way restrict the member’s right to fully participate in the community and to work, live, and learn to the fullest extent possible. Recommendations: Although the PAHP’s policy included information on member rights related to receiving information on available treatment options, HSAG recommends that the PAHP update its <i>Marketing Safeguards</i> policy and its member handbooks to specify that members also have the right to receive information on alternatives. Following the site review, the PAHP provided its member handbooks and cited information related to members obtaining rides to their dental appointments; however, it was unclear to HSAG how these sections were related to this recommendation. Additionally, HSAG recommends that the PAHP clarify in its policies and member handbooks that members have the right to receive a copy of his or her <i>dental</i> records,		

Operational Readiness Review Standards Remediation Plan		
Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
rather than “medical records.” Further, HSAG strongly recommends that the PAHP ensure that all applicable member rights are consolidated in its “Rights and Responsibilities” section of its member handbooks as HSAG noted information related to member rights throughout several sections of the member handbooks. Lastly, although the PAHP included language in its member handbook related to ensuring its members have the right to be furnished healthcare services in accordance with 42 CFR §438.206 through §438.210, HSAG recommends that the PAHP expand upon this member right in the PAHP’s member handbook, as well as in any applicable policies, procedures, or provider contracts.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Add Requirement #10 of HSAG’s <i>Member Rights Checklist</i> to policies and procedures.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	DentaQuest has added recommendations and requirement #10 of the HSAG’s Member Rights Checklist into the applicable policy and member handbooks. <i>Recommendations were also followed</i> - SII_3. MKT01-INS-Marketing Safeguards-FINAL Iowa Medicaid_CHIP<Exhibit A, #2 and 16> - SII_DQ3197 IA_Medicaid Adult (7.26) HBEN <Pg. 31> - SII_DQ4080 IA_Medicaid Child (7.26) HBEN <Pg. 32> - SII_DQ3198 IA_Medicaid Hawki (7.26) HBEN <Pg. 33>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/05/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. Although the PAHP provided HSAG with revised versions of its member handbooks that included a member right that stated, “You have the right to participate fully in your community, work, live, and learn,” HSAG recommends that the PAHP update this statement for clarity as this statement is not grammatically correct.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted
5. The PAHP uses the definitions for managed care terminology developed by HHS including: a. Appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services,	HSAG Required Evidence: - Policies and procedures - Member materials, such as the member handbook Evidence as Submitted by the PAHP: - SII_DQ3197 IA_Medicaid Adult (7.26) HBEN	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. 42 CFR §438.10(c)(4)(i) 42 CFR §457.1207 Contract C.8.07-C.8.08 Contract Exhibit B	SII_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26	
PAHP Description of Process: This is a stand-alone dental plan.		
HSAG Findings: HSAG could not find all the required definitions for managed care terminology as required by 42 CFR §438.10(c)(4)(i) and HHS’ <i>Exhibit B: Glossary of Terms/Definitions</i> . During the review, the PAHP indicated it would update the draft versions of the <i>DQ3197 IA_Medicaid Adult (7.26) HBEN</i> and <i>DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26</i> member handbooks. Following the review, the PAHP provided the DWP Adults, DWP Kids, and Hawki member handbooks; however, the updated member handbooks did not include all the required definitions for managed care terminology.		
Recommendations: HSAG strongly recommends that the PAHP include the list of required definitions for managed care terminology as required by 42 CFR §438.10(c)(4)(i) and HHS’ <i>Exhibit B: Glossary of Terms/Definitions</i> in its policies and procedures.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must:		
Include all required definitions for managed care terminology as required by 42 CFR §438.10(c)(4)(i) and HHS.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	<i>DentaQuest has added all required definitions for managed care terminology as required by 42 CFR §438.10(c)(4)(i) and HHS.Policy into the applicable member handbooks:</i> - SII_DQ3197 IA_Medicaid Adult (7.26) HBEN <Pg. 46> - SII_DQ4080 IA_Medicaid Child (7.26) HBEN <Pg. 44> - SII_DQ3198 IA_Medicaid Hawki (7.26) HBEN <Pg. 45>	
Individual(s) Responsible: [redacted]		

Operational Readiness Review Standards Remediation Plan		
Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
Completion Date: 05/05/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. However, HSAG recommends that the PAHP work with HHS to get clarification on whether the managed care terminology required under Contract C.8.07 and those definitions under Exhibit B are all required to be included in the <i>Medicaid Adult</i> , <i>Child</i> , and <i>Hawki HBEN</i> member handbooks.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted
Language and Format		
7. The PAHP makes its written materials that are critical to obtaining services, including at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in its service areas. a. Written materials that are critical to obtaining services are also made available in alternative formats upon request of the member or potential member at no cost. b. Written materials that are critical to obtaining services include 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. <i>Taglines also include teletypewriter telephone/text Telephone (TTY/TDY) telephone number of the PAHP’s member/customer service unit.</i> c. Written materials that are critical to obtaining services include information on how to request auxiliary aids and services. d. Written materials that are critical to obtaining services include the toll-free and TTY/TDY telephone number of the PAHP’s member/customer services unit.	HSAG Required Evidence: • Policies and procedures • Provider directory in English, including taglines • Provider directory in prevalent non-English languages, including taglines • Member handbook in English, including taglines • Member handbook in prevalent non-English languages, including taglines • Examples of member notices in English, including taglines (i.e., appeal, grievances, and ABD notices) • Examples of member notices in prevalent non-English languages (i.e., appeal, grievances, and ABD notices), including taglines • Definition of conspicuously visible font • Mechanisms to ensure taglines are included as part of all critical member materials Evidence as Submitted by the PAHP: • SII_DQ3197 IA_Medicaid Adult (7.26) HBEN • SII_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
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Requirement	Supporting Documentation	Score
e. Auxiliary aids and services must be made available upon request of the member or potential member at no cost. “Prevalent languages” means English and Spanish, and any language spoken by at least five percent of the general population in the PAHP’s service area. 42 CFR §438.10(d)(3) 42 CFR §457.1207 Contract C.1.19-C.1.22 Contract C.1.24(c) Contract C.1.27(b)	- SII_Reading Level_Iowa CHIP_Welcome Letter_2-26-26 - SII_Reading Level_Iowa Medicaid_Welcome Letter_2-26-26 - SII_Checklist_MKT03-INS-COMM-Member Communications Distribution	
PAHP Description of Process: The Member handbook is in development and is projected to be completed by the IA HHS due date of March 16, 2026. The ABD notices are still being developed and drafts are currently unavailable. DentaQuest will be able to provide drafts as a follow-up from the Virtual Review.		
HSAG Findings: HSAG’s review identified the findings below: - HSAG could not confirm the font size of the taglines within the <i>DQ3197 IA_Medicaid Adult (7.26) HBEN</i> and <i>DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26</i> member handbooks as the taglines were in a picture format; however, the taglines did appear to be in a small font size. The PAHP provided the <i>IA Medicaid MLI</i> document that was different than what was included in the member handbooks. - During the review, the PAHP confirmed the definition of conspicuously visible font was “...as well as large print of no less than 18-pt font size,” that was referenced on page 10 of the <i>MKT04-Health Literacy</i> policy and procedure. Following the review, the PAHP provided the DWP Adults, DWP Kids, and Hawki member handbooks; however, in the updated member handbooks, the taglines and customer service telephone number were in 12-point font size. These taglines did not align with the <i>IA Medicaid MLI</i> document that was provided as follow-up that had the taglines in 18-point font size and the customer service number in 14-point font size. - The PAHP provided the <i>CORR06-INS Letter Template Translation and Alternate Format</i> policy and procedure, which indicated “MLI contains statements for how the member can request the document translated into a non-English language or alternate format, and includes the phone number to call to make the request. i. Content in the MLI is also included in a conspicuously visible font size.” This did not provide clarity on the definition of conspicuously visible font and could potentially cause confusion for staff members as the <i>MKT04-Health Literacy</i> policy and procedure indicates an 18-point font and staff members may not be aware to go to both policies to identify the PAHP’s definition of conspicuously visible font.		

Operational Readiness Review Standards Remediation Plan		
Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Provide evidence, including updated member handbooks, to support that its written materials critical to obtaining services include taglines in accordance with 42 CFR §438.10(d)(3) and the requirements of this element. - Provide updated policies and procedures that demonstrate alignment of the definition of conspicuously visible font.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	- DentaQuest has updated the policy and procedure to demonstrate alignment of definition of conspicuously visible font. DentaQuest has updated the member handbooks to support written materials critical to obtaining services: - SII_7. MKT04-Health Literacy-FINAL - Iowa Medicaid_CHIP<Exhibit A, #2> - SII_DQ3197 IA_Medicaid Adult (7.26) HBEN <Pg. 5> - SII_DQ4080 IA_Medicaid Child (7.26) HBEN <Pg. 11> - SII_DQ3198 IA_Medicaid Hawki (7.26) HBEN <Pg. 10> - SII_7_CORR06-INS Letter Template Translation <Pg. 6>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/06/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. However, HSAG recommends that the PAHP ensure the updated conspicuously visible font definition within the <i>MKT04-Health Literacy</i> policy and procedure is included in the <i>CORR06-INS Letter Template Translation and Alternate Format</i> policy and procedure for consistency.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted
Information for Members		
12. The PAHP makes a good faith effort to give written notice of termination of a contracted provider to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. Notice to the member must be provided by the later of: Thirty calendar days prior to the effective date of the termination; or	HSAG Required Evidence: - Policies and procedures - Workflow of provider termination process - Template of written notice to members of provider termination - Tracking or reporting mechanism that demonstrates timeliness	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
b. Fifteen calendar days after receipt or issuance of the termination notice. 42 CFR §438.10(f)(1) 42 CFR §457.1207 Contract C.6.01	Evidence as Submitted by the PAHP: - SII_CORR01-INS-Member Notifications of Provider Terminations <Pg 1 Procedure A> - SII_Provider Reference Manual <Pg. 39 Section 12.01>	
PAHP Description of Process: The ABD and member notices are still being developed and drafts are currently unavailable. DentaQuest will be able to provide drafts as follow-up from the Virtual Review.		
HSAG Findings: While the PAHP’s <i>CORR01-INS-Member Notifications of Provider Terminations</i> policy included language that indicates a “good faith effort to provide written notice to a member of the termination or departure of a network provider are within fifteen calendar days after receipt or issuance of the termination notice or departure,” the policy did not include language to satisfy sub-element (a) for this element.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Provide an updated policy to include all language required by 42 CFR §438.10(f)(1).		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	<i>DentaQuest has updated the policy CORR01-INS-Member Notifications of Provider Terminations with the required language in sub-element that will be taken to a to remediate the issue.</i> SII_CORR01-INS-Member Notifications of Provider Terminations 5.5.26 <Pg.1>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/05/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
Member Handbook		
15. The member handbook includes all requirements listed in the Member Handbook Checklist. 42 CFR §438.10(g)(2) 42 CFR §457.1207 Contract C.2	HSAG Required Evidence: - Searchable (Word/PDF) version of member handbook (version that would be provided to member if paper copy requested) - Link to member handbook on PAHP’s website - HSAG will also use the results of the Member Handbook Checklist Evidence as Submitted by the PAHP: - SII_DQ3197 IA_Medicare Adult (7.26) HBEN - SII_DQ4080 IA_Medicare Child (7.26) HBEN_Draft_2.26.26 - SII_Checklist_MKT03-INS-COMM-Member Communications Distribution	☐ Met ☒ Not Met
PAHP Description of Process: The website is still in development. Once the configuration is complete, a link to the member handbook can be provided. HSAG Findings: Although the PAHP’s member handbooks contained information on member rights, they did not contain all required member rights and responsibilities as specified in 42 CFR §438.100. The PAHP’s member handbooks included information on the members’ right to be treated with respect and to have their information kept private; however, they did not specify the member right to dignity. Additionally, the PAHP’s member handbooks also did not include the following member rights as specified in 42 CFR §438.100: - Receive information on available treatment options and alternatives, presented in a manner appropriate to the member’s condition and ability to understand; - Exercise his or her rights, and that the exercise of those rights does not adversely affect the way the PAHP and its network providers or HHS treat the member; and, - In recognizing each member’s dignity and privacy, the PAHP does not in any way restrict the member’s right to fully participate in the community and to work, live, and learn to the fullest extent possible. Lastly, the PAHP’s member handbooks included language stating that “[i]f we plan to stop or reduce a service you already get, you may keep the service while we review your appeal if you ask within 10 days of the letter date (or before your current approval ends). If the final decision is not in your favor,		

Operational Readiness Review Standards Remediation Plan		
Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
you may have to pay for care you got during the appeal.” However, the member handbooks did not clearly indicate the requirements pertaining to continuation of benefits during the state fair hearing (SFH) or that members are required to pay for the cost of continued services provided during an SFH. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Update its member handbooks to include Requirements #15 and #21 in the <i>Member Handbook Checklist</i>.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	DentaQuest has updated the member handbooks to include requirements #15 and #21 in the member Handbook Checklist: - SII_DQ3197 IA_Medicaid Adult (7.26) HBEN <Pg. 31 & 32> - SII_DQ4080 IA_Medicaid Child (7.26) HBEN <Pg. 31 & 32> - SII_DQ3198 IA_Medicaid Hawki (7.26) HBEN <Pg. 32 & 33>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/05/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are not sufficient to demonstrate readiness with the requirements for this program area. Although the PAHP’s member handbooks included member rights and responsibilities as specified in 42 CFR §438.100, it did not include the member right specific to “due consideration for his or her dignity...” as noted in the previous finding. Additionally, although the PAHP’s member handbooks informed members that if the PAHP plans “to stop or reduce a service you already get, you may keep the service while we review your appeal,” information that benefits that the PAHP seeks to reduce or terminate will continue if the member <u>requests an SFH</u> within the time frames specified for filing was not found. The PAHP must submit an updated plan of correction for remediating the continued deficiency and will also be required to meet with HSAG to ensure future compliance with the program area. Lastly, please refer to all program standards for any recommendations related to enhancements to the PAHP’s member handbooks.		☐ Accepted ☐ Accepted With Recommendations ☒ Not Accepted
Updated Remediation to Address CAP Not Accepted:		
Updated Plan to Remedy Deficiency (Include a narrative with all actions that will be taken to remediate deficiency):	DentaQuest has updated the Member Rights section and State Fair Hearing language to all three handbooks. Citations are listed below. We have also reviewed all recommendations for the member handbooks edits and updated them accordingly. Comments have been added to each of the recommendations in the CAP document to identify the change.	
Responsible Individual(s):	[redacted]	

Operational Readiness Review Standards Remediation Plan			
Standard II—Member Rights and Member Information			
Requirement		Supporting Documentation	Score
Timeline/Completion Date:	05/26/2026		
Evidence as Submitted by the PAHP to Address Deficiency:	- SII_15_DQ3198 IA_Medicaid Hawki (7.26) HBEN Final_5.26.26<Pg 23 Rights and Responsibilities; Pg 26 Keeping Your Benefits During a State Fair Hearing> - SII_15_DQ3197 IA_Medicaid Adult (7.26) HBEN Final_5.26.26 <Pg 24 Rights and Responsibilities; Pg 27 Keeping Your Benefits During a State Fair Hearing> - SII_15_DQ4080 IA_Medicaid Child (7.26) HBEN Final_5.26.26<Pg 24 Rights and Responsibilities; Pg 28 Keeping Your Benefits During a State Fair Hearing>		
HSAG Feedback on Updated Remediation: Although the PAHP made enhancements to its member handbooks that met the intent of the required information related to member rights as specified in 42 CFR §438.100, HSAG strongly recommends the PAHP further enhance the language in the member rights section of its handbooks to specify that members have the right to receive information on available treatment options and alternatives, and the right to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the PAHP and its network providers or HHS treat the member.			☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted
16. The PAHP gives each member notice of any change to the member handbook that HHS defines as significant in the information specified in the member handbook, at least 30 days before the intended effective date of the change. <i>Significant changes include any change that may impact member accessibility to services and benefits in:</i> - Restrictions on the member's freedom of choice among network providers; - Member rights and protections; - Grievance and fair hearing procedures; - Amount, duration, and scope of benefits available; - Procedures for obtaining benefits, including authorization requirements;		HSAG Required Evidence: - Policies and procedures - Workflow for member handbook changes - Tracking mechanism for timely member notifications of significant changes that demonstrate the effective date of the significant change and the date members were notified	☐ Met ☒ Not Met
		Evidence as Submitted by the PAHP: - SII_DQ3197 IA_Medicaid Adult (7.26) HBEN - SII_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 - SII_Checklist_MKT03-INS-COMM-Member Communications Distribution < page 4, C. Communication of Benefit Changes to Members>	

Operational Readiness Review Standards Remediation Plan		
Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
f. <i>The extent to which, and how, members may obtain benefits from out-of-network providers;</i> g. <i>The extent to which, and how, after-hours and emergency coverage are provided;</i> h. <i>Policy on referrals for specialty care and for other benefits not furnished by the member’s primary care provider (PCP); or</i> i. <i>Cost sharing.</i> 42 CFR §438.10(g)(4) 42 CFR §457.1207 Contract C.2.19–C.2.20	SII_Checklist_MKT03-INS-COMM-Member Communications Distribution < page 7, D. Communicate changes to Enrollee>	
PAHP Description of Process: N/A		
HSAG Findings: The PAHP provided the <i>COMM-Member Communications Distribution</i> policy, which did not specify that notification of significant changes to the member handbook must be made “...at least 30 days before the intended effective date of the change...” After the review, the PAHP provided the <i>COMM-Member Communications Distribution</i> policy, with a comment of “Standard II – Element 16” on page seven; however, the specific time frame of “at least 30 days...” was not documented on this page or in this policy.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Provide updated policies and procedures that include the time frame for notifying members of significant changes as required by 42 CFR §438.10(g)(4).		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	DentaQuest has updated the policy and procedure to include the time frame for notifying members of significant changes as required by 42 CFR §438.10(g)(4): - SII 16 MKT03-INS-COMM-Member Communications Distribution Iowa Medicaid_CHIP<Exhibit D, A and B> - SII_DQ3197 IA_Medicaid Adult (7.26) HBEN <Pg. 44-45> - SII_DQ4080 IA_Medicaid Child (7.26) HBEN <Pg. 44> - SII_DQ3198 IA_Medicaid Hawki (7.26) HBEN <Pg. 43-44>	

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Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
Individual(s) Responsible: [redacted]		
Completion Date: 05/05/2026		
HSAG Feedback: The PAHP's remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
Provider Directory		
17. The PAHP makes the provider directory available in paper form upon request and electronic form. The provider directory must include the information from the Provider Directory Checklist. 42 CFR §438.10(h)(1-2) 42 CFR §457.1207 Contract C.4.01	HSAG Required Evidence: • Policies and procedures • Process for generating a paper copy of the provider directory (e.g. bulk printing, print on demand) • Copy of the member-facing provider directory in Word or PDF format (excerpts are acceptable) • Link to the online provider directory • HSAG will also use the results of the Provider Directory Checklist Evidence as Submitted by the PAHP: • SII_Checklist_MKT03-INS-COMM-Member Communications Distribution <page 6, A. Enrollee materials available in paper form> • SII_MKT11-INS-FAD Online Directory <full document> • Dental Providers DentaQuest	☐ Met ☒ Not Met
PAHP Description of Process: N/A		
HSAG Findings: The PAHP was unable to demonstrate that it would make its provider directory available in paper form, upon request, and electronic form that will include all information required federally and in Contract as included in the <i>Provider Directory Checklist</i> .		

Operational Readiness Review Standards Remediation Plan		
Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
- The PAHP’s website contained provider directories for other states in which the PAHP conducts business, and the PAHP was unable to provide evidence (e.g., test environment of a provider directory specific to Iowa) that it was collecting and would be able to display all required provider information. - The PAHP provided a template for a paper provider directory. However, the template did not include all required fields, such as whether the provider’s office/facility has accommodations for people with physical disabilities, (offices, exam room[s], equipment, including but not limited to wide entries, wheelchair access, accessible exam tables and rooms, lifts, scales, bathrooms, grab bars, or other equipment). The paper provider directory template only listed “handicap accessible.” - Following the review, the PAHP indicated on the <i>Post-Site Review Tracker</i>, “DentaQuest is still working on adding providers to our directory for IA. As soon as we have a provider added, we will provide the screen shot.”		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Provide a completed version of the Iowa paper provider directory, including all required provider data elements. - A link for the PAHP’s online provider directory, including all required provider data elements.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	<i>DentaQuest has completed and provided a paper provider directory including all required provider data elements. The directory will be continually updated as providers are added.</i> - SII_DQ3179_IA State Medicaid_Provider Directory (7.26)<Entire Document> - SII_DQ4059_IA State CHIP_Provider Directory (7.26)<Entire Document> - Link: Find a Dentist DentaQuest	
Individual(s) Responsible: [redacted]		
Completion Date: 05/05/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are not sufficient to demonstrate readiness with the requirements for this program area. Although the PAHP’s online provider directory contained website Uniform Resource Locaters (URLs), no URLs were found in the PAHP’s paper provider directory. Additionally, while the PAHP’s paper provider directory contained handicap accessible indicator codes (e.g., bathroom grab bars, accessible lifts, handicap parking), all of the facilities only listed “Handicap Accessible: Y,” and no details related to equipment were found in the paper provider directory. Upon search of a sample of providers in the paper versus online provider directories, the same providers were listed at facilities that were “wheelchair accessible” on their online profile; however, the same providers did not have the “WC – Wheelchair Accessible” indicator code listed in the paper directory. Further, while the PAHP’s paper provider directory included languages spoken at its facilities, languages were not included on individual profiles. Lastly, HSAG identified that some providers in the		☐ Accepted ☐ Accepted With Recommendations ☒ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
online and paper provider directories did not have consistent contact information (e.g., addresses). HSAG is concerned that the PAHP's paper and online provider directories do not contain accurate information with all required fields. Although HSAG understands that there could be a delay in updating the PAHP's paper provider directory, this should not apply to newly contracted providers. The PAHP must submit an updated plan of correction for remediating the continued deficiency and will also be required to meet with HSAG to ensure future compliance with the program area.		
Updated Remediation to Address CAP <i>Not Accepted</i> :		
Updated Plan to Remedy Deficiency (Include a narrative with all actions that will be taken to remediate deficiency):	We have updated the paper provider directory to include: the type of handicap accessibility at each location, URL for the Dental offices, and languages spoken for each provider. Regarding the contact information and addresses being misaligned with the provider directory (online to paper), we have changed the data source for the paper directory to match the online directory to eliminate discrepancies in contact information. There will still be potential for mismatch as the paper directory is updated monthly while the online directory is updated daily.	
Responsible Individual(s):	[redacted]	
Timeline/Completion Date:	05/26/2026	
Evidence as Submitted by the PAHP to Address Deficiency:	- SII_17_DQ3179_IA State Medicaid_Provider Directory_(7.26) - SII_17_DQ4059_IA State CHIP_Provider Directory_(7.26)	
HSAG Feedback on Updated Remediation: The PAHP's remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
New Member Communications		
24. <i>In addition to information set forth in Contract sections C.1.01 and C.1.02, the enrollment materials include all information on the New Member Communications Checklist.</i> Contract C.1.03	HSAG Required Evidence: - Policies and procedures - Member materials, such as the member handbook and welcome packet - HSAG will also use the results of the New Member Communications Checklist	☐ Met ☒ Not Met

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Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
	Evidence as Submitted by the PAHP: - SII_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft_2.27.26 - SII_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26	
PAHP Description of Process: N/A		
HSAG Findings: The PAHP was unable to confirm that it will distribute all enrollment materials to all members and their authorized representatives with all required information. During the review, the PAHP confirmed that its enrollment materials will be distributed to members through its member handbooks. However, the PAHP’s member handbooks did not contain the following information required to be in its enrollment materials: - Contact information specifying where members can ask questions regarding their cost-sharing obligations. - Procedures for changing PAHPs and circumstances under which this is possible as described in Contract. Further, although the PAHP’s member handbooks contained a Post Office (P.O.) Box mailing address in Wisconsin, following the review, the State confirmed that, “Pursuant to DentaQuest’s RFP Response, incorporated by reference into their contract with Iowa Medicaid, DentaQuest is required to have an Iowa mailing address including but not limited to the purpose of meeting Member and Provider requirements in the Contract and managed care regulations.” As such, the PAHP must include an Iowa address in its enrollment materials for its members. Recommendation: Although the PAHP’s member handbooks included a description of how to complete an oral health risk assessment, the instructions included a quick response (QR) code that did not work. During the review, PAHP staff members stated this was because the website was not yet live. HSAG strongly recommends that the PAHP proceed with launching its member website and all applicable website links.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Provide updated enrollment materials that include: - Contact information where members can ask questions regarding their cost-sharing obligations. - Procedures for changing PAHPs and circumstances under which this is possible as described in Contract. - An Iowa-specific mailing address.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	DentaQuest Developed a cost sharing policy with an Iowa specific Exhibit and has updated the member materials including the handbook with updated contact information for cost sharing, Procedures for changing PAHPs and circumstances under which this is possible as described in Contract and an Iowa specific mailing address: - SII_DQ3197 IA_Medicaid Adult (7.26) HBEN <Pg. 14, 16-17 & 27-28> - SII_DQ4080 IA_Medicaid Child (7.26) HBEN <Pg.5-6, 9 & 27-28>	

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Requirement	Supporting Documentation	Score
- SII_DQ3198 IA_Medicaid Hawki (7.26) HBEN <Pg. 5-6, 8 & 27-28> - NET34-INS-Member Cost Sharing and Financial Responsibility Policy <Pg. 1-2>		
Individual(s) Responsible: [redacted]		
Completion Date: 05/05/2026		
HSAG Feedback: The PAHP's remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
Member Services Helpline		
28. <i>The PAHP maintains a member services helpline that complies with the Member Services Helpline Checklist.</i> Contract C.1.10–C.1.16	HSAG Required Evidence: - Policies and procedures - Member informational materials - Member Services Helpline communication workflows - Member Services Helpline staff training program/topics - Member Services Helpline monitoring plan for call center performance metrics - Member Services Helpline back-up plan - Member Services Helpline testing plan/results - Member Services Helpline call scripts - Staff training materials - HSAG will also use the results of the Member Services Helpline Checklist	☐ Met ☒ Not Met
	Evidence as Submitted by the PAHP: SII_CS02-INS-Customer Service Standards-FINAL <page 1>	

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Requirement	Supporting Documentation	Score
	- SII_CS06-INS-Customer Service Monitoring Outcomes-FINAL <page 1> - SII_CS08-INS-DENT-Customer Service-Call Metric Reporting-Dental-FINAL <page 1> - SII_CS10-INS-CS Call Scripts-FINAL	
PAHP Description of Process: Staff Training materials are currently being developed. They will be submitted by May 1, 2026. HSAG Findings: Although the PAHP provided a report and policy that included information related to Contract A.27, the PAHP did not provide evidence it had a process to ensure all requirements of Contract A.27 would be met, including evidence that PAHP staff members: - Respond to all urgent requests within four hours if received prior to 1:00 p.m., and by 11:00 a.m. the next business day if received after 1:00 p.m. - Issue responses to enrolled member billing inquiries within 20 business days after the initial inquiry. - Ensure that 100 percent of provider billing inquiries will be responded to by phone or in writing within three business days. Additionally, although the PAHP provided policies related to training, the PAHP did not provide evidence that its member services helpline staff are trained on all concerns or issues as required by Contract (i.e., how to access dental healthcare services and dentists accepting new members who provide those services; identification or explanation of covered services; procedures for submitting a grievance or appeal; reporting fraud or abuse; locating a provider; dental health crises; balance billing issues; cost-sharing; primary care provider (PCP) change and/or initial attribution; or incentive programs). Further, although the PAHP submitted the <i>Customer Service-Call Handling-Claims/Authorization Related Inquiries</i> document, the processes within this document were not specific and did not adequately describe how the PAHP will ensure that there is a backup system capable of operating the telephone system, at full capacity, with no interruption of data collections. Instead, this document only indicated the following: “If a complete service outage lasts 2 hours messaging will be placed on incoming phone lines alerting callers to the outage; If the outage is intermittent, messaging will be placed on the incoming phone lines after 4 hours; Messaging will be of a general nature as to allow for appropriateness for all service areas; Customized messages will only be considered if there is a specific client requirement.” However, these processes do not ensure that the telephone system will operate without disruption for its Iowa population and does not include Iowa-specific reporting requirements. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Develop a process and tracking mechanism to demonstrate that all urgent requests are responded to within four hours if received prior to 1:00 p.m., and by 11:00 a.m. the next business day if received after 1:00 p.m. - Develop a process and tracking mechanism to demonstrate that enrolled member billing inquiries are resolved and that notices are sent within 20 business days after the initial inquiry.		

Operational Readiness Review Standards Remediation Plan		
Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
- Develop a process and tracking mechanism to demonstrate that 100 percent of provider billing inquiries are responded to by phone or in writing within three business days. - Develop a detailed backup plan that ensures that the telephone system can be operated at full capacity with no interruption of data collection and also ensures requests can be continued to be processed if the system is down. - Develop a notification plan specific to Iowa that details the procedures for notifying HHS when the phone system is inoperative or when a backup system is being used.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	- SII_28. CS05-INS-SOP - CS Call Handling - Escalation & Urgent Inquiry Handling – IA <Pg. 2 & 3> - SII_28. CS05-INS-DENT-SOP-CS Call Handling-Billing Inquiries-IA <Pg. 1 & 2> - SII_28. CS05-INS-SOP-CS Service Interruption Communications <Pg.1 & 2> - SII_NET30-INS-SOP-Iowa Medicaid CHIP Client Notification Requirements<Pg. 1>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/06/2026		
HSAG Feedback: The PAHP's remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. However, the PAHP must continue its plan to develop tracking mechanisms to monitor compliance with the time frame requirements indicated in Iowa Contract section A.27 as noted in the PAHP's updated policies.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted
Dental Call Line		
29. <i>The PAHP operates a toll-free Dental Call Line which provides nurse triage telephone services for members to receive dental advice 24 hours a day/seven days a week from trained dental professionals.</i> a. <i>The Dental Call Line is well publicized and designed as a resource to members to help discourage inappropriate emergency room use.</i>	HSAG Required Evidence: - Policies and procedures - Member informational materials - Dental Call Line communication workflows - Dental Call Line and on-call dentist schedule - Tracking mechanism for monitoring timely responses to dental decisions - Staff training materials	☐ Met ☒ Not Met
Evidence as Submitted by the PAHP:		

Operational Readiness Review Standards Remediation Plan		
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Requirement	Supporting Documentation	Score
b. <i>The Dental Call Line has a system in place to communicate all issues with the member’s health care providers, as applicable.</i> c. <i>The PAHP has a written protocol specifying when a dentist must be consulted in response to a call received.</i> d. <i>Calls requiring a dental decision are forwarded to the on-call dentist, and a response to each call which requires a dental decision is provided by the dentist within 30 minutes.</i> Contract C.1.17	• SII_Teledentistry.com Flyer • SII_Teledentistry Outreach -MESH Flyer • SII_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft_2.27.26 <page 7> • SII_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <page 7>	
PAHP Description of Process: Staff Training materials are currently being developed. They will be submitted by May 1, 2026. HSAG Findings: HSAG’s review identified the findings below: • The PAHP provided a <i>Teledentistry.com Flyer</i>, which included information regarding to “24/7 access to a dentist 365 days a year through the convenience of your telephone or video conference on your smartphone or computer.” Additionally, the PAHP provided the <i>DQ3197 IA_Medicaid Adult (7.26) HBEN Draft_2.27.26</i> and the <i>DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26</i> member handbooks which included, “After Hours Care 24/7 Emergency Care Available via Teledentistry bit.ly/IA-teledentistry 866-302-0905. For more information, see Teledentistry Page 16,” and “When to Use TeleDentistry.com Use teledentistry when: – You have a dental emergency and don't have a regular dentist – You need help after hours and your dentist is closed – You cannot get to a dentist's office right away • Want to make a teledentistry appointment? Visit our website for more information: [website].” However, the Teledentistry platform appears to be an actual billed service for members and not a nurse triage telephone service for members to receive dental advice 24 hours a day/seven days a week from trained dental professionals. During the review, HSAG asked for clarification if Teledentistry would be utilized as the toll-free dental call line, which the PAHP confirmed. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: • Distinguish its use of the term “teledentistry” for the dental call line from its use of teledentistry as a covered service offered by a network provider requiring an encounter and claim.		

Operational Readiness Review Standards Remediation Plan		
Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
Provide the dental call line that members can contact for dental advice from a trained dental professional that will not result in an encounter and claim and provide confirmation that the line is active.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	DentaQuest has updated the member handbooks to distinguish its use of the term Teledentistry call line from covered services: - SII_DQ3197 IA_Medicaid Adult (7.26) HBEN <Pg. 31> - SII_DQ4080 IA_Medicaid Child (7.26) HBEN <Pg. 26> - SII_DQ3198 IA_Medicaid Hawki (7.26) HBEN <Pg. 31> - SII_Narrative Response<Entire Document>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/05/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are not sufficient to demonstrate readiness with the requirements for this program area. The PAHP provided the <i>Narrative Response</i> document that included the following language: “When a member contacts the toll-free Dental Call Line, a Teledentistry.com agent verifies member eligibility and conducts initial intake. Calls requiring clinical decision-making are escalated to a licensed, credentialed, U.S.-based dentist, consistent with contractual and regulatory expectations....” However, this document did not include information related to a separate nurse triage telephone service line that would be used for members to utilize to receive dental advice 24 hours a day/seven days a week from trained dental professionals. Additionally, the PAHP indicated in the <i>Narrative Response</i> document that “[t]he on-call dentist provides clinical guidance and, when appropriate, conducts a limited oral evaluation via telehealth to address the member’s immediate concern. As part of this interaction, members may receive e-prescriptions, a Dental Analysis Report, and referrals to an in-network brick-and-mortar dental provider for follow-up care. A Dental Call Line interaction is considered a billable teledentistry encounter only when a clinical evaluation is performed and all requirements outlined in F.17.01 and IAC 653-13.11 (147, 148, 272C) are met. In those instances, services are rendered by qualified dental professionals and reimbursed in accordance with the contract’s telehealth parity provisions, with no cost-sharing applied to the member.” Further, this narrative confirmed that the PAHP did not fully understand the intent of this requirement, as HSAG’s review of https://www.teledentistry.com/insurance/dentaquest indicates it is a billable service (i.e., references online dental care and online dental services). Therefore, the PAHP must submit a plan of correction, including all steps that will be taken, to remediate the continued deficiency, and the PAHP will also be required to meet with HSAG to ensure future compliance with the program area.		☐ Accepted ☐ Accepted With Recommendations ☒ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
Updated Remediation to Address CAP Not Accepted:		
Updated Plan to Remedy Deficiency (Include a narrative with all actions that will be taken to remediate deficiency):	DentaQuest updated the Teledentistry website to reflect that the 24-hour line will not result in an encounter. The only time a call would result in an encounter is, when clinically appropriate, members may be connected to a licensed, credentialed dentist who can perform a limited oral evaluation using telehealth technology in a patient encounter.	
Responsible Individual(s):	Nick Barnette	
Timeline/Completion Date:	05/26/2026	
Evidence as Submitted by the PAHP to Address Deficiency:	SII_29_Teledentistry.com screenshot	
HSAG Feedback on Updated Remediation: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. Following the remediation session, the PAHP provided an <i>SII_29_24-Hour Dental Call Line Remediation</i> document, which stated, “DentaQuest will transition to a vendor-supported model for the 24/7 dental triage line...DentaQuest is actively pursuing and evaluating qualified vendors to support this model by 7/1/2026...The implementation of a vendor-supported triage model, with clear separation between triage and clinical services, is intended to enhance compliance with emergency services requirements while ensuring members have timely access to appropriate care.” HSAG strongly recommends that the PAHP proceed with contracting a qualified vendor to support the 24/7 dental triage line model by July 1, 2026, as required by the Contract.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted
Marketing		
31. The PAHP complies with the requirements listed in the Marketing Checklist. 42 CFR §438.104 Contract C.7	HSAG Required Evidence: - Policies and Procedures - Marketing program/plan for Iowa - Examples of current and planned marketing materials - Staff training materials - HSAG will also use the results of the Marketing Checklist	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
	Evidence as Submitted by the PAHP: - SII_MKT01-INS-Marketing Safeguards-FINAL<Full Document> - SII_Checklist_MKT02-INS-COM-Member Communications Development-FINAL <full document>	
PAHP Description of Process: Staff training is currently being developed.		
HSAG Findings: The PAHP was unable to demonstrate it had a process to obtain approval from HHS for all marketing materials timely. The PAHP’s <i>Member Communications Development</i> policy contained general information on obtaining approval from the State prior to distributing it to members. However, this policy did not contain specific steps on how the PAHP would obtain approval from HHS for all marketing materials at least 30 days or within the time frame requested by HHS prior to distribution. During the review, PAHP staff members stated they would send member marketing materials to HHS at least 30 days prior to distribution. HSAG requested evidence for how the PAHP will adhere to this time frame requirement (e.g., a policy with Iowa-specific information on marketing workflows, training materials, reporting/tracking mechanism); however, no supporting evidence was provided by the PAHP following the review.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Develop and provide an Iowa-specific policy that outlines the procedures for obtaining HHS’ approval for all marketing materials within at least 30 days or within the time frame requested by HHS prior to distribution.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	DentaQuest has revised its policy with procedures for obtaining HHS’ approval for all marketing materials within at least 30 days or within the time frame requested by HHS prior to distribution. See: SII_31 MKT02-INS-COM-Member Communications Development-FINAL - Iowa Medicaid_CHIP <Exhibit A, A>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/05/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations

Operational Readiness Review Standards Remediation Plan		
Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
		☐ Not Accepted
Billings and Collections		
33. <i>The PAHP imposes copayments, if required by HHS, for Iowa Dental Wellness Plan participants in accordance with the State’s 1115 waiver and Hawki members in accordance with the State’s CHIP State Plan. If HHS requires the PAHP to impose copayments, the PAHP ensures compliance with the requirements outlined in the Contract.</i> Contract F.8.06	HSAG Required Evidence: • Policies and procedures • Member materials, such as the member handbook • List of copayments imposed by the PAHP • Notification to HHS of imposed State Plan cost sharing • Staff training materials Evidence as Submitted by the PAHP: • SII_Member Handbook Prev Implementation DRAFT <full document> • SII_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft_2.27.26 • SII_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26	☐ Met ☒ Not Met
PAHP Description of Process: There are no member copayments under this plan at this time. Staff Training materials are currently being developed. They will be submitted by May 1, 2026.		
HSAG Findings: Although the PAHP indicated “[t]here are no member copayments under this plan at this time...,” no documentation was provided that demonstrated that the PAHP had evaluated the State’s 1115 waiver and Hawki members in accordance with the State’s CHIP State Plan and stipulated in written documentation of the circumstances for when members are and are not subjected to copays.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: • Develop a procedure document and update member materials that stipulate the circumstances for when members are and are not subjected to copays.		
Plan to Remedy Deficiency: (Include all actions)	DentaQuest has created a procedure document and updated member materials that stipulate circumstances for when members are and are not subjected to copays: • NET34-INS-Member Cost Sharing and Financial Responsibility Policy <Pg. 1-2>	

Operational Readiness Review Standards Remediation Plan		
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Requirement	Supporting Documentation	Score
that will be taken to remediate deficiency.)	- SII_DQ3197 IA_Medicaid Adult (7.26) HBEN <Pg. 27-28> - SII_DQ4080 IA_Medicaid Child (7.26) HBEN <Pg. 27-28> - SII_DQ3198 IA_Medicaid Hawki (7.26) HBEN <Pg. 27-28>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/05/2026		
HSAG Feedback: The PAHP's remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard III—Emergency and Poststabilization Services

Operational Readiness Review Standards Remediation Plan		
Standard III—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
Coverage and Payment		
4. The PAHP covers and pays for emergency services regardless of whether the provider that furnishes the services is Iowa Medicaid enrolled or has a contract with the PAHP. a. The PAHP must provide emergency services without requiring prior authorization (PA) or PCP referral, regardless of whether these services are provided by a contract or non-contracted provider. 42 CFR §438.114(c)(1)(i) 42 CFR §457.1228 Contract F.1.05(a) Contract F.1.08	HSAG Required Evidence: • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual, education on how to submit a claim for emergency dental services • Claim payment algorithm for emergency dental services • Mechanism(s) (e.g., edits, flags) to identify claims for emergency dental services • Staff training materials • HSAG will use results from the mock claims demonstration (i.e., mock adjudicated claims for emergency services) Evidence as Submitted by the PAHP: • Policies and Procedures: ○ SIII_UM08-INS-Authorization Review – Page 4 Numbers 7 and 8 ○ SIII_UM15-INS-Access to Services Out of Network <Full Document> • Member materials: ○ SIII_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft 2.27.26 – Page 16 ○ SIII_DQ4080 IA_Medicaid Child (7.26) HBEN Draft 2.26.26 – Page 19	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard III—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
	- SIII_CL02-INS-Claims Payment <Pg 3 Procedure B. 2> - SIII_Provider Reference Manual <Pg 19 Section 4.03 Payment of Emergency Services> - Staff training materials under review	
PAHP Description of Process: Claim payment algorithm for emergency dental services will be reviewed in the claims demonstration. DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made.		
HSAG Findings: HSAG’s review identified the following: - The <i>List of Emergency Key Words</i> document submitted after the review explained how providers can identify claims pertaining to emergency services and the process for the PAHP to adjudicate claims pertaining to emergency services. Of note, this document pertained to emergency claims and pre-service requests; however, the requirements of this element only pertain to emergency claims (i.e., post-service) and not PAs (i.e., pre-service). Further, the screenshot of a claim included in the document identified the “Claim Type” as a “Prior Auth” which is not applicable to this element, and while a provider may submit an expedited PA (i.e., pre-service), this is not same as a claim (i.e., post-service) for emergency services and a PA cannot be required for emergency services. - The two claims scenarios for emergency dental services for out-of-network (OON) providers did not align with the PAHP’s procedures for processing claims related to emergency dental services. The claim screenshots included in the <i>List of Emergency Key Words</i> document indicated that claims for emergency services are identified by the “Claim Priority” as “Emergency” and the “Emergency Claim” field as “Y.” However, both OON claims scenarios had “Regular Claim” as the “Claim Type” and “N” as the “Emergency Claim.”		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Submit two mock OON claims for emergency services, including the completed American Dental Association (ADA) claim form and adjudicated claim.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	Submitted below are 2 claims with their corresponding ADA Claim form. - SIII_4.5.WW Claim 202523098765430 TESTMBR010<Entire Document> - SIII_4. 5.ADA Claim 202523098765430 TESTMBR010<Entire Document> - SIII_4. 5.WW Claim 202523098766430 TESTMBR012<Entire Document> - SIII_4.5.ADA Claim 202523098766430 TESTMBR012<Entire Document>	
Individual(s) Responsible: [redacted]		

Operational Readiness Review Standards Remediation Plan		
Standard III—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
Completion Date: 05/05/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. However, while the two mock OON claims for emergency services identified the “Claim Type” as “Regular Claim” and the “Claim Priority” as “Emergency,” the “Emergency Claim” under “Ancillary Information” continued to have “N” under “Claim Emergency.” This does not align with the <i>List of Emergency Key Words</i> document previously submitted which indicated that “Emergency Claim” would be set to “Y.” As the emergency claim paid, the PAHP received an <i>Accepted With Recommendations</i> designation; however, the PAHP must reconcile this discrepancy.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted
5. The PAHP pays non-contracted and/or non-Iowa Medicaid enrolled providers for emergency services at the amount that would have been paid if the service had been provided under HHS’ fee-for-service Medicaid program. Contract F.1.04	HSAG Required Evidence: • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claim payment algorithm for emergency dental services • Staff training materials • Examples of emergency dental services (i.e., current dental terminology [CDT code] and corresponding fee schedule) • HSAG will use results from the mock claims demonstration (i.e., mock adjudicated claims for emergency services) Evidence as Submitted by the PAHP: • SIII_UM15-INS-Access to Services-Out of Network Page 1 letter C. • Member materials: ○ SIII_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft 2.27.26 – Page 15 ○ SIII_DQ4080 IA_Medicaid Child (7.26) HBEN Draft 2.26.26 – Page 19	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard III—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
	- SIII Provider Reference Manual <Pg 19 Section 4.03> - Staff training materials pending review	
PAHP Description of Process: DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made.		
HSAG Findings: The <i>UM15-INS-Access to Services-Out of Network</i> policy confirmed that compensation for OON providers is limited to the applicable State Medicare, Medicaid, or designated health plan fee schedule or reimbursement rate; and the <i>Provider Reference Manual</i> confirmed that both enrolled and non-enrolled providers will be paid at HHS' fee schedule. However, during the claims scenario demonstrations, while the demonstrations were in the PAHP's testing environment, PAHP staff members were unable to verbalize the linkage of the paid amount to the OON provider to any associated fee schedule.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Submit two mock OON claims for emergency services, including the charged amount, allowed amount, paid amount, and configuration to the PAHP's associated fee schedule.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	Submitted below are 2 claims with their corresponding ADA Claim form that show charged amount, allowed amount, paid amount, and configuration to DentaQuest's associated fee schedule. - SIII_4.5.9.WW Claim 202523098765430 TESTMBR010<Entire Document> - SIII_4.5.9.ADA Claim 202523098765430 TESTMBR010<Entire Document> - SIII_4.5.9.WW Claim 202523098766430 TESTMBR012<Entire Document> - SIII_4.5.9.ADA Claim 202523098766430 TESTMBR012<Entire Document>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/05/2026		
HSAG Feedback: The PAHP's remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard III—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
7. While the PAHP is required to reimburse providers for the screening examination, the PAHP is not required to reimburse providers for non-emergency services rendered in an emergency room for treatment of conditions that do not meet the prudent layperson standard. a. The PAHP does not deny or pay less than the allowed amount for the CDT code on the claim without a clinical record review to determine if the prudent layperson standard was met. b. The PAHP bases coverage decisions for emergency services on the severity of the symptoms at the time of presentation and shall cover emergency services where the presenting symptoms are of sufficient severity to constitute an emergency dental condition in the judgment of a prudent layperson, even if the condition turned out to be non-emergency in nature. c. The prudent layperson review is conducted by a PAHP staff member who does not have dental training. d. The PAHP does not impose restrictions on coverage of emergency services more restrictive than those permitted by the prudent layperson standard. e. In addition to using the prudent layperson standard, the PAHP endeavors to incorporate emergency dental condition as defined by the American Dental Association Emergency Dental Condition Guidelines in their review of emergency claims. Contract F.1.02	HSAG Required Evidence: • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claim algorithm for emergency dental services • Staff training materials • Examples of emergency dental services (i.e., CDT code and corresponding fee schedule) • Workflow for conducting a prudent layperson review • Department/staff members responsible for conducting a prudent layperson review • Mechanism(s) to identify claims requiring a prudent layperson review • Mechanism(s) to document the outcome of a prudent layperson review • One mock example of a prudent layperson review Evidence as Submitted by the PAHP: • SIII_UM08-INS-Authorization Review page 4 number 8 and 11 • Member materials: ○ SIII_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft_2.27.26 – Pages 15-17 ○ SIII_DQ4080 IA_Medicaid Child (7.26) HBEN Draft_2.26.26 – Pages 18-19 • SIII_Provider Reference Manual <Pg 19 Section 4.03> • Staff Training materials pending review	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard III—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
PAHP Description of Process: DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made.		
HSAG Findings: The PAHP’s policies, claims scenario demonstrations, and discussion with PAHP staff members confirmed that the PAHP’s claim payment review process for emergency dental treatment included a clinical and/or Dental Consultant review. The PAHP provided no documentation confirming that a “prudent layperson review” is conducted by a PAHP staff member who does not have dental training. After the review, the PAHP provided the following statement, “Our Clinical Review Specialist teams determine whether services meet the definition of emergency care by applying the prudent layperson standard. Specifically, reviews are based on symptoms that a layperson could reasonably identify at the time of presentation, such as pain, swelling, or signs of infection, rather than relying on predefined lists of diagnoses or outcomes. This ensures that determinations are grounded in the severity of presenting symptoms, consistent with the intent of the standard.” However, the PAHP’s contract with HHS requires that the prudent layperson review be conducted by a PAHP staff member who does not have dental training. The PAHP’s qualifications for Clinical Review Specialists included dental assisting experience or a degree in a dental field; therefore, the PAHP would not be able to have a staff member who does not have dental training conduct a prudent layperson review.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Submit a policy outlining the PAHP’s procedures for implementing HHS’ requirement that a prudent layperson review is conducted by a PAHP staff member who does not have dental training. - Submit evidence (e.g., system screenshots) for how the prudent layperson review by a PAHP staff member will be documented. - Submit staff training materials related to the prudent layperson review.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	- SIII_7 CL03-INS- Layperson Emergency Review<Entire Document> - SIII_7_Screenshots of prudent layperson review of ER claim<Entire Document> - SIII_7_IA - Prudent Layperson Review Job Aid<Entire Document>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/11/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. However, the <i>CL03-INS-Layperson Emergency Review</i> policy and <i>IA–Prudent Layperson Review Job Aid</i> confirmed that following the prudent layperson review, a medical necessity review is conducted following the PAHP’s normal protocol. HSAG cautions the PAHP from denying payment for services rendered when the prudent layperson		☐ Accepted ☒ Accepted With Recommendations

Operational Readiness Review Standards Remediation Plan		
Standard III—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
review confirms that an emergency dental condition existed. While the PAHP must ensure that all Medicaid covered services delivered are medically necessary and the PAHP must monitor its providers for program integrity purposes, HSAG recommends that should the PAHP deny payment for emergency treatment after the prudent layperson standard was met, the PAHP should maintain clear documentation for the rationale for the denial of payment for the emergency services delivered.		☐ Not Accepted
Additional Rules for Emergency Services		
9. A member who has an emergency medical [dental] condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member. 42 CFR §438.114(d)(2) 42 CFR §457.1228 Contract F.1.03 Contract F.1.07	HSAG Required Evidence: • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Staff training materials • Claim payment algorithm for emergency dental services • HSAG will use results from the mock claims demonstration (i.e., mock adjudicated claims for emergency services) Evidence as Submitted by the PAHP: • SII_Utilization Management Program Description Page 11 Post-Stabilization of Care and Dental Services Section • Member materials: ○ SIII_DQ3197 IA_Medicaid Adult (7.26) HBEN_Draft_2.27.26 – Page 4, 33 ○ SIII_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 – Page 4, 36 • SIII_Provider Reference Manual <Pg 19 Section 4.03> • Staff training materials pending review	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard III—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
PAHP Description of Process: DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made.		
HSAG Findings: While the claims scenario demonstrations for emergency dental treatment included no member financial liability, the two OON scenarios were for a non-emergency PA and not post-service claims for emergency dental treatment; therefore, they are unable to be accepted as confirmation of member financial liability or lack thereof.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Submit two mock OON claims for emergency services, including member financial liability.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	Submitted below are 2 claims for emergency services with their corresponding ADA Claim form that show charged amount, allowed amount, paid amount, and configuration to DentaQuest's associated fee schedule. - SIII_4.5.9.WW Claim 202523098765430 TESTMBR010<Entire Document> - SIII_4.5.9.ADA Claim 202523098765430 TESTMBR010<Entire Document> - SIII_4.5.9.WW Claim 202523098766430 TESTMBR012<Entire Document> - SIII_4.5.9.ADA Claim 202523098766430 TESTMBR012<Entire Document>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/05/2026		
HSAG Feedback: The PAHP's remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
Coverage and Payment of Poststabilization Care Services		
11. The PAHP is financially responsible for post-stabilization care services obtained within or outside the PAHP that are pre-approved by a plan provider or other PAHP representative. 42 CFR §422.113(c)(2)(i)	HSAG Required Evidence: - Policies and procedures - Provider materials, such as the provider manual - Workflow for claims processing for poststabilization care services	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard III—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
42 CFR §438.114(e) 42 CFR §457.1228 Contract F.1.10(a)(1)	- Staff training materials - PA requirements for poststabilization care services Evidence as Submitted by the PAHP: - SII_Utilization Management Program Description Page 11 Post-Stabilization of Care and Dental Services Section - SIII Provider Reference Manual <Pg 19 Section 4.03> - Staff training materials pending review	
PAHP Description of Process: DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made. HSAG Findings: HSAG’s review identified the findings below: - As poststabilization care services may be obtained within the PAHP’s network or outside the PAHP’s network that are pre-approved by the PAHP, HSAG requested clarification on the PAHP’s process should the member seek OON emergency dental treatment and, subsequently, the OON provider submitted a PA request for continued treatment needed after initially addressing the emergency dental condition. HSAG also asked if coverage of OON poststabilization care services would be considered for continuity of care and for members who may reside in geographical shortage areas or in service areas where a member may not have access to an in-network provider within HHS’ network adequacy standards. After the review, the PAHP did not submit additional documentation and explained that it is still developing its policy for reviewing poststabilization care services for OON providers. - The <i>Provider Reference Manual</i> included the following statements: “DentaQuest is financially responsible for eligible member’s post-stabilization of care, regardless of location, when a plan is pre-approved by an enrolled provider. No preauthorization is required for poststabilization services.” Based on this language, the PAHP appears to misunderstand the federal provision. These statements conflict with one another and it is unclear if the PAHP is indicating that poststabilization care services require or do not require pre-approval/PA. Further, an enrolled provider would not “pre-approve” a “plan,” rather, the PAHP (as the dental plan) would authorize or preapprove services requested by a provider. Recommendations: The <i>Utilization Management Program Description</i> indicated that “[i]n the dental context, the concept of ‘post-stabilization of care’ generally does not apply in the same way for Medicaid, Medicare Advantage, or commercial dental plans. Dental services do not fall under the medical emergency framework, and dental benefit programs typically do not use ‘stabilization’ as a coverage category. Instead: 1. Dental benefits-regardless of payer type- are adjudicated based on CDT codes submitted by the treating provider. 2. Coverage and payment determinations are tied to the specific procedure performed, not to a poststabilization status. 3. Dental claims are evaluated according to the members’ benefit plan, clinical policies, documentation guidelines, and fee schedules.” While HSAG agrees that poststabilization care dental services may align with standard dental treatment and		

Operational Readiness Review Standards Remediation Plan		
Standard III—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
with HHS’ associated dental benefit package, HSAG is reminding the PAHP that the poststabilization care services provisions do apply to dental PAHPs. Therefore, HSAG recommends that the PAHP ensure that staff training materials include poststabilization care services, the applicability to the PAHP, and processes for how the PAHP implements the poststabilization care services requirements.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: • Submit its policy for covering poststabilization care services for OON providers (when pre-approved by the PAHP), when finalized by the PAHP. • Update the <i>Provider Reference Manual</i> to align the process for providers, including OON, to request PA of poststabilization care services once the PAHP finalizes its process. • Review the <i>Provider Reference Manual</i> and revise any confusing/incorrect information (refer to the second bullet above in <i>HSAG Findings</i>).		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	• Provider Reference Manual<Pg. 48 > • SIII_NET33-ENT-Emergency and Post-Stabilization Dental Services<Pg.1 & Pg. 4>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/08/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
13. The PAHP is financially responsible for poststabilization care services obtained within or outside the PAHP that are not pre-approved by a plan provider or PAHP representative, but administered to maintain, improve, or resolve the member’s stabilized condition <i>without PA</i> if:	HSAG Required Evidence: • Policies and procedures • Provider materials, such as the provider manual • Workflow for claims review process for poststabilization care services • Staff training materials	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard III—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
a. The PAHP does not respond to a request for pre-approval within one hour. b. The PAHP cannot be contacted. c. The PAHP representative and the treating provider cannot reach an agreement concerning the member’s care and a plan provider is not available for consultation. In this situation, the PAHP must give the treating provider the opportunity to consult with a plan provider and the treating provider may continue with care of the patient until a plan provider is reached or one of the criteria in 42 CFR §422.113(c)(3) is met. 42 CFR §422.113(c)(2)(iii) 42 CFR §422.113(c)(3) 42 CFR §438.114(e) 42 CFR §457.1228 Contract F.1.10(b)	- Process to track requests for pre-approval of poststabilization care services and timeliness of the PAHP’s response Evidence as Submitted by the PAHP: - SII_Utilization Management Program Description Page 11 Post-Stabilization of Care and Dental Services Section - SIII_Provider Reference Manual <Pg 19 Section 4.03> - Staff training materials pending review	
PAHP Description of Process: DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made.		
HSAG Findings: While the requirements of this element were included in the <i>Provider Reference Manual</i>, PAHP staff members were unable to speak to the PAHP’s process for complying with the one-hour time frame for responding to requests for pre-approval of poststabilization care services. After the review, the PAHP again cited the <i>Provider Reference Manual</i>; however, it does not provide assurances of a process for implementation. As a reminder, should an in-network or OON provider contact the PAHP requesting a PA for poststabilization care services, the PAHP must respond to the requesting provider within one hour. If the provider is unable to contact the PAHP or the PAHP does not respond to the provider’s request within one hour, the provider can proceed with delivering services, and the PAHP is financially liable for those services.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Develop a procedure describing the PAHP’s process to implement the poststabilization care requirements, including how the PAHP will respond to requests for preapproval for poststabilization care services within one hour.		
Plan to Remedy Deficiency:	SIII_NET33-ENT-Emergency and Post-Stabilization Dental Services<Pg.1 & Pg. 4>	

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Standard III—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
(Include all actions that will be taken to remediate deficiency.)		
Individual(s) Responsible: [redacted]		
Completion Date: 05/08/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. However, HSAG recommends that the PAHP maintain the capability to track and report compliance with the one-hour response time for PA of poststabilization care services when requested from in-network or OON providers.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted

Standard IV—Availability of Services

Operational Readiness Review Standards Remediation Plan		
Standard IV—Availability of Services		
Requirement	Supporting Documentation	Score
Delivery Network		
1. The PAHP maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical or mental disabilities. 42 CFR §438.206(b)(1) 42 CFR §457.1230(a) Contract E.1.05 Contract E.1.21	HSAG Required Evidence: • Policies and procedures • Provider materials, such as the provider manual • One example of each type of provider contract (individual dentist/group) • One example of each type of provider contract (Federally Qualified Health Center [FQHC] and screening center) • One example of each type of provider contract (maternal health center) • Provider Network Onboarding Plan (as requested in the PAHP Questionnaire) • Network adequacy analyses, such as GeoAccess mapping Evidence as Submitted by the PAHP: • SIV_NET05-INS-Provider Network Adequacy <Pg 2 Procedure D> • SIV_NET07-INS-Access to Dental Services for Members <Pg 2-3 Procedure B 1,2,5,6 and Pg 4 Procedure D> • SIV_Iowa Provider Office Reference Manual<Full Document> • SIV_230206 IA MA MC HIX Provider Agreement <Full Document>	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard IV—Availability of Services		
Requirement	Supporting Documentation	Score
	- SIV_2026.02.26 DRAFT Provider Agreement FQHC <Full document> - SIV_2026.02.04 Iowa Provider Education Plan <Full Document> - SIV_NET01-INS-Network Development Maintenance and Use<Full Document> - SIV_Sample Network Analysis – GEO Report<Full Document>	
PAHP Description of Process: DentaQuest utilizes a single Provider Agreement for all contracted providers. Page 1 demonstrates the various types of contracts for which a Provider can credential. The appropriate box will be checked for an individual's contract. The GEO is a sample of what we provide, an Iowa version of the GEO will be available post go-live.		
HSAG Findings: The PAHP confirmed that its provider network consisted of 28 contracted providers at the time of the review, indicating that substantial gaps remain in the PAHP building an adequate provider network. While HSAG understands that it takes time for a new PAHP to build its provider network, and the PAHP indicated that it had a plan to outreach to recruit and contract with dental providers and build its network, concerns remain that the PAHP was not able to demonstrate that more progress had been made in building its provider network. Further, HSAG had requested that the PAHP submit a provider network onboarding plan that included all requirements outlined in question 10 of the <i>Readiness Review Questionnaire</i>; however, the PAHP's Provider Onboarding Plan did not include the number/mix of provider types by specialty expected to be contracted with the PAHP by July 1, 2026, and the number/mix of provider types by specialty currently contracted with the PAHP. Further, in the GeoAccess reports the PAHP submitted in follow-up, each type of specialty (i.e., oral surgery, orthodontia, prosthodontia, periodontia, endodontia, and pediatric specialties) was not included but rather reported as a whole, as "specialists." Without the specificity in the PAHP's network adequacy reports, it does not provide an accurate picture of whether the PAHP has an adequate network, where provider type gaps exist, and if the PAHP meets the required time and distance access standards.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Demonstrate that significant progress has been made toward achieving an adequate network with an appropriate range of providers to serve members assigned to the PAHP. - Submit the number/mix of provider types by specialty expected to be contracted with the PAHP by July 1, 2026, and the number/mix of provider types by specialty currently contracted with the PAHP for each county and urbanicity. - Submit network adequacy reports weekly that demonstrate significant progress toward establishing a sufficient provider network and include, at a minimum, provider counts by provider type and a time and distance analysis once the PAHP receives an enrollment file from HHS.		

Operational Readiness Review Standards Remediation Plan		
Standard IV—Availability of Services		
Requirement	Supporting Documentation	Score
Submit provider listings for the Dental Wellness Plan (DWP) Adults, DWP Kids, and Hawki programs routinely that include the provider name, provider location, and program(s) served. Recommendations: While not specific to this element but this entire standard, HSAG strongly recommends that the PAHP ensure it includes the specific procedures for how the PAHP implements the Iowa-specific contract requirements in its policies. These procedures can be included as an appendix to a policy, SOP, workflow, and/or other formal guidance document.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	<i>DentaQuest_Hawki and DWP_Contracted Provider Network Counts_current as of 05.08.2026</i>, demonstrates how many unique providers by specialty and by county have been contracted as of May 8, 2026. Within the next week, we also expect to finalize contracting efforts with FQHCs and the dental schools. The document, <i>DentaQuest_Hawki and DWP_Anticipated Provider Network Counts_05.08.2026</i>, provides a unique provider count by county and by specialty that we expect to have contracted by July 1, 2026. DentaQuest has been supplying B11 reports on a weekly basis, which includes GEO access information (on the tab, Data Tab 2) to demonstrate network adequacy. The most recent B11 report provided on May 8, 2026 has been provided – see attachment, <i>DentaQuest AccQual B-11 Network Adequacy V3 May 08 SFY26</i>. Within this document, you can also find (on the tab, Data Tab 1) provider listings for unique providers that have been contracted for DWP Adults, DWP Children, and Hawki. This document also demonstrates the provider name, provider location, and program(s) served. - SIV_ DentaQuest_Hawki and SIV_DWP_Anticipated Provider Network Counts_05.08.2026 <Entire Document (Tab 1 & 2)> - SIV_DentaQuest_Hawki and DWP_Contracted Provider Network Counts_current as of 05.08.2026 <Entire Document (Tab 1 & 2)> - SIV_DentaQuest AccQual B-11 Network Adequacy V3 May 08 SFY26 <Entire Document>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/09/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are not sufficient to demonstrate readiness with the requirements for this program area. Although the PAHP has made some progress in building its provider network, significant provider gaps remain. The May 15, 2026, network adequacy reports submitted by the PAHP listed that there are 104 Hawki and 100 DWP providers that are fully contracted, and 49 providers in the process of contracting. Based on the PAHP’s anticipated provider network counts submitted on May 8, 2026, the PAHP indicated that it anticipated it would contract with 391 providers for the Hawki program and 366 providers for the DWP programs, which also confirms significant gaps in building the PAHP’s		☐ Accepted ☐ Accepted With Recommendations ☒ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard IV—Availability of Services		
Requirement	Supporting Documentation	Score
provider network as the number of providers presently contracted is under a third of what the PAHP anticipates to contract with based on the PAHP’s contracting goals. The PAHP indicated that contracts are in process for the Iowa dental schools and FQHCs which will assist in filling some provider gaps, but it is not clear the types of providers (e.g., general dentist, specialty dentist) included as part of the dental schools and FQHCs. The PAHP’s contingency plan included strategies for use of single case agreements and authorizing services for non-network providers for a period of time, which provides some assurances that the PAHP will be able to provide services to its enrolled members and pay provider claims on July 1, 2026; however, the fact that the PAHP has not demonstrated significant progress in building its provider network still remains a concern. As such, the PAHP must submit a plan of correction, including all steps that will be taken, to remediate the continued deficiency, and the PAHP will also be required to meet with HSAG to ensure future compliance with the program area. Further, the PAHP will be required to submit weekly network adequacy reports to HHS and HSAG to provide continued assurances that the network will be sufficient to support timely access to care and services for the PAHP’s enrolled members on and after July 1, 2026. Lastly, the PAHP must continue to work diligently to expand its network to fill gaps in its provider network and provide updates based on outreach attempts and finalized contracting and credentialing efforts.		
Updated Remediation to Address CAP <i>Not Accepted</i> :		
Updated Plan to Remedy Deficiency (Include a narrative with all actions that will be taken to remediate deficiency):	DentaQuest has provided documentation to remediate the deficiencies indicated: Narrative including the remediation plan, detailed listing of the FQHC and Iowa dental school providers, and all network reports available to date. We will continue recruitment, contracting, and credentialing efforts to build and maintain the network.	
Responsible Individual(s):	[redacted], [redacted]	
Timeline/Completion Date:	Remediation plan: 5/26/2026 List of FQHC, U of IA: 5/26/2026 Network Reports: 05/22/2026 Recruitment efforts: Ongoing	
Evidence as Submitted by the PAHP to Address Deficiency:	• SIV_SV_2026.05.26 Network Adequacy Narrative • SIV_1_DentaQuest_B11 GEO_05.22.2026 • SIV_1_DentaQuest_Hawki and DWP_Contracted Provider Network Counts_current as of 05.22.2026 • SIV_1_DentaQuest_Hawki and DWP_Anticipated Provider Network Counts_05.08.2026 • SIV_1_B11 Dental Onboarding Network Adequacy_05.22.2026 • SIV_1_2026.05.25 List of Univ of Iowa Dentists	

Operational Readiness Review Standards Remediation Plan		
Standard IV—Availability of Services		
Requirement	Supporting Documentation	Score
	SIV_1_2026.05.25 List of FQHC Dentists	
HSAG Feedback on Updated Remediation: The PAHP’s remediation plan and supporting documentation are not sufficient to demonstrate readiness with the requirements for this program area. The PAHP indicated that two of 13 FQHCs have signed contracts, and that the PAHP is finalizing a contract with the University of Iowa Dental School. Although these providers may help address some network gaps, concerns remain because the PAHP continues to not show significant progress in building its provider network. In addition, while the PAHP submitted a four-step recruitment plan to expand the network, two of the four approaches have start dates after the PAHP’s go-live date. While PAHP staff members indicated that their primary focus was on the “Pre-Go Live Contract Signature Campaign” approach, not implementing the other approaches earlier or, at minimum, initiating before go-live is problematic and is potentially impacting the PAHP’s ability to build a sufficient network. Although the PAHP has a contingency plan that includes strategies for use of single case agreements and a process for authorizing services and paying claims from non-network providers for a minimum of 90 days, the PAHP must: - Prioritize and continue efforts to expand its provider network to support timely access to care and services for enrolled members on and after July 1, 2026. - Continue to follow HHS guidance on network adequacy reporting and any additional requirements requested by HHS to demonstrate that the PAHP has a sufficient network to provide services to its membership.		☐ Accepted ☐ Accepted With Recommendations ☒ Not Accepted
2. The PAHP provides for a second opinion from a network provider, or arranges for the member to obtain one outside the network, at no cost to the member.	HSAG Required Evidence: - Policies and procedures - Member materials, such as the member handbook - Coverage/authorization guidelines Evidence as Submitted by the PAHP: - SIV_CGA04-INS-Monitoring complaints <Pg 2 Section A, 1, (b) (vi)> - SIV_CGA06-INS-Member Complaints <Pg 6 Section D>	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard IV—Availability of Services		
Requirement	Supporting Documentation	Score
	SIV_Utilization Management Program Description <Pg 9 Second Opinions>	
PAHP Description of Process: The member handbook is currently in development and is projected to be completed by the IA HHS due date of 3/16/26. DentaQuest will ensure second opinions are referenced in the Member Handbook by the date requested by HHS.		
HSAG Findings: Although the <i>CGA04-INS-Monitoring Complaints</i> policy and procedure included that the PAHP's Complaints and Grievances Specialist would arrange for a second opinion consultation as a step for a complaint/grievance resolution, and the DWP Adults, DWP Kids, and Hawki member handbooks included in the "Rights and Responsibilities" section that a member has the right to a second opinion, none of these documents adequately included how members are informed of the process to obtain a second opinion.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Include detailed language in member-facing materials (e.g., member handbook) that informs member that a second opinion is available and the process to obtain a second opinion, either from a network provider or from an OON provider, at no cost to the member.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	- SIV_2. CS05-INT-SOP-CS Call Handling-Second Opinions-IA<Pg. 3-4> - SIV_DQ3197 IA_Medicaid Adult (7.26) HBEN P. <Pg. 32> - SIV_DQ4080 IA_Medicaid Child (7.26) HBEN P. <Pg. 31> - SIV_DQ3198 IA_Medicaid Hawki (7.26) HBEN P. <Pg. 48>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/05/2026		
HSAG Feedback: The PAHP's remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. However, the <i>CS Call Handling-Second Opinions-IA</i> SOP included an inaccurate effective date (i.e., 05/0/2026). As such, HSAG recommends that the PAHP review and ensure that the SOP is updated to reflect an accurate effective date.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted
8. <i>The PAHP ensures that no provider bills a member for all or any part of the cost of treatment service, except as allowed for Title</i>	HSAG Required Evidence: - Policies and procedures - Provider contract template - Provider materials, such as the provider manual	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard IV—Availability of Services		
Requirement	Supporting Documentation	Score
<i>XIX cost sharing and client participation as described in Section F.8 of the contract.</i> Contract F.4.08	- Plan for provider monitoring of balance billing practices Evidence as Submitted by the PAHP: - SIV_2026.02.29 DRAFT Provider Agreement FQHC <Pg 10 Section 1.4 Hold Harmless> - SIV_230206 IA MA MC HIX Provider Agreement<Pg 10 Section 1.4 Hold Harmless> - SIV_Provider Reference Manual <Pg 11 Balance Billing definition> - SIV_CGA04-INS-Monitoring complaints <Pg 2 Procedure A>	
PAHP Description of Process: Note: DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made.		
HSAG Findings: HSAG’s review identified the following findings: - Although the <i>DQ Provider ORM Draft Review v2</i> (provider manual) included information to inform providers of the prohibition of balance billing members for covered services, specifics related to Contract Section F.8 were not clearly identified (e.g., cost sharing, exempt populations, copayments for Iowa DWP members in accordance with Iowa Administrative Code-441 IAC §779.1[13]). - The provider agreement templates submitted had cited language that applied to Medicare Advantage members and not Medicaid members, and the Iowa Medicaid Addendum did not include the requirements of this element. The PAHP submitted its <i>CGA04-INS-Monitoring Complaints</i> policy; however, it was not clear how the PAHP would confirm and subsequently monitor all providers to ensure provider adherence to cost-sharing and balance billing requirements through the PAHP’s complaints process. - In follow-up, the PAHP submitted its <i>NET32-INS Access and Availability Survey</i> policy and procedure; however, the exhibit included appointment standards and the PAHP’s availability of services survey process, and not the requirements of this element. Recommendations: HSAG strongly recommends that the PAHP establish monitoring mechanisms to ensure that providers do not balance bill members for all or part of any covered services except when allowed under Title XIX or through Contract.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Update its provider manual to include all applicable Contract requirements regarding cost sharing. - Update applicable policies and procedures to include the requirements of this element.		

Operational Readiness Review Standards Remediation Plan		
Standard IV—Availability of Services		
Requirement	Supporting Documentation	Score
Include language within its provider agreements for the Iowa DWP Adult, DWP Kids, and Hawki programs that the provider is prohibited from billing a member for all or any part of the cost of treatment service, except as allowed for Title XIX cost-sharing and client participation as described in Section F.8 of the Contract.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	- HHS approved the Provider Participation Agreement on February 6, 2026. The required cost sharing provision is located in the base Provider Participation Agreement at page 4, section 5(b). - SIV_Email HHS Approval of DQ Provider Participation Agreement 020626<Entire Document> - SIV_Provider Participation Agreement IA<Pg.4,Section 5(b)> - SIV_8_NET34-INS-Member Cost Sharing and Financial Responsibility <Pg. 1 & 3>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/05/2026		
HSAG Feedback: The PAHP's remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. Although the PAHP provided its provider agreement and <i>NET34-INS-Member Cost Sharing and Financial Responsibility</i> policy that included cost sharing information, updates to the provider manual (e.g., cost sharing, exempt populations, and copayments for Iowa DWP members in accordance with Iowa Administrative Code-441 IAC §779.1[13]) were not completed. As the provider manual is typically used as a means to inform providers of contract and programwide requirements, HSAG strongly recommends that the PAHP include the requirements from the Contract in the provider manual. Additionally, HSAG strongly recommends that the PAHP consult with HHS to ensure that the <i>NET34-INS-Member Cost Sharing and Financial Responsibility</i> policy aligns with HHS Contract requirements, specifically, all requirements outlined in Section F.8.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted
Timely Access		
9. The PAHP meets and requires its network providers to meet HHS standards for timely access to care and services, taking into account the urgency of the need for services. Refer to the Appointment Times Checklist. 42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a)	HSAG Required Evidence: - Policies and procedures - Provider materials, such as the provider manual and provider contract - Plan to monitor compliance with appointment time standards (e.g., surveys, (submit contract, if survey to be conducted by a delegate), time frames/schedule,	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard IV—Availability of Services		
Requirement	Supporting Documentation	Score
Contract E.5.01(a) Contract Exhibit C: General Access Standards	notice of results template to providers, corrective action plan [CAP] process, etc.) - HSAG will also use the results of the Appointment Times Checklist Evidence as Submitted by the PAHP: - SIV_NET05-INS-Provider Network Adequacy <Pg. 2, Procedure: B.1 and Pg. 2, D.3 and D.6> - SIV_Provider Reference Manual <Pg 17 Section 4.01 ¶2> - SIV_NET32-INS Access and Availability Survey <Full Document> - SIV_PEC05-INS-Provider Disciplinary Action CAP and Appeal Policy <Pg 3 Procedure B 1>	
PAHP Description of Process: Note: DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made.		
HSAG Findings: Although the PAHP’s provider manual included the contractually required appointment time access standards, the <i>NET32-INC Access and Availability Survey, Exhibit A</i> policy did not include the appointment standards for emergency and poststabilization services standards. Of note, the emergency and poststabilization services access standards were included in the <i>NET05-INC-Provider Network Adequacy FINAL</i> policy and procedure; however, it did not include the contractually required dentist and specialty care access standards, indicating inconsistencies between applicable policies exist and may be confusing to PAHP staff members.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Update applicable policies and procedures to include all contractually required appointment time access standards to ensure consistency in information provided to PAHP staff members.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	Our policies are structured to address these requirements distinctly and ensure comprehensive compliance. Internally, we maintain a robust Access & Appointment Availability process that is tasked with surveying providers each quarter. This process ensures providers are consistently meeting the necessary appointment standards. Specifically, the <i>NET32-INS Access and Availability, Exhibit A</i>, lays	

Operational Readiness Review Standards Remediation Plan		
Standard IV—Availability of Services		
Requirement	Supporting Documentation	Score
	out the required standards for Primary Care Physician/Dentist and Specialty Care appointment access, as it pertains to our quarterly appointment surveys. These are the criteria our quarterly provider surveys are based on, allowing us to monitor compliance closely. - SIV_NET32-INS Access and Availability Survey<Pg. 4> In addition, DentaQuest takes a separate approach to ensure compliance with emergency and poststabilization services access standards. These requirements are detailed in our P&P, <i>NET05-INS Provider Network Adequacy, Exhibit P</i>. Since these particular standards are not included in our quarterly provider surveys, we have outlined them within the <i>NET05-Provider Network Adequacy</i> P&P to ensure that these critical access requirements are thoroughly addressed. - SIV_NET05-INS-Provider Network Adequacy<Pg. 6>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/09/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. However, the PAHP’s <i>NET32-INS Access and Availability Survey</i> policy indicated that “each quarter, surveys are conducted on 25% of the general practice provider office locations in-network” to confirm appointment availability. HSAG strongly recommends that the PAHP also ensure oversight and monitoring of the contractually required specialty care access standards for specialty referrals for oral surgery, orthodontia, prosthodontia, periodontia, endodontia, and pediatric specialties.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted

Standard V—Assurances of Adequate Capacity and Services

Operational Readiness Review Standards Remediation Plan		
Standard V—Assurances of Adequate Capacity and Services		
Requirement	Supporting Documentation	Score
Basic Rule		
1. The PAHP gives assurances to HHS and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with HHS’s standards for access to care under 42 CFR §438.207, including the standards at §438.68 and §438.206(c)(1). a. The PAHP submits documentation to HHS, in a format specified by HHS, to demonstrate that it complies with the following requirements: i. Offers an appropriate range of preventive, dental primary care, and specialty services available for patient referrals that is adequate for the anticipated number of members for the service area. ii. Maintains a network of providers, actively accepting patient referrals, that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. 42 CFR §438.207(a) 42 CFR §438.207(b) (1-2) 42 CFR §457.1230(b) Contract E.1.01(b) Contract E.1.24 Contract E.1.26-E.1.27 Contract Exhibit C: General Access Standards	HSAG Required Evidence: • Policies and procedures • Provider Network Onboarding Plan (as requested via the Questionnaire) • Plan for network adequacy monitoring • Network adequacy reports/analyses (i.e., provider network and performance target reports, including the projected number of providers required for each provider type and contracting status) • HSAG will also use the results of the Network Adequacy Checklist Evidence as Submitted by the PAHP: • SV_NET01-INS-Network Development Maintenance and Use <Pg 1-2, A. 1, A. 2, A. 3 & A. 4> • SV_NET05-INS-Provider Network Adequacy <Full Document> • SV_SAMPLE Network Analysis - GEO Report <Full Document> • SV_2026.02.04 Iowa Provider Education Plan <Full Document> • SV_NET32-INS Access and Availability Survey <Pg 1-2 Process 1-3>	☐ Met ☒ Not Met
PAHP Description of Process: The Iowa GEO Report will not be available until after go-live; therefore, a sample GEO Report is included to illustrate the process we will use moving forward to monitor and maintain network adequacy.		

Operational Readiness Review Standards Remediation Plan		
Standard V—Assurances of Adequate Capacity and Services		
Requirement	Supporting Documentation	Score
HSAG Findings: HSAG’s review identified the following findings: - The PAHP confirmed that its provider network consisted of 28 contracted providers at the time of the review, indicating that substantial gaps remain in the PAHP building an adequate provider network. While HSAG understands that it takes time for a new PAHP to build its provider network and the PAHP indicated it had a plan to outreach to recruit and contract with dental providers and build its network, concerns remain that the PAHP was not able to demonstrate that more progress had been made in building its provider network. - HSAG had requested that the PAHP submit a provider network onboarding plan that included all requirements outlined in question 10 of the <i>Readiness Review Questionnaire</i>; however, the PAHP’s Provider Onboarding Plan did not include the number/mix of provider types by specialty expected to be contracted with the PAHP by July 1, 2026, and the number/mix of provider types by specialty currently contracted with the PAHP, rather included a screenshot of a county analysis that included dental location specific detail and recruitment target, but it did not include all specialty provider types outlined in Contract. Further, while the PAHP indicated as part of its Provider Onboarding Plan that it has a current network in Iowa serving Medicare Advantage members and indicated that the PAHP would use this network to “...accelerate Medicaid network expansion, support continuity of care where applicable, and efficiently scale provider participation to meet Iowa Medicaid managed care program requirements,” it was unclear how many providers are included in this network, if the PAHP has confirmed that these providers will also accept Medicaid members, and if any of these providers are also contracted to serve DWP Adults, DWP Kids, and Hawki members. - The GeoAccess reports the PAHP submitted in follow-up, each type of specialty (i.e., oral surgery, orthodontia, prosthodontia, periodontia, endodontia, and pediatric specialties) was not included but rather reported as a whole, as “specialists.” Without the specificity in the PAHP’s network adequacy reports, it does not provide an accurate picture of whether the PAHP has an adequate network, where provider type gaps exist, and if the PAHP meets the required time and distance access standards. Recommendations: While not specific to this element but this entire standard, HSAG strongly recommends that the PAHP ensure it includes the specific procedures for how the PAHP implements the Iowa-specific contract requirements in its policies. These procedures can be included as an appendix to a policy, SOP, workflow, and/or other formal guidance document. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Demonstrate that significant progress has been made toward achieving an adequate network with an appropriate range of providers to serve members assigned to the PAHP. - Submit the number/mix of provider types by specialty expected to be contracted with the PAHP by July 1, 2026, and the number/mix of provider types by specialty currently contracted with the PAHP for each county and urbanicity. - Submit network adequacy reports routinely that demonstrate significant progress toward establishing a sufficient provider network and include, at a minimum, provider counts by provider type and a time and distance analysis once the PAHP receives an enrollment file from HHS. Additionally, the PAHP must ensure that it calculates the time and distance for each provider type using the personal residences of members.		

Operational Readiness Review Standards Remediation Plan			
Standard V—Assurances of Adequate Capacity and Services			
Requirement		Supporting Documentation	Score
Submit provider listings for the DWP Adults, DWP Kids, and Hawki programs routinely that include the provider’s name, provider location, and program(s) served.			
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	Please reference the below documents: - SV_1_DentaQuest AccQual B-11 Network Adequacy V3 May 08 SFY26 <Entire Document> - SV_1_DentaQuest_Hawki and DWP_Contracted Provider Network Counts_current as of 05.08.2026 <Entire Document> - DentaQuest is submitting the B-11 report weekly on Fridays that includes the GEO Access report and a full list of credentialed Providers for each of the IA Programs including the Provider’s name, provider location, and programs served.		
Individual(s) Responsible: [redacted]			
Completion Date: 05/09/2026			
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are not sufficient to demonstrate readiness with the requirements for this program area. Although the PAHP has made some progress in building its provider network, significant provider gaps remain. The May 15, 2026, network adequacy reports submitted by the PAHP listed that there are 104 Hawki and 100 DWP providers that are fully contracted, and 49 providers in the process of contracting. Based on the PAHP’s anticipated provider network counts submitted on May 8, 2026, the PAHP indicated that it anticipated it would contract with 391 providers for the Hawki program and 366 providers for the DWP programs, which also confirms significant gaps in building the PAHP’s provider network as the number of providers presently contracted is under a third of what the PAHP anticipates to contract with based on the PAHP’s contracting goals. The PAHP indicated that contracts are in process for the Iowa dental schools and FQHCs which will assist in filling some provider gaps, but it is not clear the types of providers (e.g., general dentist, specialty dentist) included as part of the dental schools and FQHCs. The PAHP’s contingency plan included strategies for use of single case agreements and authorizing services for non-network providers for a period of time, which provides some assurances that the PAHP will be able to provide services to its enrolled members and pay provider claims on July 1, 2026; however, the fact that the PAHP has not demonstrated significant progress in building its provider network still remains a concern. As such, the PAHP must submit a plan of correction, including all steps that will be taken, to remediate the continued deficiency, and the PAHP will also be required to meet with HSAG to ensure future compliance with the program area. Further, the PAHP will be required to submit weekly network adequacy reports to HHS and HSAG to provide continued assurances that the network will be sufficient to support timely access to care and services for the PAHP’s enrolled members on and after July 1, 2026. Lastly, the PAHP must			☐ Accepted ☐ Accepted With Recommendations ☒ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard V—Assurances of Adequate Capacity and Services		
Requirement	Supporting Documentation	Score
continue to work diligently to expand its network to fill gaps in its provider network and provide updates based on outreach attempts and finalized contracting and credentialing efforts.		
Updated Remediation to Address CAP Not Accepted:		
Updated Plan to Remedy Deficiency (Include a narrative with all actions that will be taken to remediate deficiency):	DentaQuest has provided documentation to remediate the deficiencies indicated: Narrative including the remediation plan, detailed listing of the FQHC and Iowa dental school providers, and all network reports available to date. We will continue recruitment, contracting, and credentialing efforts to build and maintain the network.	
Responsible Individual(s):	[redacted], [redacted]	
Timeline/Completion Date:	Remediation plan: 5/26/2026 List of FQHC, U of IA: 5/26/2026 Network Reports: 05/22/2026 Recruitment efforts: Ongoing	
Evidence as Submitted by the PAHP to Address Deficiency:	- SIV_SV_2026.05.26 Network Adequacy Narrative - SIV_1_DentaQuest_B11 GEO_05.22.2026 - SIV_1_DentaQuest_Hawki and DWP_Contracted Provider Network Counts_current as of 05.22.2026 - SIV_1_DentaQuest_Hawki and DWP_Anticipated Provider Network Counts_05.08.2026 - SIV_1_B11 Dental Onboarding Network Adequacy_05.22.2026 - SIV_1_2026.05.25 List of Univ of Iowa Dentists - SIV_1_2026.05.25 List of FQHC Dentists	
HSAG Feedback on Updated Remediation: The PAHP’s remediation plan and supporting documentation are not sufficient to demonstrate readiness with the requirements for this program area. The PAHP indicated that two of 13 FQHCs have signed contracts, and that the PAHP is finalizing a contract with the University of Iowa Dental School. Although these providers may help address some network gaps, concerns remain because the PAHP continues to not show significant progress in building its provider network. In addition, while the PAHP submitted a four-step recruitment plan to expand the network, two of the four approaches have start dates after the PAHP’s go-live date. While PAHP staff members indicated that their primary focus was on the “Pre-Go Live Contract		☐ Accepted ☐ Accepted With Recommendations ☒ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard V—Assurances of Adequate Capacity and Services		
Requirement	Supporting Documentation	Score
Signature Campaign” approach, not implementing the other approaches earlier or, at minimum, initiating before go-live is problematic and is potentially impacting the PAHP’s ability to build a sufficient network. Although the PAHP has a contingency plan that includes strategies for use of single case agreements and a process for authorizing services and paying claims from non-network providers for a minimum of 90 days, the PAHP must: • Prioritize and continue efforts to expand its provider network to support timely access to care and services for enrolled members on and after July 1, 2026. • Continue to follow HHS guidance on network adequacy reporting and any additional requirements requested by HHS to demonstrate that the PAHP has a sufficient network to provide services to its membership.		
State Requirements		
6. <i>The PAHP has strategies, policies, and procedures describing how it utilizes and partners with community entities and advocates, including transportation and enabling services, and documents such in the Policy and Procedure Manual (PPM). At a minimum, the PAHP must include strategies for:</i> a. <i>Developing member referral networks with emergency departments and urgent care clinics to provide outreach and referral processes for members who present with urgent and emergent dental conditions and need referral including educating providers on use of the Dental Call Line.</i> Contract E.1.18	HSAG Required Evidence: • Policies and procedures • Community engagement strategies • Community partners resource list Evidence as Submitted by the PAHP: • SV_Iowa Provider Office Reference Manual <Pg 35 Section 10.06>	☐ Met ☒ Not Met
PAHP Description of Process: The strategies and community partner resource list will be developed after go-live, once network development is complete. HSAG Findings: The PAHP did not submit policies and procedures as required for this element. In follow-up to the review, the PAHP submitted its <i>DQ Case Management and Care Coordination Manual</i>; however, it did not include information related to a member referral network with emergency departments and urgent care clinics to provide outreach, a referral process for members who present with urgent and emergent dental conditions and require referrals to resources, and educating providers on use of the dental call line.		

Operational Readiness Review Standards Remediation Plan		
Standard V—Assurances of Adequate Capacity and Services		
Requirement	Supporting Documentation	Score
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Develop formal policies and procedures that describe strategies the PAHP utilizes and partner with community entities and advocates, including transportation and enabling services, and, at a minimum, detail strategies for: - Developing member referral networks with emergency departments and urgent care clinics to provide outreach and referral. - Processes for members who present with urgent and emergent dental conditions and need referral. - Educating providers on use of the dental call line.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	- SV_6_CM02-INS-MCD-Continuity and Coordination of Care <p.3, Appendix D, section C> - Provider Reference Manual <Pg. 4>	
Individual(s) Responsible: [redacted]		
Completion Date:		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. However, HSAG recommends that the PAHP include within Appendix D of its <i>CM02-INS-MCD-Continuity and Coordination of Care</i> policy additional details regarding how it utilizes and partners with community entities and advocates, including transportation and enabling services, and its oversight processes of its member referral network.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted

Standard VI—Coordination and Continuity of Care

Operational Readiness Review Standards Remediation Plan		
Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
Clinical Records Documentation		
3. <i>The PAHP maintains in its information system (IS) the information necessary to assist in authorizing and monitoring services as well as providing data necessary for quality assessment and other evaluative activities, and the information includes all the requirements listed in the Clinical Records Checklist.</i> Contract K.30	HSAG Required Evidence: • Policies and procedures • Screenshots of information system fields • Staff training materials • HSAG will also use the results of the system demonstration (i.e., mock care coordination record) • HSAG will also use the results of the Clinical Records Checklist Evidence as Submitted by the PAHP: • SVI_IA_DENTAL_CMPDT.01 <Pg 7 Systems and Tools>	☐ Met ☒ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG’s review identified the findings below: • For Requirement #2 in the <i>Clinical Records Checklist</i>, PAHP staff members explained that documentation of clinical services requested, services authorized, services provided, and the application of UM criteria would be documented in the PAHP’s Windward system. However, staff members noted that they would not substitute services, so this would not be documented in Windward. However, if, during the course of a PA request, the PAHP identifies alternative services the provider may want to consider that are more clinically appropriate than the service that was requested, the PAHP must document this in its system in a place where care coordinators and case managers will be able to access the information. • For Requirement #3 in the <i>Clinical Records Checklist</i>, PAHP staff members noted that there was not a specific location in Windward (either in the care coordination module or the prior authorization module) to notate the reasons for the non-authorization based on Iowa Administrative Code (IAC) citations and substitutions offered. • For Requirement #4 in the <i>Clinical Records Checklist</i>, PAHP staff members indicated that there is currently no place to document missed appointments and subsequent attempts to follow up with the member in the Windward system and that the PAHP will identify an area to record this information.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must:		

Operational Readiness Review Standards Remediation Plan		
Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
- Provide evidence (e.g., screenshots) of where in the information system the PAHP will document services substituted when the PAHP identifies alternative services the provider may want to consider that are more clinically appropriate than the service that was requested. - Provide evidence (e.g., screenshots) of where in the information system the PAHP will document services not authorized, including the reasons for the non-authorization based on IAC citations and substitutions offered. - Provide evidence (e.g., screenshots) of where in the information system the PAHP will document missed appointments and subsequent attempts to follow up with the member. - Submit staff training materials that include these Iowa-specific requirements, explaining where this information must be documented in the information system.	SVI_3_Screenprint Alternate Services <Entire Document>, Screen print from Windward to show approval for an alternate service than what was requested. The screenprint shows the code requested and the Paid code that is approved. - SVI_UM01-INS-IA Dental Practice Guidelines and Prior Authorization <Pg. 3> - SVI_3_Screen shot IAC rule reference <Entire Document> - SVI_3_Screenshot_Broken Appointments <Entire Document> - SVI_3_Training_Job Aid_Broken Appointments <Entire Document> • SVI_3_IAC Rule reference training <Entire Document> - SVI_3_Training_Job Aid_Broken Appointments <Entire Document> - SVI_3_IAC Rule reference training <Entire Document> - SVI_3_Alternate Service training <Entire Document>	
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)		
Individual(s) Responsible: [redacted]		
Completion Date: 05/11/2026		
HSAG Feedback: The PAHP's remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. Specifically related to alternative services, the PAHP provided a screenshot of an example of a submitted procedure code and an example of the paid code, which was different than the submitted code as expected; however, HSAG recommends that the PAHP also ensure that it maintains documentation within the system that notates the discussion or communication with the dental provider regarding the actual reason that the submitted code was not authorized and the alternative services that the PAHP identified for provider consideration that would be more clinically appropriate to treat the member's dental condition. Additionally, the PAHP submitted evidence to demonstrate where in its system it documents services not covered based on the IAC and the reasons for the denial. However, based on the documentation provided, it was not clear where in this section of		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
the system the substitutions offered would be noted. Therefore, HSAG recommends that the PAHP have a section of the system clearly noted with any substitutions that may be offered that will be approved. The <i>Alternate Service</i> training should also be updated to clarify this information. Further, although the PAHP provided evidence that the member’s case manager will document broken appointments within the note section of its system, including follow-up calls with the member, it is not clear whether this documentation will apply to all members and not just members in case management. Therefore, HSAG recommends that the PAHP ensure that policies and procedures address how the system is documented when it identifies missed appointments for any members, including members not in case management. Additionally, the PAHP should ensure that it has the capability to run reports on the “Note Type” field and the “Note” section to ensure it can readily identify members with broken appointments. This will be critical for future compliance reviews. Finally, the PAHP should consider updating its training documents and job aids to be formally documented, including putting the instructions and guidance on DentaQuest letterhead with date of approval, date of implementation, last reviewed and updated date(s), department(s) receiving and responsible for complying with the training, etc.		
5. The PAHP ensures that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards. 42 CFR §438.208(b)(5) 42 CFR §457.1230(c) Contract G.2.30	HSAG Required Evidence: • Policies and procedures • Care coordination program description • Provider materials, such as the provider manual and provider contract • Method(s) for monitoring provider member health records Evidence as Submitted by the PAHP: • SVI_Provider Reference Manual <Pg 30 first bullet>	☐ Met ☒ Not Met
PAHP Description of Process: Note: DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made.		
HSAG Findings: The information related to the patient health record found on pages 38–41 of the <i>Provider Office Reference Manual (ORM)</i> included standards for organization, content, and compliance; however, the PAHP did not cite other documents for this element. During the review, HSAG requested the process for how the PAHP will ensure that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards (e.g., a chart audit process). HSAG also requested the <i>HIPAA Companion Guide</i> referenced on page 38 of the <i>ORM</i>. However, these documents were not submitted as requested.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must:		

Operational Readiness Review Standards Remediation Plan		
Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
- Develop and submit a process for how the PAHP will ensure that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards (i.e., a chart audit process). - Submit the <i>HIPAA Companion Guide</i> referenced in the <i>ORM</i>.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	- DentaQuest requires its providers to maintain and share the member's health records in accordance with professional standards. In addition, we have revised the Provider Reference Manual to correctly reference the HIPAA Companion guide, which we are including with this submission. - SVI_5_Provider Participation Agreement IA<Pg. 4, section 4d & Pg. 3, section f4> - Provider Reference Manual <Pg. 71-72> - SVI_HIPAA Companion Guide <Entire Document>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/05/2026		
HSAG Feedback: The PAHP's remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. The <i>Provider Reference Manual</i> under section 13.00 <i>The Patient Record</i> appropriately included the specific content that must be included in each dental record. Additionally, although not provided as supporting evidence, the <i>Provider Reference Manual</i> also indicated under section 16.00 <i>Clinical Criteria and Clinical Practice Guidelines</i> that "every Provider in the DentaQuest program is subject to random chart/treatment audits. Providers are required to comply with any request for records." Additionally, there were subsequent statements throughout this manual that required providers to maintain appropriate documentation for audit purposes. Further, the manual stated that "[t]he Utilization Review department performs compliance audits based on grievances, complaints, or as the result of a Focused Review." However, HSAG strongly recommends, and the PAHP must demonstrate during future compliance reviews, that it has documentation of the process that the PAHP will use to conduct random audits, and/or focused audits, to ensure its providers are maintaining documentation of member health records that comply with the PAHP's expectations and professional health standards.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
Initial Oral Health Risk Screening		
7. The PAHP makes a best effort to conduct an initial screening of each member's needs within 90 days of the effective date of enrollment for all new members including subsequent attempts if the initial attempt to contact the member is unsuccessful. a. <i>The PAHP must document at least three attempts to conduct the screening.</i> 42 CFR §438.208(b)(3) 42 CFR §457.1230(c) Contract G.2.09–10 Contract G.2.13	HSAG Required Evidence: • Policies and procedures • Care coordination program description • Initial screening template • Initial screening tracking and monitoring mechanisms • Staff training materials • HSAG will also use the results of the system demonstration (i.e., mock care coordination record) Evidence as Submitted by the PAHP: • SVI_IA_DENTAL_CMPDT.01 <Pg 7 Oral Health Screening and Equity Self-Assessment Tools> • SVI_CM02-INS-MCD-Continuity and Coordination of Care <Pg 2 Procedure B 1>	☐ Met ☒ Not Met
PAHP Description of Process:		
HSAG Findings: During the review, PAHP staff members explained that once the telephonic screening process is completed, it will include an instructions document that will be provided to the vendor, TrachMar, which is the vendor that will be delegated to conduct the initial screenings. The PAHP provided an example instructions document that would be provided to TrachMar; however, the document was for another state and did not confirm the process that will be implemented for Iowa.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: • Provide the procedure document that outlines how the PAHP will conduct an initial screening of each member's needs within 90 days of the effective date of enrollment for all new members, including the process for documenting at least three call attempts if the initial attempt to contact the member is unsuccessful. • Submit the Iowa-specific instructions document that will be provided to TrachMar, which must include the appropriate time frames for making the initial screening calls and the three attempts required by HHS.		

Operational Readiness Review Standards Remediation Plan		
Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	- SVI-CM02-INS-Continuity and Continuation of Care <Pg. 3> - SVI_7_IA Welcome Calls_HRA Vendor Instructions <Entire Document>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/06/2025		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. The PAHP provided its <i>Continuity & Coordination of Care</i> policy, which appropriately indicated that three attempts will be made to screen members within 90 days of the effective date of enrollment. Additionally, this policy contained an appendix specifically for Iowa that stipulated the <i>Oral Health Risk Assessment Data Collection</i> procedures and the steps for documenting the screening attempts including the date of each call, the disposition of the call(s), and that this information (i.e., responses) will be documented in a detailed response file. The <i>Welcome Call and OHRA Instructions: Iowa</i> document for the PAHP’s vendor also included detailed instructions with the PAHP’s expectations for obtaining the monthly call file, outreaching to members at least three times on different days and different times, and the required details that must be included in the response file. However, it was not clear where the PAHP will maintain documentation of the calls outside of the response file. Therefore, HSAG strongly recommends that the PAHP either create a process for maintaining these outreach attempts, and outreach dispositions, within its information systems; or update its internal policies and procedures to outline the process for how the PAHP’s system notates this information.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted
Transition/Continuity of Care		
11. The PAHP must implement a transition of care policy that is consistent with federal requirements and at least meets HHS’ defined transition of care policy. The PAHP implements mechanisms to ensure the continuity of care of members transitioning in and out of the PAHP’s enrollment pursuant to all requirements in 42 CFR §438.62. The PAHP demonstrates the	HSAG Required Evidence: - Policies and procedures - Care coordination program description - Member materials, such as the member handbook and welcome packet - Mechanisms to ensure continuity of care - Staff training materials	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
following components are implemented to ensure continuity of care during transitions: - The member has access to services consistent with the access they previously had and is permitted to retain their current provider <i>for 90 days if that provider is enrolled in Iowa Medicaid.</i> - The member is referred to appropriate providers of services that are in the network. - The member is referred to appropriate providers of services that are in the network. - HHS, in the case of FFS, or the PAHP that was previously serving the member, fully and timely complies with requests for historical utilization data from the new PAHP in compliance with Federal and State law. - Consistent with Federal and State law, the member’s new provider(s) are able to obtain copies of the member’s medical records, as appropriate. - Any other necessary procedures as specified by the Secretary to ensure continued access to services to prevent serious detriment to the member’s health or reduce the risk of hospitalization or institutionalization. Possible transitions include but are not limited to: (i) initial program implementation; (ii) initial enrollment with the PAHP; (iii) transitions between PAHPs during the first 90 days of a member’s enrollment; and (iii) at any time for cause as described in Contract Section B.5.05. 42 CFR §438.62(b)(1)(i-vi) Contract G.2.34–G.2.35	- Transition of care program, including a process to obtain historical data (PAs, claims) from State and/or previous PAHP - Process to use historical data for transitions of care (e.g., add PAs to system) - Process to allow members to retain current providers Evidence as Submitted by the PAHP: - SVI_IA_DENTAL_CMPDT.01 <Pg 15 Assistance and Desired Outcomes>	
PAHP Description of Process:		

Operational Readiness Review Standards Remediation Plan		
Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
HSAG Findings: While the PAHP’s policies and procedures included the appropriate transition of care time frame, the member handbooks indicated that members may be able to keep seeing their current dentist for at least 30 days, even if the dentist is not in the PAHP’s network and that the PAHP will notify the member if a longer time applies. However, the requirement for Iowa Medicaid is that members can see their current dentist for 90 days. Additionally, the member handbooks were in draft form.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Update its member handbooks to ensure members have access to services consistent with the access they previously had and are permitted to retain their current provider for 90 days if that provider is enrolled in Iowa Medicaid. - Submit the final draft of the member handbooks with HHS’ approval.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	- SVI_DQ3197 IA_Medicaid Adult (7.26) HBEN <Pg 17-18> - SVI_DQ4080 IA_Medicaid Child (7.26) HBEN <Pg. 6-8> - SVI_DQ3198 IA_Medicaid Hawki (7.26) HBEN <Pg. 5-7>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/08/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard VII—Coverage and Authorization of Services

Operational Readiness Review Standards Remediation Plan		
Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
Utilization Management Program		
4. <i>The PAHP has a UM committee directed by the PAHP's Dental Director. The committee is responsible for:</i> a. <i>Monitoring providers' requests for rendering dental health care services to its members.</i> b. <i>Monitoring the medical appropriateness and necessity of dental health care services provided to its members.</i> c. <i>Reviewing the effectiveness of the utilization review process and making changes to the process as needed.</i> d. <i>Writing policies and procedures for UM that conform to industry standards including methods, timelines and individuals responsible for completing each task.</i> e. <i>Confirming the PAHP has an effective mechanism in place for assuring dental service access in areas, including within the State's identified Dental Health Professional Shortage Areas (DHPSAs).</i> Contract G.3.05	HSAG Required Evidence: • Policies and procedures • UM program description • UM committee charter • Current and planned UM committee members and plan to initiate UM committee meetings • Identified DHPSAs • Plan to assure access to dental services in DHPSAs Evidence as Submitted by the PAHP: • SVII_UM Program Description <page 14, Utilization Management Committee> • SVII_DentaQuest Utilization Management Committee Charter <Full Document> • SVII_DentaQuest UM Organizational Chart <Full Document>	☐ Met ☒ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG's review identified the findings below: • HSAG noted multiple inconsistencies between the <i>UM Program Description</i>, <i>DentaQuest Utilization Management Committee Charter</i>, <i>DentaQuest UM Organizational Chart</i>, and the <i>Iowa Staffing Plan</i> as they related to responsible UM program staff positions. • The <i>UM Program Description</i> and <i>DentaQuest Utilization Management Committee Charter</i> included discrepant information on meeting frequency and meeting responsibilities. • The <i>DentaQuest Utilization Management Committee Charter</i> referenced Medicare federal requirements, which are not applicable to the Iowa Medicaid managed care program. • The PAHP's Dental Director's involvement and responsibilities related to UM were not clear.		

Operational Readiness Review Standards Remediation Plan

Standard VII—Coverage and Authorization of Services

Requirement	Supporting Documentation	Score
- During the review, HSAG requested that the PAHP reconcile all documents to ensure they consistently and accurately reflect the PAHP’s UM program structure, committee structure, and staffing; and meet Iowa-specific UM staffing and committee requirements. HSAG specifically requested that the PAHP address processes confirming that the PAHP has an effective mechanism in place for assuring dental service access in areas, including within HHS’ identified Dental Health Professional Shortage Areas (DHPSAs), as the documentation submitted did not specifically address this requirement, and language within the <i>UM08-INS-Authorization Review</i> policy indicated that requests for services from OON providers would be systematically denied. Since OON service requests would be systematically denied, it is unclear how the PAHP assures that members residing in DHPSAs will have access to dental services, and when the PAHP has an inadequate provider network where a member resides, that may necessitate the approval of OON services in accordance with 42 CFR §438.206(b)(4). - After the review, the PAHP provided a <i>New Program Description</i> and an <i>Updated DentaQuest Organizational Chart</i>. However, the organizational chart did not meet contract requirements. The “Utilization Management Director” key staff person “[m]anages all elements of the UM program and staff under the supervision of the Dental Director. This includes but is not limited to functions related to PA, medical necessity determinations, concurrent and retrospective reviews, and other programs as described in the Contract.” However, the key staff person is identified as the “Associate Director, UM Technology,” who has no UM direct reports and there is no dotted line between the “Associate Director, UM Technology” and the “Iowa Dental Director.” Further, the “Clinical Review Specialists” and “Utilization Management Administrative Staff” report directly to the “Manager, Utilization Management,” who reports to the “Director, Utilization Management.” The “Associate Director, UM Technology,” who the PAHP identified as the UM key staff person, does not have a direct linkage to UM staff. This organizational structure does not meet the intent of the requirement, “Manages all elements of the UM program and staff under the supervision of the Dental Director.” Further, the organizational chart has the “Director, Utilization Management” reporting to herself, which would not be appropriate. - While the <i>DentaQuest-Iowa Personnel Organizations Structure-03.31.2026</i> provided after the review suggested that the “Clinical Review Specialists” report to the “Utilization Management Director,” this conflicts with the <i>Updated DentaQuest Organizational Chart</i> also provided after the review, which indicated that the “Clinical Review Specialists” report to the “Manager, Utilization Management,” who is not the same person identified as the “Utilization Management Director” key staff person. Additionally, the <i>DentaQuest-Iowa Personnel Organizations Structure-03.31.2026</i> provided no linkage between the “Utilization Management Director” key staff person and the “Iowa Dental Director.” However, the “Utilization Management Director” key staff person is responsible for managing all elements of the UM program and staff under the supervision of the “Dental Director.” - After the review, the PAHP updated the Iowa exhibit to its <i>UM08</i> policy to include the requirements of this element and identified the PAHP’s Dental Director as the UM committee chair. The <i>New Program Description</i> also indicated that the chair of the UM committee was the “Iowa Dental Director.” However, while the <i>Breakdown of UM Committees</i> document included the UM committee’s “Frequency & Meeting Overview,” “Attendees,” and “Voting Attendees,” the PAHP’s Dental Director was not listed as either an “Attendee” or “Voting Attendee” even though the PAHP’s contract requires the UM committee to be directed by the PAHP’s Dental Director. The <i>IDAC Draft 4</i> document, also submitted after the review, which was the <i>Iowa Dental Advisory Committee Charter</i>, did list the PAHP’s Dental Director as a member; however, this was not the UM committee charter. The		

Operational Readiness Review Standards Remediation Plan		
Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<i>Breakdown of UM Committees</i> document and <i>New Program Description</i> specifically reference a UM committee and does not include a committee referred to as the Iowa Dental Advisory Committee as part of the UM committee structure. Further, while the <i>New Program Description</i> suggested that the chair of the UM committee is an attendee of the UM subcommittees, the <i>Breakdown of UM Committees</i> document did not list the PAHP’s Dental Director as a member of any sub-committee. Lastly, while the <i>Breakdown of UM Committees</i> document confirmed that the “Care Delivery and Compliance Committee” and the “Quality Initiatives Task Force Subcommittee” are no longer free-standing committees and instead were rolled into the “Quality Oversight Committee,” these committees were still referenced under the “Utilization Management Committee” section of the <i>New Program Description</i>. HSAG was unable to reconcile the conflicting information presented in the PAHP’s documents. While the Iowa exhibit to its <i>UM08</i> policy was updated and included the requirements of sub-element (e), it provided no context of how the PAHP will implement the requirement. Additionally, the <i>Updated UM08-INS-SOP-Insufficient Information Received</i> and <i>UM08</i> policies submitted after the review addressed processes to obtain missing clinical information from requesting providers to make coverage decisions, and the Iowa exhibit indicated that the process pertained to “contracted providers” under the “Provider outreach for Prior Authorizations” sub-heading. The <i>UM08</i> policy also continued to indicate that “[a]ny out of network or ineligible Providers are systemically denied, unless allowed under contract or regulation.” Based on HSAG’s desk review, discussion during the interview sessions, and review of documents submitted after the review, HSAG could not confirm that the PAHP had adequate mechanisms in place for assuring member access to dental services, including within the HHS’ identified DHPSAs.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Reconcile all documents submitted by the PAHP for this element to accurately and consistently reflect the UM staffing and committee structure and the role of the PAHP’s Dental Director. All discrepant information must be corrected. - Update its organizational chart to demonstrate the “Utilization Management Director” key staff person required by Contract meets contract requirements (i.e., manages all elements of the UM program and staff under the supervision of the Dental Director, including but is not limited to functions related to PA, medical necessity determinations, concurrent and retrospective reviews, and other programs as described in the Contract). - Provide a detailed plan for how, from a UM perspective, it will assure member access to dental services in all service areas, including HHS’ identified DHPSAs and in areas in which the PAHP may have an insufficient provider network.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	- SVII_Iowa UM Organization Chart<Entire Document> - SVII_4_UM08-INS-IA-Authorization Review <Pg. 9> - SVII_4.5. Utilization Management Program Description<Entire Document> - SVII_Breakdown of UM Committees<Entire Document>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/08/2026		

Operational Readiness Review Standards Remediation Plan		
Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. However, the <i>Utilization Management Program Description</i> continued to include the “Care Delivery and Compliance Committee” and the “Quality Initiatives Task Force Subcommittee,” which the PAHP previously confirmed are no longer free-standing committees and instead were rolled into the “Quality Oversight Committee.” The PAHP must correct the <i>Utilization Management Program Description</i> . Further, as the <i>DentaQuest Utilization Management Committee Charter</i> was not resubmitted, the PAHP must ensure that it aligns with the requirements of the Iowa Medicaid managed care program.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted
5. <i>The PAHP’s Dental Director participates in monthly Iowa Medicaid Medical Director meetings to provide recommendations for clinical criteria to ensure clinical policies are implemented consistently.</i> a. <i>The PAHP’s Dental Director communicates critical information from the Iowa Medicaid Medical Director meetings internally to ensure policies and procedures are implemented as agreed upon by the clinical team.</i> Contract G.3.05	HSAG Required Evidence: - UM program description - Dental Director job description - Workflow for communicating critical information from HHS meetings to internal UM staff or other departments, as applicable Evidence as Submitted by the PAHP: - SVII_UM Program Description <pages 2-4, Org structure and resources; pages 14-15, Committee Structure> - SVII_DentaQuest UM Organizational Chart	☐ Met ☒ Not Met
PAHP Description of Process: HSAG Findings: The documents cited by the PAHP did not include the requirements of this element. HSAG requested that the PAHP include the requirement in its Iowa-specific <i>UM Program Description</i> . The PAHP submitted a <i>New Program Description</i> after the review, however, cited no page number. HSAG searched for associated key words and was unable to locate the specific requirement.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Provide documentation to support awareness of the PAHP’s Dental Director’s required participation in monthly Iowa Medicaid Medical Director meetings and the process for how the Dental Director will communicate critical information from the Iowa Medicaid Medical Director meetings internally to ensure policies and procedures are implemented as agreed upon by the clinical team.		
Plan to Remedy Deficiency:	SVII_4.5. Utilization Management Program Description<Pg. 16>	

Operational Readiness Review Standards Remediation Plan		
Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
(Include all actions that will be taken to remediate deficiency.)		
Individual(s) Responsible: [redacted]		
Completion Date: 05/05/2026		
HSAG Feedback: The PAHP's remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
Coverage		
6. The PAHP: a. Identifies, defines, and specifies the amount, duration, and scope of each service that the PAHP is required to offer. b. Ensures the services are furnished in an amount, duration, and scope for the same services furnished to members under fee-for-service (FFS) Medicaid, as set forth in 42 CFR §440.230, and for members under the age of 21, as set forth in 42 CFR §441 Subpart B. c. Ensures each service is sufficient in the amount, duration, and scope to reasonably achieve its purpose.	HSAG Required Evidence: • Policies and procedures • Member materials, such as the member handbook and benefits grid • UM program description • Hierarchy of coverage guidelines/criteria • Process for applying the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit • Staff training materials	☐ Met ☒ Not Met
42 CFR §438.210(a)(1-2) 42 CFR §438.210(a)(3)(i) 42 CFR §440.230 42 CFR §441 Subpart B 42 CFR §457.1230(d) Contract F.6.01–F.6.04	Evidence as Submitted by the PAHP: • SVII_UM08-INS-Authorization Review <pages 4-6, Procedure A 4-6> • SVII_UM01-INS-Clinical Algorithms <pages 1-2, Procedure A> • SVII_UM Program Description <page 8, EPSDT>	
PAHP Description of Process:		

Operational Readiness Review Standards Remediation Plan		
Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
HSAG Findings: HSAG’s review identified the findings below: - The <i>Provider Reference Manual</i> and the <i>ORM</i> submitted after the review were not final and did not include a benefit grid for Hawki. - The PAHP submitted an affirmation statement confirming it will conduct a final analysis to ensure the benefits are aligned with the Iowa Medicaid managed care program; however, the claims scenario review suggested that the PAHP did not consistently follow HHS’ <i>Iowa Medicaid DWP CDT Codes Requiring Prior Authorization</i> and <i>Iowa Medicaid Dental Wellness Plan CDT Codes Requiring Additional Documentation with the Claim</i>. During the review, PAHP staff members implied that the PAHP’s coverage policies could not be more restrictive than HHS. HSAG requested that the PAHP clarify with HHS whether the PAHP must follow HHS’ PA and claim payment review (i.e., documentation requirements for claims processing/prepayment review [PPR]) policies or if the PAHP has the flexibility to define its internal coverage policies as long as they are no more restrictive than HHS. Documentation submitted after the review did not confirm that the PAHP sought HHS’ guidance. However, after the review, HHS confirmed that the PAHP must adhere to 42 CFR 438.210, which requires the PAHP’s service authorization processes to be no more restrictive than the State Medicaid program. - The three versions of the member handbook (i.e., DWP Adult, DWP Kids, and Hawki) included “Covered Dental Services” and “Non-Covered Benefits” sections; however, the handbooks were in draft form.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Provide a detailed project plan to reconcile its PA and PPR processing policies to ensure they are no more restrictive than HHS’ requirements (as the claims scenario demonstrations did not provide assurances that the claims processed in alignment with HHS [e.g., PPR review was required by the PAHP when HHS does not require additional documentation to be submitted for the dental code]). - Submit the final draft of the member handbooks with HHS’ approval. - Submit the final draft of the <i>ORM</i> with a completed Hawki benefit grid with HHS’ approval.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	DentaQuest has aligned its documents to ensure they are no more restrictive than HHS’ requirements. DentaQuest will work with HHS to determine if any additional clinical requirements are advisable. - SVII_PA and PPR Iowa Project Plan for HSAG <Entire Document> - SVII_Exhibit 2 – IA HHS Pre-Payment Review Process Approval Folder: - SVII_Approved (11496 - DentaQuest - Document Review - DENTAQUEST)<Entire Document> - SVII_MCO Review Attachment - 12-1-2025<Entire Document> - SVII_MCO Review Attachment - 1-5-2026<Entire Document> - SVII_MCO Review Attachment - 1-5-2026<Entire Document> - SVII_MCO Review Comments - 12-2-2025<Entire Document>	

Operational Readiness Review Standards Remediation Plan		
Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
f. SVII_MCO Review Document - 1-5-2026<Entire Document> - SVII_DQ3197 IA_Medicaid Adult (7.26) HBEN <Pg. 21-23 - SVII_DQ4080 IA_Medicaid Child (7.26) HBEN <Pg. 20-22> - SVII_DQ3198 IA_Medicaid Hawki (7.26) HBEN <Pg. 20-23> - Provider Reference Manual <Pg. 152-161>		
Individual(s) Responsible: [redacted]		
Completion Date: 05/11/2026		
HSAG Feedback: The PAHP's remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. However, the PAHP must continue to work with HHS to ensure its PA/PPR processes are no more restrictive than HHS' requirements and that any deviations are approved by HHS. The PAHP must also work with HHS to ensure that the member handbooks and provider manual align with HHS' covered benefits and PA/PPR requirements and are approved by HHS.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted
8. The PAHP may place appropriate limits on a service on the basis of criteria applied under the <i>Medicaid</i> State Plan (<i>MSP</i>), the <i>Children's Health Insurance Program (CHIP) State Plan</i>, and/or the <i>Iowa Administrative Code (IAC)</i>, such as medical necessity, or on utilization control procedures, or otherwise permitted under an approved State Plan waiver, provided that: a. The services furnished can reasonably achieve their purpose. 42 CFR §438.210(a)(4) 42 CFR §441.20 42 CFR §440.230(d) 42 CFR §457.1230(d) Contract F.6.06 Contract F.6.09	HSAG Required Evidence: - Policies and procedures - Utilization management plan - Member materials, such as the member handbook - Hierarchy of coverage guidelines/criteria - Staff training materials Evidence as Submitted by the PAHP: - SVII_UM01-INS-Clinical Algorithms <page 1-2, Procedure A> - SVII_Member Handbook Prev Implementation DRAFT <page 40>	☐ Met ☒ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG's review identified the findings below: The <i>Provider Reference Manual</i> and the <i>ORM</i> submitted after the review were not completed and did not include a benefit grid for Hawki.		

Operational Readiness Review Standards Remediation Plan		
Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
- The PAHP submitted an affirmation statement confirming it will conduct a final analysis to ensure the benefits are aligned with the Iowa Medicaid managed care program; however, the claims scenario review suggested that the PAHP did not consistently follow HHS’ <i>Iowa Medicaid DWP CDT Codes Requiring Prior Authorization</i> and <i>Iowa Medicaid Dental Wellness Plan CDT Codes Requiring Additional Documentation with the Claim</i>. During the review, PAHP staff members implied that the PAHP’s coverage policies could not be more restrictive than HHS. HSAG requested that the PAHP clarify with HHS whether the PAHP must follow HHS’ PA and claim payment review (i.e., documentation requirements for claims processing/PPR) policies or if the PAHP has the flexibility to define its internal coverage policies as long as they are no more restrictive than HHS. Documentation submitted after the review did not confirm that the PAHP sought HHS’ guidance. However, after the review, HHS confirmed that the PAHP must adhere to 42 CFR 438.210, which requires the PAHP’s service authorization processes to be no more restrictive than the State Medicaid program. - The three versions of the member handbook (i.e., DWP Adult, DWP Kids, and Hawki) included “Covered Dental Services” and “Non-Covered Benefits” sections; however, the handbooks were in draft form.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Provide a detailed project plan to reconcile its PA and PPR processing policies to ensure they are no more restrictive than HHS’ requirements (as the claims scenario demonstrations did not provide assurances that the claims processed in alignment with HHS [e.g., PPR review was required by the PAHP when HHS does not require additional documentation to be submitted for the dental code]). - Submit the final draft of the member handbooks with HHS’ approval. - Submit the final draft of the <i>ORM</i> with a completed Hawki benefit grid with HHS’ approval.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	DentaQuest has aligned its documents to ensure they are no more restrictive than HHS’ requirements. DentaQuest will work with HHS to determine if any additional clinical requirements are advisable. The system has also been aligned to comply with the requirements. - SVII_PA and PPR Iowa Project Plan for HSAG <Entire Document> - SVII_Exhibit 2 – IA HHS Pre-Payment Review Process Approval Folder: - SVII_Aproved (11496 - DentaQuest - Document Review - DENTAQUEST)<Entire Document> - SVII_MCO Review Attachment - 12-1-2025<Entire Document> - SVII_MCO Review Attachment - 1-5-2026<Entire Document> - SVII_MCO Review Attachment - 1-5-2026<Entire Document> - SVII_MCO Review Comments - 12-2-2025<Entire Document> - SVII_MCO Review Document - 1-5-2026<Entire Document> - SVII_DQ3197 IA_Medicaid Adult (7.26) HBEN <Pg. 21-23 >	

Operational Readiness Review Standards Remediation Plan		
Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
	- SVII_DQ4080 IA_Medicaid Child (7.26) HBEN <Pg. 20-22> - SVII_DQ3198 IA_Medicaid Hawki (7.26) HBEN <Pg.20-23 > - Provider Reference Manual <Pg. 152-161>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/11/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. However, the PAHP must continue to work with HHS to ensure its PA/PPR processes are no more restrictive than HHS’ requirements and that any deviations are approved by HHS. The PAHP must also work with HHS to ensure that the member handbooks and provider manual align with HHS’ covered benefits and PA/PPR requirements and are approved by HHS.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted
10. <i>The PAHP ensures the provision of covered benefits in accordance with the member’s eligibility group.</i> a. <i>The PAHP provides benefits to members of CHIP (known as “Hawki”) as described in Special Contract Exhibits D and E. Members not otherwise specified in Contract Section F.6.16 or who are enrolled in the Hawki program who are enrolled with the PAHP are eligible for all medically necessary covered benefits in Iowa’s State Plan as amended and all waivers approved by CMS.</i> b. <i>The PAHP ensures that individuals eligible for the Iowa Dental Wellness Plan (DWP) receive Iowa DWP benefits as described in the State Plan and summarized in Special Contract Exhibit E.</i> Contract F.6.16–F.6.18 Contract Exhibit D: Eligible Enrolled Members and Excluded Populations Contract Exhibit E: Covered Benefits	HSAG Required Evidence: - Benefits grid - Member materials, such as the member handbook - Provider materials, such as the provider manual - Staff training materials Evidence as Submitted by the PAHP: - SVII_Provider Reference Manual <pages 69-135, Exhibit A Benefits Covered> - SVII_Member Handbook Prev Implementation DRAFT <full document>	☐ Met ☒ Not Met
PAHP Description of Process: HAWKI benefits are currently in process of being configured. Once completed, the benefits will be in the Provider Reference Manual mimicking the layout of pages 69-135 Exhibit A. The benefits will also be displayed within the Member Handbook.		

Operational Readiness Review Standards Remediation Plan		
Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made. HSAG Findings: HSAG’s review identified the findings below: - The <i>Provider Reference Manual</i> and the <i>ORM</i> submitted after the review were not completed and did not include a benefit grid for Hawki. - The PAHP submitted an affirmation statement confirming it will conduct a final analysis to ensure the benefits are aligned with the Iowa Medicaid managed care program; however, the claims scenario review suggested that the PAHP did not consistently follow HHS’ <i>Iowa Medicaid DWP CDT Codes Requiring Prior Authorization</i> and <i>Iowa Medicaid Dental Wellness Plan CDT Codes Requiring Additional Documentation with the Claim</i>. During the review, PAHP staff members implied that the PAHP’s coverage policies could not be more restrictive than HHS. HSAG requested that the PAHP clarify with HHS whether the PAHP must follow HHS’ PA and claim payment review (i.e., documentation requirements for claims processing/PPR) policies or if the PAHP has the flexibility to define its internal coverage policies as long as they are no more restrictive than HHS. Documentation submitted after the review did not confirm that the PAHP sought HHS’ guidance. However, after the review, HHS confirmed that the PAHP must adhere to 42 CFR 438.210, which requires the PAHP’s service authorization processes to be no more restrictive than the State Medicaid program. - The three versions of the member handbook (i.e., DWP Adult, DWP Kids, and Hawki) included “Covered Dental Services” and “Non-Covered Benefits” sections; however, the handbooks were in draft form. - After the review, the PAHP submitted screenshots confirming its system has the capability to assign and track the Iowa Medicaid managed care program’s eligibility groups (i.e., DWP Adults, DWP Kids, Hawki); however, the PAHP’s system was not configured with the Iowa Medicaid managed care program benefit package for each eligibility group. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Provide a detailed project plan to reconcile its PA and PPR processing policies to ensure they are no more restrictive than HHS’ requirements (as the claims scenario demonstrations did not provide assurances that the claims processed in alignment with HHS [e.g., PPR review was required by the PAHP when HHS does not require additional documentation to be submitted for the dental code]). - The final draft of the member handbooks with HHS’ approval. - The final draft of the <i>ORM</i> with a completed Hawki benefit grid with HHS’s approval. - Confirmation that its system is configured to align with the Iowa Medicaid managed care program benefit package for DWP Adults, DWP Kids, and Hawki.		

Operational Readiness Review Standards Remediation Plan		
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Requirement	Supporting Documentation	Score
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	DentaQuest has aligned its documents to ensure they are no more restrictive than HHS' requirements. DentaQuest will work with HHS to determine if any additional clinical requirements are advisable. The system has also been aligned to comply with the requirements. - SVII_PA and PPR Iowa Project Plan for HSAG <Entire Document> - SVII_Exhibit 2 – IA HHS Pre-Payment Review Process Approval Folder: - SVII_Approved (11496 - DentaQuest - Document Review - DENTAQUEST)<Entire Document> - SVII_MCO Review Attachment - 12-1-2025<Entire Document> - SVII_MCO Review Attachment - 1-5-2026<Entire Document> - SVII_MCO Review Attachment - 1-5-2026<Entire Document> - SVII_MCO Review Comments - 12-2-2025<Entire Document> - SVII_MCO Review Document - 1-5-2026<Entire Document> - SVII_DQ3197 IA_Medicaid Adult (7.26) HBEN <Pg. 21-23 > - SVII_DQ4080 IA_Medicaid Child (7.26) HBEN <Pg. 20-22> - SVII_DQ3198 IA_Medicaid Hawki (7.26) HBEN <Pg.20-23 > Provider Reference Manual <Pg. 152-161>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/11/2026		
HSAG Feedback: The PAHP's remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. However, the PAHP must continue to work with HHS to ensure its PA/PPR processes are no more restrictive than HHS' requirements and that any deviations are approved by HHS. The PAHP must also work with HHS to ensure that the member handbooks and provider manual align with HHS' covered benefits and PA/PPR requirements and are approved by HHS.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted

Operational Readiness Review Standards Remediation Plan		
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Requirement	Supporting Documentation	Score
11. <i>The PAHP provides EPSDT services to all DWP members under 21 years of age in accordance with law.</i> a. <i>EPSDT covers dental services regardless of whether these services are provided under the State Plan and regardless of any restrictions that may be imposed on coverage.</i> b. <i>The PAHP partners with Maternal Health, Screening Center, and Public Health agencies to ensure the completion of dental screens and preventive visits in accordance with the EPSDT periodicity schedule.</i> c. <i>The PAHP implements outreach, monitoring, and evaluation strategies for EPSDT, including collaboration with local community stakeholders and public health agencies.</i> d. <i>The PAHP develops provider and member education activities that increase beneficiary awareness of and access to applicable EPSDT services.</i> e. <i>The PAHP does not require a PA or PCP (if applicable) referral for the provision of EPSDT screening services.</i> Contract F.6.25–F.6.26 Contract G.3.09(c)	HSAG Required Evidence: • Policies and procedures • Benefits grid • Member materials, such as the member handbook • Provider materials, such as the provider manual • Process for applying the EPSDT benefit • Claims payment algorithm for EPSDT • Staff training materials Evidence as Submitted by the PAHP: • SVII_Member Handbook Prev Implementation DRAFT <full document> • SVII_UM08-INS-Authorization Review <page 8, Procedure E> • SVII_UM08-INS-Authorization Review <page 10 Exhibit AY bullets 1, 2> • SVII_Qual Mgmt Plan – Outreach <Full Document>	☐ Met ☒ Not Met
PAHP Description of Process: HSAG Findings: HSAG’s review identified the findings below: • During the review, PAHP staff members explained that its system has “rejects” that would trigger a clinical review for services under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. However, no evidence of this system functionality was provided to confirm the process for implementation. • After the review, the PAHP submitted its DWP Adult member handbook, which specified that no PA or PCP referral was needed for EPSDT services and that each service is reviewed for medical necessity even when the service is not normally a covered benefit. However, this information was missing from the DWP Kids and Hawki member handbooks.		

Operational Readiness Review Standards Remediation Plan

Standard VII—Coverage and Authorization of Services

Requirement	Supporting Documentation	Score
- The <i>ORM</i> submitted after the review was updated to include information on the EPSDT benefit and indicated that no PA is required for EPSDT screening services but may be required for diagnostic or treatment services. However, the DWP Adult member handbook submitted after the review indicated that EPSDT services do not require a PA (i.e., implying PA is not required for any EPSDT service). The <i>UM08-INS-Authorization Review</i> policy indicated that for EPSDT services, PA is required and PAs need to adhere to the IAC. This policy did not differentiate between screening services and diagnostic or treatment services. - The <i>UM08-INS-Authorization Review</i> policy indicated if the PAHP finds an EPSDT service (i.e., “code”) medically necessary but does not meet IAC criteria, that a “Waiver of Administrative Rule” (referred to as an “Exception to Policy”) can be submitted to Iowa Medicaid. While the PAHP’s contract with HHS indicates that if the PAHP makes a determination that a service typically not covered by Medicaid may be medically necessary, that an Exception to Policy may be initiated. However, it is unclear if the PAHP’s process meets HHS’ expectations (e.g., does HHS require an Exception to Policy for EPSDT services determined to be medically necessary but do not meet IAC criteria, or is the PAHP required to approve the service according to the EPSDT benefit and medical necessity [i.e., without an Exception to Policy]). Recommendations: HSAG’s review identified the recommendations below: - The DWP Kids and Hawki member handbooks had a paragraph repeated twice under the EPSDT section (i.e., “For information about EPSDT services that are NOT dental (like medical check-ups, mental healthcare, or other health services)...Contact your medical managed care organization...They handle all the other EPSDT benefits”). HSAG recommends that the PAHP correct this prior to finalizing these handbooks. - HSAG recommends that the PAHP be prepared to demonstrate the authorization of services covered under the EPSDT benefit when requested or rendered when the services are not covered under the Iowa Medicaid benefit (e.g., non-covered service, benefit limit reached). - While the <i>IA_DENTAL_CMPDT.03</i> document (i.e., case management program description) submitted after the review generally addressed provisions for partnering with I-Smile Coordinators and community partners, HSAG recommends that the PAHP’s UM staff training include processes for ensuring the completion of dental screens and preventive visits in accordance with the EPSDT periodicity schedule by partnering with maternal health, screening centers, and public health agencies. - HSAG recommends that the PAHP review, through its UM committee, the provision of EPSDT benefits; for example, review data related to services that were denied under the Iowa Medicaid benefit but approved under the EPSDT benefit, and review data related to services denied for members under the age of 21 to determine if there are opportunities for improvement or gaps in the PAHP’s PA and PPR processes. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Submit evidence of its process to authorize the provision of services under the EPSDT benefit (e.g., “reject” codes, system screenshots, claims scenario, mock PA or PPR). Note, according to the PAHP’s contract with HHS, “...screenings need not be conducted by a Medicaid provider to trigger EPSDT coverage for follow up diagnostic services and medically necessary treatment by a qualified Medicaid provider.” Therefore, the PAHP’s submission must also demonstrate compliance with this expectation.		

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Requirement	Supporting Documentation	Score
- Reconcile and update, where appropriate, the <i>ORM</i>, the member handbooks (i.e., DWP Adult, DWP Kids, and Hawki), and <i>UM08-INS-Authorization Review</i> policy to ensure they accurately and consistently reflect the PAHP's PA requirements for EPSDT services, including screening and diagnostic and treatment services, and if and how they differ. - Provide HHS' confirmation if the PAHP's Exception to Policy for EPSDT meets contract requirements.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	- SVII_11_UM08-INS-IA-Authorization Review <Pg. 7-8> - Provider Reference Manual <Pg. 57- 59> - SVII_DQ4080 IA_Medicaid Child (7.26) HBEN <Pg. 29> - SVII_DQ3197 IA_Medicaid Adult (7.26) HBEN <Pg. 26> It appears that there was a miscommunication during the audit review surrounding EPSDT requirement – we have removed the Waiver language from the policy that was added when trying to remediate this audit finding. Services will be processed per Federal EPSDT regulations, and the Waiver process is not required.	
Individual(s) Responsible: [redacted]		
Completion Date: 05/11/2026		
HSAG Feedback: The PAHP's remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. However, the Hawki member handbook was not cited as evidence of the PAHP's remediation plan. HSAG reviewed the Hawki member handbook and it did not include the "Early Periodic Screening Diagnosis and Treatment (EPSDT)" sub-heading (i.e., between the "Limited or Not Covered Benefits" and "Early Dental Treatment" sub-headings). Therefore, the PAHP must update the Hawki member handbook as it applies to EPSDT.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted
Coordination With Medicare		
12. <i>The PAHP provides medically necessary covered services to members who are also eligible for Medicare if the service is not covered by Medicare.</i> a. <i>The PAHP ensures that services covered and provided under the Contract are delivered without charge to members who are dually eligible for Medicare and Medicaid.</i> b. <i>The PAHP coordinates with Medicare payers, Medicare Advantage Plans, and Medicare providers as appropriate to</i>	HSAG Required Evidence: - Policies and procedures - UM program description - Plan to coordinate care with other payors - Staff training materials Evidence as Submitted by the PAHP:	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<i>coordinate the care and benefits of members who are also enrolled with Medicare.</i> c. <i>The PAHP develops and documents a plan to coordinate care for duals.</i> Contract J.4.10	SVII_UM Program Description <page 13, Care Coordination>	
PAHP Description of Process: HSAG Findings: HSAG requested that the PAHP update its <i>UM Program Description</i>, or submit any other documentation, to address processes for coordinating the provision of dental benefits for members who are dual eligible. After the review, the PAHP cited the <i>New Program Description</i>; however, the PAHP provided no citation or page number. HSAG searched for associated key words and was unable to determine the PAHP’s process for coordinating care with members who are also eligible for Medicare. The only references to Medicare HSAG located were the following statements: “...in the dental context, the concept of ‘post-stabilization of care’ generally does not apply in the same way for Medicaid, Medicare Advantage, or commercial dental plans” and “...in the event that the involved plan covers Medicaid or Medicare members, the State Dental Consultant will be requested to submit an opinion as to coverage under the state program.” The PAHP also cited the <i>Utilization Management Workplan 2025</i> as evidence after the review; however, HSAG was unable to correlate it to the requirements of this element. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Submit documentation that adequately addresses processes for coordinating the provision of dental benefits for members who are dual eligible.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	- SVII_CL01-INS-SOP-TPL and COB process<Pg. 1 & 3> - SVII_12_UM08-INS-IA-Authorization Review < Pg. 6>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/08/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations

Operational Readiness Review Standards Remediation Plan		
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Requirement	Supporting Documentation	Score
		☐ Not Accepted
Authorization of Services		
13. The PAHP and its subcontractors have in place, and follow, written policies and procedures for the processing of requests for initial and continuing authorization of services. a. <i>UM policies and procedures are exclusive to Iowa and do not contain documentation from other State Medicaid programs or product lines operated by the PAHP.</i> 42 CFR §438.210(b)(1) 42 CFR §457.1230(d) Contract G.3.03 Contract G.3.06 Contract G.3.11	HSAG Required Evidence: • Policies and procedures • UM program description • List of delegated entities performing UM functions • Delegated written contracts (for entities responsible for delegated UM functions) • Delegation oversight of policies and procedures • Oversight and monitoring plan for delegated UM functions • Staff training materials Evidence as Submitted by the PAHP: • SVII_11a_DQ_IA2026_PAHP_RR_File Review_Delegation_D1 <Universe File Template tab> • SVII UM Program Description <Full Document>	☐ Met ☒ Not Met
PAHP Description of Process:		
HSAG Findings: The PAHP’s UM policies were not exclusive to Iowa. Instead, the PAHP submitted corporate policies with, or without, an Iowa exhibit, when applicable.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: • Create and submit UM policies that are specific to the Iowa Medicaid managed care program; or alternatively, • Submit HHS’ approval that corporate policies, with or without an Iowa exhibit, when applicable, are acceptable for the Iowa Medicaid managed care program.		

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Requirement	Supporting Documentation	Score
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	- SVII_13_UM08-INS-IA-Authorization Review <Entire document> - SVII_13_UM01-INS-IA-Dental Practice Guidelines and Prior Authorizations <Entire document> - SVII_13_UM15-INS-Access to Services Out of Network-IA <Entire document>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/09/2026		
HSAG Feedback: The PAHP's remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. However, while the PAHP submitted three policies specific to Iowa Medicaid, HSAG recommends that the PAHP ensure that all UM policies are exclusive to the Iowa Medicaid managed care program and/or include an Iowa-specific addendum for all applicable Iowa requirements and as approved by HHS.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted
Timeframe for Decisions		
20. For standard authorization decisions, the PAHP provides notice as expeditiously as the member's condition requires and within HHS established time frames that may not exceed seven calendar days following receipt of the request for service. 42 CFR §438.210(d)(1) 42 CFR §438.404(c)(3) 42 CFR §457.1230(d) 42 CFR §457.1260(c)(3)	HSAG Required Evidence: - Policies and procedures - UM program description - Tracking and reporting mechanism(s) (i.e., screenshots of UM system, mock report template to monitor timeliness) - Staff training materials - System screenshots of field where the date of receipt of the request and the date of the mailing of the ABD notice are documented - HSAG will also use the results of the system demonstration (i.e., mock service authorization cases) Evidence as Submitted by the PAHP: - SVII_UM08-INS-Authorization Review <page 3, Procedure A. Prior Auth Review 2.>	☐ Met ☒ Not Met

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Requirement	Supporting Documentation	Score
PAHP Description of Process: PAHP systems are still being configured and developed. Mock reporting is not available yet. Staff Training materials are currently being developed. They will be submitted by May 1, 2026.		
HSAG Findings: HSAG’s review identified the findings below: • HSAG requested that the PAHP update its provider manual to include the seven-calendar-day time frame for standard PAs. While the PAHP submitted the <i>ORM</i> after the review, it provided no citation or page number. HSAG searched for associated keys words/numbers and was unable to confirm that the PAHP updated the provider manual as requested. • While the PAHP’s system had the capability to track and report the date of receipt of a PA request and the date the ABD notice was generated, PAHP staff members explained that its mail gets picked up at 12:00 p.m. and 4:00 p.m.; notices generated after 4:00 p.m. will be mailed the following day; and that its printing and mailing department is working seven days a week with the exception of holidays. HSAG requested the PAHP’s print and fulfillment process to confirm the PAHP’s stated process; however, it was not provided after the review. • Discussion confirmed that the PAHP did not currently have the capability to consider mail pick up times when calculating PA TATs. As TATs must be calculated from the date of receipt to the date the ABD notice was sent to the member, the PAHP’s processing and reporting procedures must consider mail pick up times since ABD notices may not be mailed on the same day they are generated. Further, if letters are dated prior to the actual mailing date, the PAHP is not providing members with their full appeal filing time frames.		
Recommendations: The PAHP’s policy allows 30 calendar days and the option for a 14-calendar-day extension for a PPR (i.e., post-service review of claim for payment). As 42 CFR 438.210 includes no specific time frames for PPRs, HSAG recommends that the PAHP consult with HHS to verify if its process meets HHS’ expectations.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: • Update and resubmit its <i>ORM</i> to include the required seven-calendar-day PA TAT. • Provide its print and fulfillment process. • Develop a plan and timeline for calculating TATs using the date the ABD notice enters the mailing stream.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	• Provider Reference Manual<Pg. 65-66 > • SVII_20-21_INT04-INS-Outbound Correspondence<Pg. 7> • SVII_20_UM08-INS-IA-Authorization Review <Pg. 7> • SVII_20-21_UM09-INS-SOP-Turnaround Time Calculations and Monitoring <Entire Document> • SVII_20_UM Standard TAT Monitoring Screenshot<Entire Document>	
Individual(s) Responsible: [redacted]		

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Requirement	Supporting Documentation	Score
Completion Date: 05/08/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. However, the <i>UM Standard TAT Monitoring Screenshot</i> included a “pend_description” of “UM-Auth-Extended TAT” with a seven-calendar day TAT and “UM-Auth-2 day” with a five-calendar day TAT. HSAG could not determine the applicability of this monitoring screenshot as the <u>standard</u> TAT is <u>seven calendar days</u> with a possible <u>14-day extension</u> . As the PAHP submitted other documentation supporting adequate remediation, the PAHP received an <i>Accepted With Recommendations</i> designation. However, the PAHP must verify that the data from the screenshot aligns with the requirements of this element and the PAHP’s remediation plan and update, as necessary.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted
21. For cases in which a provider indicates, or the PAHP determines, that following the standard timeframe could seriously jeopardize the member’s life or health or ability to attain, maintain, or regain maximum function, the PAHP must make an expedited authorization decision and provide notice as expeditiously as the member’s health condition requires and no later 72 hours after receipt of the request for service.	HSAG Required Evidence: • Policies and procedures • UM program description • Tracking and reporting mechanism(s) (i.e., screenshots of UM system, mock report template to monitor timeliness) • Staff training materials • System screenshot of field where the date and time of receipt of the request and the date and time of the mailing of the ABD notice are documented • HSAG will also use the results of the system demonstration (i.e., mock service authorization cases) Evidence as Submitted by the PAHP: • SVII_UM08-INS-Authorization Review <page 3, Procedure A. Prior Auth Review 2.>	☐ Met ☒ Not Met
PAHP Description of Process: PAHP systems are still being configured and developed. Mock reporting is not available yet. Staff Training materials are currently being developed. They will be submitted by May 1, 2026.		
HSAG Findings: HSAG’s review identified the findings below: • HSAG requested that the PAHP update its provider manual to include the 72-hour time frame for expedited PAs. While the PAHP submitted the <i>ORM</i> after the review, it provided no citation or page number. HSAG searched for associated keys words/numbers and was unable to confirm that the PAHP		

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Requirement	Supporting Documentation	Score
updated the provider manual as requested. HSAG did note that “expedited” is a term used to identify a claim related to emergency dental treatment; however, expedited reviews and the 72-hour TAT for expedited reviews apply to PA (i.e., pre-service) and not claims (i.e., post-service). - While the PAHP updated its member handbooks to include time frames for processing expedited PAs, it indicated that the time frame was “72 hours (3 days).” However, 72 hours does not necessarily equate to three days; for example, if the PA request was received on January 5, 2026, at 9:00 a.m., and the ABD notice entered the mailing stream on January 8, 2026, at 4:00 p.m., the PAHP’s TAT for this PA is noncompliant (i.e., while the notice entered the mailing stream on day three, the TAT calculation is 79 hours). TATs must be calculated in hours, not days. - While the PAHP’s system had the capability to track and report the date of receipt of a PA request and the date the ABD notice was generated, PAHP staff members explained that its mail gets picked up at 12:00 p.m. and 4:00 p.m.; notices generated after 4:00 p.m. will be mailed the following day; and that its printing and mailing department is working seven days a week with the exception of holidays. HSAG requested the PAHP’s print and fulfillment process to confirm the PAHP’s stated process; however, it was not provided after the review. - Discussion confirmed that the PAHP did not currently have the capability to consider mail pick up times when calculating PA TATs. As TATs must be calculated from the date/time of receipt to the date/time the ABD notice was sent to the member, the PAHP’s processing and reporting procedures must consider mail pick up times since ABD notices may not be mailed on the same day/time they are generated. Further, if letters are dated prior to the actual mailing date, the PAHP is not providing members with their full appeal filing time frames. Recommendations: HSAG’s review identified the recommendations below: - The PAHP appeared to use the terms “emergent” and “urgent” interchangeably as an expedited PA review process. While a rendering provider, based on clinical judgment, is responsible for determining whether to request an expedited PA (i.e., pre-service expedited request) or render emergency services to treat an emergency dental condition (i.e., submits a claim for emergency services post-service), they are distinct processes which should be clearly delineated. HSAG also acknowledges that the PAHP is using the same system for processing PAs and claims, and a medical necessity review may occur for both processes. However, HSAG recommends that the PAHP review and update all policies and the provider manual to ensure the language aligns with the federal rule (i.e., use of the term “expedited” when referring to the PA requests [i.e., pre-service] in which following the standard time frame could seriously jeopardize the member’s life or health or ability to attain, maintain, or regain maximum function) and use of the term “emergency” when referring to claims for emergency services (i.e., post-service). - The PAHP’s policy allows for 30 calendar days and the option for a 14-calendar-day extension for a PPR (i.e., post-service review of claim for payment). As 42 CFR §438.210 includes no specific time frames for PPRs, HSAG recommends that the PAHP consult with HHS to verify if its process meets HHS’ expectations. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Update and resubmit its <i>ORM</i>, including the 72-hour time frame for expedited PAs. - Update and resubmit the member handbooks. - Provide its print and fulfillment process.		

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Requirement	Supporting Documentation	Score
Develop a plan and timeline for calculating TATs using the date/time the ABD notice entered the mailing stream.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	- Provider Reference Manual <Pg. 65-66> - SVII_DQ3197 IA_Medicaid Adult (7.26) HBEN <Pg. 26> - SVII_DQ4080 IA_Medicaid Child (7.26) HBEN <Pg. 84> - SVII_DQ3198 IA_Medicaid Hawki (7.26) HBEN <Pg. 26> - SVII_20-21_INT04-INS-Outbound Correspondence<Pg.7> - SVII_20-21_UM09-INS-SOP-Turnaround Time Calculations and Monitoring <Entire Document> - SVII_21_UM Expedited TAT Monitoring Screenshot<Entire Document>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/11/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area <u>with the expectation that the PAHP will remove “(3 days)”</u> from the “For urgent reviews, DentaQuest will make a decision within 72 hours (3 days)” statement of the DWP Adult, DWP Kids, and Hawki member handbooks. Further, the <i>UM Standard TAT Monitoring Screenshot</i> included a “pend_description” of “UM-Auth-Extended TAT” with a seven-calendar day TAT and “UM-Auth-2 day” with a five-calendar day TAT. HSAG could not determine the applicability of this monitoring screenshot as the <u>expedited</u> TAT is <u>72 hours</u> with a possible <u>14-day extension</u> . As the PAHP submitted other documentation supporting adequate remediation, the PAHP received an <i>Accepted With Recommendations</i> designation. However, the PAHP must verify that the data from the screenshot aligns with the requirements of this element and the PAHP’s remediation plan and update, as necessary.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted
22. For standard and expedited authorization decisions, the PAHP may extend the resolution timeframe up to an additional 14 calendar days if: - The member, or the provider, requests the extension; or - The PAHP justifies to HHS upon request a need for additional information and how the extension is in the member’s interest.	HSAG Required Evidence: - Policies and procedures - UM program description - Tracking and reporting mechanism(s) (i.e., screenshots of UM system, mock report template to monitor timeliness) - Extension notice template - Staff training materials	☐ Met ☒ Not Met

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Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
42 CFR §438.210(d)(1)(i-ii) 42 CFR §438.210(d)(2)(ii) 42 CFR §457.1230(d) 42 CFR §457.1260(c)(3) Contract G.3.17 Contract H.3.06–H.3.07 Contract H.3.11	- System screenshot of the field where the date of the extension and rationale for extension are documented - HSAG will also use the results of the system demonstration (i.e., mock service authorization cases) Evidence as Submitted by the PAHP: - SVII_UM08-INS-Authorization Review <page 4, Procedure A. Prior Auth Review 4.>	
PAHP Description of Process: PAHP systems are still being configured and developed. Mock reporting is not available yet. Staff Training Materials are currently being developed. They will be submitted by May 1, 2026.		
HSAG Findings: HSAG’s review identified the findings below: - The <i>UM08-INS-Authorization Review</i> policy included misleading and inaccurate information related to the extension process for standard and expedited appeals and potentially intermingled Medicaid, Medicare, and commercial requirements. Specifically: “The extension period, within which a decision must be made by DentaQuest begins...On the date when DentaQuest receives the provider’s response (even if not all the information is provided), or...At the end of the time given to the provider to supply the information if no response is received from the provider. DentaQuest may deny the request if the information is not received within the timeframe, and the member may appeal the denial.” This language inaccurately suggests that the PAHP would stop the TAT clock when an extension is applied. “DentaQuest may extend the urgent pre-service timeframe due to a lack of information, once, for forty-eight (48) hours, under the following conditions...Within twenty-four (24) hours of receipt of the urgent pre-service request, DentaQuest asks the provider, member, or the member’s representative for the specific information necessary to make the decision...DentaQuest gives the provider, member, or member’s authorized Representative at least forty-eight (48) hours to provide the information...The extension period, within which a decision must be made by DentaQuest, begins is stated above in section A, part 5.” This language inaccurately suggests that the extension period for expedited PAs is only 48 hours, that members are responsible for providing missing information, and that the PAHP would stop the TAT clock when an extension is applied. After the review, the PAHP cited an updated <i>UM08</i> policy that included the requirements of this element verbatim in an Iowa exhibit; however, the inaccurate language in the body of the policy remained mostly unchanged. Since the Iowa exhibit included no context for its process of implementation, it was unclear if the extension procedures in the body of policy still applied. Further, the following statement was added to the expedited PA extension provisions, “The timeframe with which a determination is required to be made does not stop when the request is pending for additional information to complete the determination”; however, this same clarification was not made under the standard PA extension provisions. It is concerning that the PAHP did not attempt to make any changes to the body of the document as HSAG communicated to the PAHP that the policy was noncompliant for all Medicaid lines of business (LOBs).		

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- During the review, PAHP staff members explained that extensions are tracked within its system when the case shows it is pending for documentation. However, this would imply that any case pending for documentation equates to an extension, which is not accurate. The PAHP could request and receive documentation prior to the due date and would not necessitate an extension in all instances. Further, an extension should not automatically be applied when requesting additional documentation but rather when the PAHP has not received the requested documentation by the PA due date. Therefore, HSAG requested a screenshot for how the PAHP's system would differentiate between an actual extension as opposed to a case that was pending for documentation. This documentation was not submitted as requested. - After the review, the PAHP cited its <i>Updated UM08-INS-SOP-Insufficient Information Received</i> policy; however, it addressed procedures for requesting additional clinical information, which may result in an extension but did not provide clarity into the PAHP's process as described in policy <i>UM08</i>. - Under Element 23, HSAG requested that an extension template be provided. After the review, the PAHP submitted two <i>IA Medicaid PA denial that needed ext</i> notices. Both notices were ABD notices. An extension is very different from an ABD, and an ABD notice is not an appropriate notice to send to a member when an extension is applied. Further, the ABD notice provides members with appeal rights; however, members have grievance rights and not appeal rights for extensions. - After the review, the PAHP submitted an <i>IA Medicaid preservice pend</i> notice template which, based on the content of the template, may be aligned with the extension provisions. However, this notice template was not cited as evidence for Elements 22 and 23 and cited as evidence for Element 28, which is a different requirement than the extension provisions. It also did not include grievance rights. The culmination of these findings is concerning and confirms that the PAHP does not have effective procedures in place for extensions and that PAHP staff members do not understand the extension provisions. Recommendations: The PAHP's policy allows 30 calendar days and the option for a 14-calendar-day extension for a PPR (i.e., post-service review of claim for payment). As 42 CFR §438.210 includes no specific time frames for PPRs, HSAG recommends that the PAHP consult with HHS to verify if its process meets HHS' expectations.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Update and resubmit its <i>UM08-INS-Authorization Review</i> policy to include accurate procedures for extensions. - Submit evidence that its system has the capability to track extensions. - Submit staff training materials on extensions (e.g., extension time frames, when an extension can be applied [i.e., when additional clinical information is pending from a provider and not solely for the convenience of the PAHP]; and extensions should not be applied prematurely but when the PAHP is unable to make a decision by the due date).		

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Requirement	Supporting Documentation	Score
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	- SVII_22-23_UM08-INS-IA-Authorization Review <Pg. 4> - SVII_22-23_Extension Tracking screenshots<Entire Document> - SVII_22-23 Extension Process Training Materials<Entire Document>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/08/2026		
HSAG Feedback: The PAHP's remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. However, according to the <i>Extension Process Training Materials</i> , when an extension is initiated, "[i]f information is not received, on day 13 of extension period the authorization will be denied." As clinical information could be obtained on day 13 or 14 of the extension period in which a decision should be made, HSAG recommends that the PAHP wait until day 14 of the extension period to make the determination if clinical information is not received.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted
23. If the PAHP meets the criteria set forth for extending the timeframe for standard and expedited service authorization decisions consistent with 42 CFR §438.210(d)(1)(ii) and 42 CFR §438.210(d)(2)(ii), it: - Gives the member written notice of the reason for the decision to extend the timeframe and informs the member of the right to file a grievance if he or she disagrees with that decision; and - Issues and carries out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires. 42 CFR §438.210(d)(1)(ii) 42 CFR §438.210(d)(2)(ii) 42 CFR §438.404(c)(4)(i-ii) 42 CFR §457.1230(d) Contract H.3.08–H.3.09	HSAG Required Evidence: - Policies and procedures - UM program description - Tracking and reporting mechanism(s) (i.e., screenshots of UM system, mock report template to monitor timeliness) - Extension notice template - Staff training materials - System screenshot of the field where the notice of extension is documented - HSAG will also use the results of the system demonstration (i.e., mock service authorization cases) Evidence as Submitted by the PAHP: - SVII_UM08-INS-Authorization Review <page 3-4, Procedure A. Prior Auth Review 3, 4 & 8>	☐ Met ☒ Not Met
PAHP Description of Process: PAHP systems are still being configured and developed. Mock reporting is not available yet.		

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HSAG Findings: HSAG’s review identified the findings below: • The <i>UM08-INS-Authorization Review</i> policy indicated that an extension notice with grievances rights would be provided to a member for standard PAs; however, this same requirement was not included in the policy for expedited PA extensions. This was not corrected after the review as requested by HSAG. • HSAG requested that an extension template be provided as one was not originally provided as requested. After the review, the PAHP submitted two <i>IA Medicaid PA denial that needed ext</i> notices. Both notices were ABD notices. An extension is very different from an ABD, and an ABD notice is not an appropriate notice to send to a member when an extension is applied. Further, the ABD notice provides members with appeal rights; however, members have grievance rights and not appeal rights for extensions. • After the review, the PAHP submitted an <i>IA Medicaid preservice pend</i> notice template which, based on the content of the template, may be aligned with the extension provisions. However, this notice template was not cited as evidence for Elements 22 and 23 and cited as evidence for Element 28, which is a different requirement than the extension provisions. It also did not include grievance rights. The culmination of these findings is concerning and confirms that the PAHP does not have effective procedures in place for extensions and that PAHP staff members do not understand the extension provisions.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: • Update and resubmit its <i>UM08-INS-Authorization Review</i> policy to include accurate procedures for extensions. • Submit an extension notice with member grievance rights. • Submit evidence that its system has the capability to generate and maintain extension notices. • Submit staff training materials on extensions (e.g., use of correct extension notice template).		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	• SVII_22-23_UM08-INS-IA-Authorization Review <Pg. 4> • SVII_23_IA Medicaid Prior Authorization Extension<Entire Document> • SVII_22-23 Extension Tracking screenshots<Entire Document> • SVII_22-23 Extension Process Training Materials<Entire Document>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/08/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are not sufficient to demonstrate readiness with the requirements for this program area. The template informs members that “[w]e need more time to decide because we asked your dentist for more information so we can decide if this service is medically necessary for you. When we asked your dentist for		☐ Accepted ☐ Accepted With Recommendations

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Requirement	Supporting Documentation	Score
this information, we gave your dentist a date when we needed to get this information. We have not received the information we need from your dentist by the date that was given. Your dentist can send in a new request with the information we need.” However, this language implies that a member’s provider must submit a new request which is misleading. A provider should not have to submit a new PA request; rather, the PAHP should be reaching out to the provider in efforts to obtain the missing clinical information prior to the end of the extension period. Therefore, the PAHP must submit a plan of correction, including all steps that will be taken, to remediate the continued deficiency, and the PAHP will also be required to meet with HSAG to ensure future compliance with the program area.		☒ Not Accepted
Updated Remediation to Address CAP Not Accepted:		
Updated Plan to Remedy Deficiency (Include a narrative with all actions that will be taken to remediate deficiency):	DentaQuest has updated the content in the extension letter.	
Responsible Individual(s):	[redacted], [redacted]	
Timeline/Completion Date:	5/21/2026	
Evidence as Submitted by the PAHP to Address Deficiency:	SVII_23_IA Medicaid Prior Authorization Extension <Entire Document>	
HSAG Feedback on Updated Remediation: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
25. The PAHP <i>mails the</i> notice not later than the date of action if: - The PAHP has factual information confirming the death of a member; - The PAHP receives a clear written statement signed by a member that: - The member no longer wishes services; or	HSAG Required Evidence: - Policies and procedures - UM program description - ABD notice template(s) - Tracking and reporting mechanism(s) (i.e., screenshots of UM system, mock report template to monitor timeliness) - Staff training materials	☐ Met ☒ Not Met

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Requirement	Supporting Documentation	Score
ii. Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information; c. The member has been admitted to an institution where the member is ineligible under the plan for further services; d. The member’s whereabouts are unknown and the post office returns agency mail directed to the member indicating no forwarding address; e. The PAHP establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth; or f. A change in the level of medical care is prescribed by the member’s physician. 42 CFR §431.213 42 CFR §438.210(c) 42 CFR §438.404(c)(1) 42 CFR §457.1230(d) Contract H.3.03	- Three mock examples of an ABD notice sent to a member that meets one of the criteria of this element (e.g., one example for a deceased member, one example for a member who no longer wishes to receive services, and one example for member who is no longer eligible for services through the PAHP [e.g., member incarcerated]) - System screenshot of the field where the date of the ABD notice, reason for the ABD, and effective date of the action are documented for advance notices - HSAG will also use the results of the system demonstration Evidence as Submitted by the PAHP: - SVII_UM Program Description < - SVII_IA Medicaid NABD letter template <Full Document> - SVII_INT02-INS-Undeliverable Member Mail <page 2, Procedure B. Undeliverable Mail Returned>	
PAHP Description of Process: PAHP systems are currently being developed and configured. Mock reporting is not available yet. HSAG Findings: The documentation cited as evidence by the PAHP did not include the requirements of this element, and discussion during the review did not provide assurances of an understanding of a process for implementation. HSAG requested that the requirements of this element be incorporated into its policy. However, after the review, the PAHP submitted a <i>CS10.01-INS-SOP Change in Enrollee Circumstances</i> policy, which addressed program integrity procedures for notifying HHS about changes in a member’s circumstance that may affect a member’s eligibility (i.e., change in residence or death of a member). However, this policy does not fully address this element. The PAHP did not incorporate the requirements of this element in a UM policy or indicate that an ABD notice would be sent by the date of the action when one of the listed scenarios occurs. Recommendations: HSAG’s review identified the recommendations below: As 42 CFR §438.404(c)(1) requires the PAHP to send notice according to 42 CFR §431.213, which HHS is required to comply with (i.e., as the “State or local agency”), HSAG recommends that that PAHP consult with HHS should it have any clarifying questions on HHS’ expectations for providing members with an ABD notice when the PAHP is aware when any of the scenarios outlined in 42 CFR §431.213 occur.		

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HSAG recommends that the PAHP expand on the procedures for implementation and incorporate any guidance received by HHS, if applicable.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Incorporate the requirements of this element in its <i>UM08-INS-Authorization Review</i> policy. - Incorporate the requirements of this element and procedures for implementation in staff training materials.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	- SVII_25-26_UM08-INS-IA-Authorization Review <Pg. 6-7> - SVII_25-26_Staff Training Termination Process<Entire Document> 3 different mocked up termination notices are in the Supporting Documents folder: - SVII_Standard 7, Element 25_ - Mocked up IA Medicaid PA Term - member death <Entire Document> - SVII_Standard 7, Element 25_ - Mocked up IA Medicaid PA Term - member no longer wants service <Entire Document> - SVII_Standard 7, Element 25_ - Mocked up IA Medicaid PA Term - member no longer eligible <Entire Document>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/08/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. However, HSAG recommends that the PAHP revise the <i>Mocked up IA Medicaid PA Term - member death</i> notice to include member-centric language. For example, instead of “You” (as the member has passed), use the name of the member and include language such as that the PAHP was informed of the unfortunate passing of [member name]. Additionally, the mock ABD notice for “member death” and “member no longer eligible” included the following statement: “This letter does not change your other care.” However, for these two scenarios, that is not accurate. As such, HSAG recommends that the PAHP update these templates accordingly.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted
26. The PAHP may shorten the period of advance notice to five days before the date of action if: - The PAHP has facts indicating that action should be taken because of probable fraud by the member; and - The facts have been verified, if possible, through secondary sources.	HSAG Required Evidence: - Policies and procedures - UM program description - ABD notice template(s) - Tracking and reporting mechanisms (e.g., screenshots of UM system, mock report template to monitor timeliness)	☐ Met ☒ Not Met

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Requirement	Supporting Documentation	Score
42 CFR §431.214 42 CFR §438.210(c) 42 CFR §438.404(c)(1) 42 CFR §457.1230(d) Contract H.3.02	- Workflow/communication channels to ensure ABD notice is mailed to members due to probable fraud by the member - One mock example of an ABD notice sent to a member due to probable fraud - Staff training materials Evidence as Submitted by the PAHP: - SVII_UM Program Description - SVII_IA Medicaid NABD letter template <Full Document>	
PAHP Description of Process: PAHP systems are currently being configured and developed. Mock reporting is not available yet. Staff Training materials are currently being developed. They will be submitted by May 1, 2026.		
HSAG Findings: The documentation cited as evidence by the PAHP did not include the requirements of this element, and discussion during the review did not provide assurances of an understanding of a process for implementation. HSAG requested that the requirements of this element be incorporated into its policy. However, after the review, the PAHP submitted a <i>CS10.01-INS-SOP Change in Enrollee Circumstances</i> policy, which addressed program integrity procedures for notifying HHS about changes in a member’s circumstance that may affect a member’s eligibility (i.e., change in residence or death of a member). However, this policy does not address this element. The PAHP did not incorporate the requirements of this element in policy or indicate that an ABD notice would be sent at least five days prior to the date of the action due to probable member fraud.		
Recommendations: HSAG’s review identified the recommendations below: - As 42 CFR §438.404(c)(1) requires the PAHP to send notice according to 42 CFR §431.214, which HHS is required to comply with (i.e., as the “State or local agency”), HSAG recommends that that PAHP consult with HHS should it have any clarifying questions on HHS’ expectations for providing members with a five day advance notice due to member fraud. - HSAG recommends that the PAHP expand on the procedures for implementation and incorporate any guidance received by HHS, if applicable.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Incorporate the requirements of this element in its <i>UM08-INS-Authorization Review</i> policy. - Incorporate the requirements of this element and procedures for implementation of staff training materials.		

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Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	- SVII_25-26_UM08-INS-IA-Authorization Review <Pg. 6-7> - SVII_25-26_Staff Training Termination Process<Entire Document>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/08/2026		
HSAG Feedback: The PAHP's remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
27. The PAHP mails the ABD notice for denial of payment at the time of any action affecting the claim. 42 CFR §438.210(c) 42 CFR §438.404(c)(2) 42 CFR §457.1230(d) Contract H.3.04	HSAG Required Evidence: - Policies and procedures - Workflow/guidelines for payment denial on a claim to trigger ABD notice - UM program description - ABD notice template for denial of payment - Tracking and reporting mechanism(s) (e.g., screenshots of UM system, mock report template to monitor timeliness) - Staff training materials - One mock ABD notice to a member for the denial of payment on a claim, including screenshots of the date of receipt of the claim and the date of the action on the claim (using test data) - HSAG will also use the results of the system demonstration	☐ Met ☒ Not Met
Evidence as Submitted by the PAHP:		

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	- SVII_UM Program Description < page 7, Prepayment review> - SVII_IA Medicaid NABD letter template <Full Document> - SVII_CORR-02 INS Claim letter templates <Pg 1 Procedure A. Denial Notification b. i.>	
PAHP Description of Process: PAHP systems are currently being configured and developed. Mock reporting is not available yet. Staff Training materials are currently under development. They will be submitted by May 1, 2026.		
HSAG Findings: - The <i>CORR-02 INS Claim letter templates</i> policy indicated that the PAHP can send claim denial letters for all denials or for a subset of denial categories and that the PAHP will work with the “plan” to define the situations in which claim denial letters will be sent. As the PAHP is the “plan,” this latter statement is unclear. HSAG questioned if the PAHP is sending ABD notices for all denial categories or a subset of denial categories and how the PAHP defined the situations in which ABD notices for claim payment denials will be sent. PAHP staff members explained that when an “N” status is applied to a record, it triggers the generation of an ABD notice. However, PAHP staff members later clarified that the “N” status only applies to PAs. However, this element solely applies to ABD notices sent to members due to the denial of payment on a claim (i.e., post-service claim for payment and not a pre-service PA request). HSAG requested that the PAHP submit documentation demonstrating how it determines when an ABD notice is sent to a member (or not) when the PAHP denies a post-service request for payment (i.e., claim). - After the review, the PAHP submitted an <i>IA Medicaid PA denial that needed ext</i> notice. However, based on the title of the document (i.e., “PA denial”), this notice does not apply to the requirement (i.e., claim payment denial post-service). As such, HSAG could not determine the PAHP’s intent for submitting the <i>IA Medicaid PA denial that needed ext</i> notice as evidence. Further, as the title of the notice implied it was related to an “extension” (i.e., “ext”), HSAG struggled to understand the applicability of the notice. Recommendations: The PAHP’s policy allows 30 calendar days and the option for a 14-calendar-day extension for a PPR (i.e., post-service review of claim for payment). As 42 CFR §438.210 includes no specific time frames for PPRs, HSAG recommends that the PAHP consult with HHS to verify if its process meets HHS’ expectations.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Provide evidence of its business rules that trigger or do not trigger the generation of an ABD notice for claim payment denials. This must address any claim payment denials if the payment for services was denied through PPR (e.g., Dental Consultant review) or without manual review, and “clean” claims versus claims that do not meet the definition of a “clean” claim.		

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Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	In our CORR-02 INS Claim Letter Templates, Section A Denial Notification, it does state that we will work with the plan to determine which situations in which claim denial letters will be sent. In this instance, the “plan” is our client. This is because some clients, specifically those where there is no member liability, do not want members to receive claim letters as this could cause confusion for the members. The policy then goes on to describe the member notification letter and its contents. Appeal and grievance rights are included. Providers always receive claim determination letters, no matter the claim outcome. - SVII_27_Denial - IA Medicaid NABD letter<Entire Document> - SVII_27_Partial Denial - IA Medicaid NABD letter<Entire Document> - SVII_27_CORR-02 INS Claim letter templates<Pg. 5>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/08/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area with the expectations that <u>the PAHP will address HSAG’s recommendations:</u> - HSAG requested that the PAHP provide evidence of its business rules that trigger or do not trigger the generation of an ABD notice for claim payment denials. However, instead of business rules, the PAHP resubmitted the <i>CORR-02 INS Claim letter templates</i> policy which indicated that the PAHP will send notification for “all claim denials” (as opposed to a subset of claims). However, the federal Medicaid managed care rule specifies that ABD notices must be sent to members for “[t]he denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a “clean claim” at § 447.45(b) of this chapter is not an adverse benefit determination.” Therefore, the PAHP must review its process and verify if it is sending ABD notices to members for which the claim does not meet the definition of a “clean claim” and an ABD notice is not required. For example, if a provider does not submit a clean claim and it is rejected, an ABD notice would not be required to be sent to the member. Rather, the PAHP should be requesting that the provider resubmit a clean claim. If payment is denied on receipt of the clean claim, an ABD notice must then be sent to a member. - The PAHP’s statement, “In this instance, the ‘plan’ is our client. This is because some clients, specifically those where there is no member liability, do not want members to receive claim letters as this could cause confusion for the members,” is not compliant with the federal Medicaid managed care rule. For clarity, HSAG is providing an excerpt from the federal register: “We decline to adopt the commenters' suggestion to exempt all claims that do not result in enrollee liability from the definition of adverse benefit determination. While this may seem a minor expansion of the types of claims our revision		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted

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<i>targets, it actually would, in some states, increase the number of eliminated notices exponentially. These notices are an important beneficiary protection as they may be the only notification an enrollee receives alerting them that a claim has been submitted on their behalf. If the enrollee then begins to receive bills from the provider, they are already aware of the situation and have the information needed to appeal or obtain information from the managed care plan about their cost sharing rights and responsibilities. Further, the provision of these notices when there is a denial of coverage (or payment), is consistent with the principle that enrollees are entitled to be active participants in their health care; without full understanding of what is covered, enrollees are not able to make knowledgeable decisions about their health care coverage and their use of health care.”</i> The PAHP is required to send ABD notices to members for clean claim payment denials regardless of member liability. Therefore, if the PAHP does not follow this expectation, it is noncompliant with the federal Medicaid managed care rule in other markets. As such, HSAG recommends that the PAHP implement systemic changes across all Medicaid lines of business to comply with this rule.		
28. For standard and expedited service authorization decisions not reached within the required timeframes specified in 42 CFR §438.210(d) (which constitutes a denial and is thus an ABD), the PAHP provides notice on the date that the timeframes expire. 42 CFR §438.210(c-d) 42 CFR §438.404(c)(5) 42 CFR §457.1230(d) Contract H.3.12–H.3.13	HSAG Required Evidence: • Policies and procedures • UM program description • ABD notice template for untimely determination • Tracking and reporting mechanism(s) (i.e., screenshots of UM system, mock report template to monitor timeliness) • Tracking and reporting mechanism(s) (e.g., to track ABD notices sent for untimely decisions versus denials for medical necessity) • Staff training materials • One mock case example of an untimely authorization decision, including the date of receipt of the authorization request and ABD notice • HSAG will also use the results of the system demonstration	☐ Met ☒ Not Met

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Requirement	Supporting Documentation	Score
	Evidence as Submitted by the PAHP: - SVII_UM08-INS-Authorization Review <page10-11, Exhibit AY - Iowa> - SVII_UM Program Description <page 7, Prior Authorization Review> - SVII IA Medicaid NABD letter template <Full document>	
PAHP Description of Process: PAHP systems are currently being configured and developed. Mock reporting is not available yet. Staff Training Materials are currently under development. They will be submitted by May 1, 2026.		
HSAG Findings: HSAG’s review identified the findings below: - HSAG was unable to locate the requirements of this element based on the PAHP’s citations in the <i>UM08-INS-Authorization</i> policy and <i>UM Program Description</i>. During the interview session, HSAG requested clarification as to how the PAHP documents and tracks denials for untimeliness versus denials based on medical necessity. Discussion with PAHP staff members suggested that it was documented and tracked based on the denial code and denial code explanation. HSAG requested the denial code and denial code explanation for untimely decisions and the associated ABD notice. - After the review, the PAHP submitted four notice templates (i.e., <i>IA Medicaid standard PA denial</i>, <i>IA Medicaid preservice pend</i>, <i>IA Medicaid PA denial that needed ext</i>, and <i>IA Medicaid expedited PA denial</i>), none of which applied to an untimely service authorization. - The denial code and denial explanation referenced by the PAHP in the interview session were not provided after the review. The culmination of these findings is concerning and confirms that the PAHP does not have effective procedures in place for processing untimely service authorizations and that PAHP staff members do not understand the requirement. As a reminder, if the PAHP fails to render the service authorization decision timely (i.e., within seven calendar days or 72 hours [with a possible extension, when applicable]), the service request is considered a denial, and the PAHP is required to send an ABD notice on the date that the authorization review expired.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Incorporate the requirements of this element in its <i>UM08-INS-Authorization Review</i> policy. - Submit system screenshots or other evidence demonstrating a process to track service authorization denials due to the PAHP’s failure to make a decision timely. - Provide a mock ABD notice for the PAHP’s failure to make a decision timely. - Incorporate the requirements of this element and procedures for implementation in staff training materials.		

Operational Readiness Review Standards Remediation Plan		
Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	- SVII_28_UM08-INS-IA-Authorization Review <Pg. 3> - SVII_28_Mocked Up IA Medicaid Untimely Coverage Decision<Entire Document> - SVII_28_Untimely Determination- Staff Training Material<Entire Document>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/09/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are not sufficient to demonstrate readiness with the requirements for this program area. The <i>Mocked Up IA Medicaid Untimely Coverage Decision</i> notice template informed members that the PAHP did not make a decision timely. However, it only informed members that “[s]ince we were late, we have to send you this notice” and did not inform the member because of the PAHP’s failure to render a decision timely, the service is considered denied. Therefore, the PAHP must submit a plan of correction, including all steps that will be taken, to remediate the continued deficiency, and the PAHP will also be required to meet with HSAG to ensure future compliance with the program area.		☐ Accepted ☐ Accepted With Recommendations ☒ Not Accepted
Updated Remediation to Address CAP Not Accepted:		
Updated Plan to Remedy Deficiency (Include a narrative with all actions that will be taken to remediate deficiency):	DentaQuest has updated the IA Medicaid Untimely Coverage Decision notice to indicate the services are denied, and subject to the appeal process, since the decision was not made within the required timeframe	
Responsible Individual(s):	[redacted]	
Timeline/Completion Date:	5/22/2026	
Evidence as Submitted by the PAHP to Address Deficiency:	SVII_28_Mocked Up IA Medicaid Untimely Coverage Decision<page 2>	
HSAG Feedback on Updated Remediation: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. However, regarding the statement, “Our plan made this decision because we did not make the decision within the time frame your plan requires,” HSAG recommends that the PAHP remove “your plan requires” and instead indicate “within the time frame required.”		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
Transition of Care		
32. During the first two years of the contract, the PAHP honors all existing authorizations for covered benefits for a minimum of 90 days, without regard to whether such services are being provided by contract or non-contract providers, when a member transitions to the PAHP from another source of coverage. a. The PAHP honors existing exceptions to policy granted by the Director for the scope and duration designated. b. At all other times, the PAHP honors all existing authorizations for a minimum of 30 days when a member transitions to the PAHP from another source of coverage, without regard to whether services are being provided by contract or non-contract providers. c. When a member transitions to another program contractor, the PAHP provides the receiving entity with information on any current service authorizations, utilization data and other applicable clinical information such as disease management or care coordination notes. Contract F.16.09 Contract G.2.36	HSAG Required Evidence: • Policies and procedures • Transition of care claim edits • Transition of care program, including a process to obtain historical data (PAs, exceptions to policy [ETP], claims) from relinquishing PAHP • Process to use historical data for transitions of care (e.g., add PAs and ETP to system) • Staff training materials Evidence as Submitted by the PAHP: • SVII_UM17-INS-GOV-Continuation of Care <page 1 Policy and Procedure> • SVII_UM17-INS-GOV-Continuation of Care <page 4, Exhibit M –Iowa>	☐ Met ☒ Not Met
PAHP Description of Process: Staff Training materials are currently in development. They will be submitted by May 1, 2026.		
HSAG Findings: HSAG’s review identified the findings below: • During the interview session, PAHP staff members confirmed that a file with existing PAs and claims history will be provided by HHS. PAHP staff members further explained that PAs will be integrated into the PAHP’s system to ensure member access and provider payment for services and that claims history will be made available to staff. After the review, the PAHP provided the following statement: “The detail file is scheduled to be received between 4/1 and 4/23. Authorizations were scheduled for 2/9-3/9 but this has not been received.” • HSAG requested clarification as to whether the transition of care file from HHS also includes approved exceptions to policy. No additional information was provided by the PAHP after the review.		

Operational Readiness Review Standards Remediation Plan		
Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
- The PAHP originally submitted a 2024 version of the member handbook, which included the statement, “Before 90 days, your provider must check with us to keep giving your services to you. If your provider is not in our plan, we will help you find a new provider that is in our plan, schedule an appointment, and move your health records to the new provider.” This statement contradicts the contract requirement to honor all existing authorizations for covered benefits for a minimum of 90 days, without regard to whether such services are being provided by contracted or non-contracted providers. HSAG reviewed the revised member handbooks after the review and noted that this language was no longer included. However, it is unknown how the PAHP is informing members of the transition of care requirements, which is critical information for a member to know. - After the review, HSAG could not locate documentation that the <i>ORM</i> specifically informed providers of the 90-day transition of care time frame requirements for the Iowa Medicaid managed care program, which is critical information for a provider to know.		
Required Actions: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. - Confirmation that the transition of care file(s) has been received from HHS and integrated into the PAHP’s system. - Evidence for how the PAHP is informing members of the transition of care requirements (e.g., member handbook). - Evidence for how the PAHP is informing providers of the 90-day transition of care period (e.g., <i>ORM</i>).		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	To date, DentaQuest has not received a transition of care file. - SVII_DQ3197 IA_Medicaid Adult (7.26) HBEN P. <Pg. 18-19> - SVII_DQ4080 IA_Medicaid Child (7.26) HBEN P. <Pg. 6-8> - SVII_DQ3198 IA_Medicaid Hawki (7.26) HBEN P. <Pg. 5-7> - Provider Reference Manual <Pg. 56>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/11/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. However, as the PAHP has yet to receive a transition of care file from HHS, HSAG recommends that the PAHP continue to collaborate with HHS to obtain the file and integrate the data from file, including PAs and claims, into its system.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
Public Reporting Prior Authorization Metrics		
33. The PAHP makes the following data (excluding covered drugs) from the previous calendar year publicly accessible by posting them on its website: - A list of all items and services that require PA. - The percentage of standard PA requests that were approved, aggregated for all items and services. - The percentage of standard PA requests that were denied, aggregated for all items and services. - The percentage of standard PA requests that were approved after appeal, aggregated for all items and services. - The percentage of PA requests for which the timeframe for review was extended, and the request was approved, aggregated for all items and services. - The percentage of expedited PA requests that were approved, aggregated for all items and services. - The percentage of expedited PA requests that were denied, aggregated for all items and services. - The average and median time that elapsed between the submission of a request and a determination by the PAHP, for standard PA, aggregated for all items and services. - The average and median time that elapsed between the submission of a request and a decision by the PAHP, for expedited PAs, aggregated for all items and services. 42 CFR §438.210(f) 42 CFR §457.1230(d)	HSAG Required Evidence: - Policies and procedures - List of all services requiring a PA - Plan to publicly report list of services requiring a PA - Screenshot of website with list of services requiring a PA - Plan to publicly report PA metrics Evidence as Submitted by the PAHP: - SVII_Provider Reference Manual <pages 69-135 Exhibit A Benefits grid (see column labeled “Prior Authorization Required”)>	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
PAHP Description of Process: The provider portal and member websites are still in development phases. Furthermore, Iowa is a new plan and has no data to aggregate for PAs at this time. This process will be developed. DentaQuest is currently reviewing HHS feedback on our ORM. Some updates are pending DentaQuest Legal and Compliance review before changes can be made.		
HSAG Findings: While the PAHP’s <i>ORM</i> included PA and PPR requirements for each dental code, it does not meet the intent of the requirements of this element. No documentation was provided to support the PAHP’s awareness that a list of all items and services that require PA are required to be posted on the PAHP’s website. If the PAHP intends to use its <i>ORM</i> as the mechanism to report this information, the PAHP must have a readily accessible webpage for members and stakeholders to know where to locate this information.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: • Provide clarification on the format for how the PAHP will post a list of all items and services that require PA on its website. • Provide a link to the landing page(s) for where the list of all items and services that require a PA will be posted. • Submit documentation supporting awareness of the public reporting of PA metrics (i.e., sub-elements ([b]–[i])) and a plan to ensure it will be able to accurately report on the PA metrics to publicly post by March 31, 2027.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	• SVII_33, Public Reporting Prior Authorization Metrics<Entire Document> • SVII_33. ADS06-INS-UM and Appeals System Controls<Entire Document>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/07/2026		
HSAG Feedback: The PAHP’s remediation plan is sufficient to demonstrate readiness with the requirements for this program area with the expectation that <u>the PAHP will address HSAG’s recommendations</u>: • While a list of all items and services that require PA for the Iowa Medicaid managed care program has yet to be posted on its website, the PAHP’s plan is to report PA requirements following the same process for how it posts PA requirements for other lines of business. However, the items and services were listed by CDT only. According to the federal register: – “<i>In the CMS Interoperability and Prior Authorization proposed rule we discussed the importance of accountability for payer prior authorization practices and proposed that certain data be made publicly available for patients and providers to better understand the types of items and services which required prior authorization and how each payer</i>		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<i>performed over time for approvals and denials... Public disclosure of the items and services which are subject to prior authorization, as well as organizational performance, offers useful information to providers, patients, and other interested parties.”</i> The above excerpt is clear in that the list of items and services that require a PA is for “patients” (i.e., members) in addition to providers and other stakeholders. The PAHP cannot presume its membership will know what items and services coincide with each CDT. Further, the PAHP is required to provide all member information in accordance with 42 CFR §438.10(c)(1) which requires information for members to be provided in a manner and format that is easily understood. As such, the PAHP must develop a member-centric version of its PA list. HSAG further recommends that the PAHP post the member-centric list on its Iowa Medicaid member website. While the PAHP included an “Interoperability Reports” footer link on the Iowa Medicaid member website, the PAHP cannot presume that members will equate “Interoperability Reports” as meaning a report for PA metrics. As such, when the member-centric version of the PA’s list is posted on the PAHP’s Iowa Medicaid member website, the PAHP must also include an explanation for how members can access the PAHP’s PA reports and provide a link to the location on its website.		

Standard VIII—Provider Selection

Operational Readiness Review Standards Remediation Plan		
Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
General Rules		
1. The PAHP implements written policies and procedures for selection and retention of network providers and those policies and procedures, at a minimum, meet the requirements of 42 CFR §438.214. a. The PAHP develops, implements, and adheres to written policies and procedures related to provider credentialing and recredentialing, which includes standards of conduct that articulate the PAHP's understanding of the requirements and that direct and guide PAHP's and subcontractors' compliance with all applicable federal and State standards related to provider credentialing, including those required in 42 CFR. Parts 438 and 455, Subpart E [provider screening and enrollment], which includes the following: - A training plan designed to educate staff in the credentialing and re-credentialing requirements. - Provisions for monitoring and auditing compliance with credentialing standards. - Provisions for prompt response and corrective action when non-compliance with credentialing standards is detected. - A description of the types of providers that are credentialed. - Methods of verifying credentialing assertions, including any evidence of prior provider sanctions. 42 CFR §438.214(a) 42 CFR §438.214(b)(2)	HSAG Required Evidence: - Policies and procedures - Credentialing training plan, including State or Iowa-specific requirements - Staff training materials - List of delegates performing credentialing functions - Credentialing monitoring and auditing plan for credentialing functions performed by the PAHP and delegates Evidence as Submitted by the PAHP: - SVIII_PEC01-INS-Credentialing Guidelines<Full Document> - SVIII_NET01-INS-Network Development Maintenance and Use<Pages 1-2, Procedure A. Initial Network Development, Element 1-4, - SVIII_NET01-INS-Network Development Maintenance and Use Pages 5-6, Procedure B. Network Retention, Element C. Ongoing Recruitment> - SVIII_PEC04-INS-Provider Maintenance and Ongoing Monitoring <Page 4, Procedure F. Ongoing Monitoring> - SVIII_Credentialing Plan Description<Full Document>	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
42 CFR §438.214(e) 42 CFR §457.1233(a) Contract E.3.02–E.3.03	- SVIII_QA04-INS-Credentialing Quality Audits-FINAL<Full Document> - SVIII_Quality Assurance Credentialing Methodology 2025<Full Document> - SVIII_2023_DentaQuest_NCQA_Certificate - SVIII_Credentials Committee Charter	
PAHP Description of Process: Staffing materials are currently under development. They will be submitted by May 1, 2026.		
HSAG Findings: HSAG’s review identified the findings below: - HSAG requested that the PAHP update its policies and/or Iowa exhibit with the state-specific requirements (i.e., sub-elements [a] and [i]-[v]) of this element; however, HSAG was unable to locate those updates. - While the PAHP submitted its <i>IA State-Specific Training</i> document in follow-up, HSAG was unable to determine if this training plan was used to ensure staff were trained on Iowa-specific requirements when credentialing providers for the Iowa Medicaid managed care program. - The PAHP did not clarify its provisions for prompt response and corrective action, or provide sufficient evidence to address noncompliance with credentialing standards when detected. Recommendations: While not specific to this element but the entire standard, HSAG recommends that the PAHP proceed with its plan to update and finalize its <i>ORM</i> and ensure it provides sufficient information to providers and reflects the requirements of this standard. Further, the PAHP must ensure its <i>ORM</i> reflects all appropriate content for the Iowa Medicaid managed care program. Finally, although additional findings were documented in Standard II—Member Rights and Member Information related to the provider directory, HSAG strongly recommends that the PAHP ensure it has a sufficient process and is following up with providers as necessary to obtain information regarding specific accessibility accommodations (e.g., equipment such as accessible exam chairs) so that the provider directory can be updated appropriately.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Include the state-specific requirements (i.e., sub-elements [a] and [i]-[v]) within its policies and procedures. - Provide an updated training plan that includes completed and expected completion training dates for Iowa-specific requirements. - Develop and submit policies and procedures for promptly responding to and requiring corrective action when noncompliance with credentialing standards is detected.		
Plan to Remedy Deficiency: (Include all actions)	- SVIII_1,17_PEC01-INS-Credentialing Guidelines_IA <Pg. 15 Exhibit FF, last bullet> - SVIII_1_2026.05.07-Iowa General Provider Training<Entire Document>	

Operational Readiness Review Standards Remediation Plan		
Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
that will be taken to remediate deficiency.)		
Individual(s) Responsible: [redacted]		
Completion Date: 05/11/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. While the PAHP updated its <i>PEC01-INS-Credentialing Guidelines IA</i> and its <i>Iowa General Provider Training</i> , HSAG requested an updated training plan specifically for PAHP staff members that included Iowa-specific credentialing requirements. HSAG strongly recommends that the PAHP ensure its credentialing training plan and training materials for PAHP staff members are aligned with Iowa-specific credentialing requirements.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted
Practitioner Monitoring		
17. <i>The PAHP develops and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints, and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identifies occurrences of poor quality. The PAHP implements ongoing monitoring by:</i> <i>Collecting and reviewing Medicare and Medicaid sanctions and exclusions.</i> <i>Collecting and reviewing sanctions, and limitations and expiration on licensure.</i> <i>Collecting and reviewing complaints.</i> <i>The PAHP investigates all practitioner-specific member complaints upon their receipt and evaluates the practitioner’s history of complaints if applicable.</i>	HSAG Required Evidence: - Policies and procedures - Practitioner monitoring plan Evidence as Submitted by the PAHP: - SVIII_PEC01 INS <page 7, Credentialing Guidelines 4. Ongoing Monitoring c.i>	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
ii. <i>The PAHP evaluates the history of all complaints for all practitioners at least every six months.</i> d. <i>Collecting and reviewing information from identified adverse events at least monthly.</i> 42 CFR §438.214(e) Contract G.7.03		
PAHP Description of Process: HSAG Findings: While the PAHP submitted its <i>CGA04-INS Monitoring of Complaints</i> policy after the review, the policy did not clearly indicate how often adverse events are collected and reviewed (i.e., at least monthly). Recommendations: HSAG strongly recommends that the PAHP align ongoing monitoring language across three policies shared, including <i>PEC01-INS Credentialing Guidelines</i> , <i>CGA04-INS Monitoring of Complaints</i> , and <i>PEC04-INS Provider Directory Maintenance and Ongoing Monitoring</i> , as it is unclear at what point a complaint is referred to the PAHP’s Peer Review Committee. Both policies <i>PEC01-INS Credentialing Guidelines</i> and <i>PEC04-INS Provider Directory Maintenance and Ongoing Monitoring</i> indicate that “[a]ny complaint identified as involving Quality of Care [QOC] is referred to the Company’s Peer Review Committee for evaluation.” In contrast, the <i>CGA04-INS Monitoring of Complaints</i> policy indicates that “Minor Complaints are tracked as they are resolved until Complaints total three (3) or more in a month to include a six (6) month look back period. At that point, a Clinical Quality Committee Member reviews the Provider file and a recommendation is made to the Clinical Quality Committee and a copy of the committee minutes are sent to the credentialing committee for review and recommendations.” Additionally, the policy does not clearly define a minor QOC complaint versus a significant QOC complaint.		
Required Actions: In order to receive a <i>Met</i> score, the PAHP must: Update policies and procedures to include that identified adverse events are collected and reviewed at least monthly.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	- SVIII_1,17_PEC01-INS-Credentialing Guidelines_IA <Pg 16 Exhibit FF, First Bullet> - SVIII_17_CGA04-INS-Monitoring complaints<Pg. 2> - SVIII_17, 19_PEC04-INS-Provider Directory Maintenance and Ongoing Monitoring <Pg 4 F 5; Pg 5 Forms and other related documents>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/09/2026		



Operational Readiness Review Standards Remediation Plan		
Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard X—Grievance and Appeal Systems

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
Grievance System General Requirements		
1. The PAHP defines a grievance as an expression of dissatisfaction about any matter other than an ABD. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the PAHP to make an authorization decision. 42 CFR §438.228 42 CFR §438.400(b) 42 CFR §457.1260(a)(2)(ii) Contract Exhibit B: Glossary of Terms/Definitions	HSAG Required Evidence: • Policies and procedures • Member materials, such as the member handbook • Staff training materials Evidence as Submitted by the PAHP: • Policies and procedures ○ SX_CGA06-INS-Member Complaints and Grievances <Pg 2 Definitions> • Member materials, such as the member handbook ○ SX_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft_2.27.26 <pgs. 17-20> ○ SX_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 <pgs. 13, 21, 22> • Staff training materials ○ SX_2026 CG Training Syllabus ○ SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA	☐ Met ☒ Not Met
PAHP Description of Process:		
HSAG Findings: HSAG’s review identified the findings below: • The <i>CGA06-INS-Member Complaints and Grievances</i> policy defined a grievance as “an expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD)” and indicated that grievances may also be referred to as “complaints.” However, the <i>IA Provider ORM Draft Review v2 3.25.26</i> defined a grievance as “an expression of dissatisfaction about any matter other than an action” but identified complaints as “any oral or written expression of dissatisfaction by an enrollee submitted to DentaQuest or to a state agency and resolved by close of business the following day.” Additionally, the <i>CGA06-INS-Member Complaints and Grievances</i> policy indicated that an inquiry is “a written or verbal question or request for		

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
information posed to DentaQuest with regard to such issues as benefits, contracts, and organization rules,” whereas the <i>ORM</i> defined an inquiry as “the first contact with DentaQuest (verbal or written) expressing dissatisfaction from the Member or provider on behalf of the member, an attorney on behalf of a Member, a government agency or an authorized representative acting on behalf of the Enrolled Member and with the Enrolled Member’s written consent.” • The <i>ORM</i> also indicated that complaints must be resolved by close of business the day following receipt or be moved into the grievance system. Additionally, during the review, PAHP staff members explained that if a member expresses dissatisfaction, but the member services representative can resolve the issue during the call, the grievance will not be tracked. PAHP staff members also indicated that the member services representative will ask the member if they want to file a grievance. In follow-up documentation, the PAHP provided the <i>IA Medicaid Appeals Grievances Delegated CRD Process Draft</i>, which outlined the process to only track grievances that could not be resolved during the first call. The <i>CGA06-INS-Member Complaints and Grievances</i> policy also indicated that if a grievance is not resolved during the first call, it is handled by a Complaint and Grievance Specialist (C&G Specialist). However, all expressions of dissatisfaction must be tracked, investigated, and resolved as grievances through the grievance process, regardless of whether the member wants to “file” a grievance or when the issue is resolved. Additionally, the <i>ORM</i> was in draft form. • While the three versions of the member handbooks (i.e., DWP Adult, DWP Kids, and Hawki) included an appropriate definition of grievances, the definition must also specifically indicate that a dispute of an extension of time proposed by the PAHP to make an authorization decision qualifies as a grievance. Additionally, the member handbooks were in draft form.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: • Update the definitions of inquiries, complaints, and grievances to ensure consistency across PAHP documents (i.e., policies and procedures, member handbooks, <i>ORM</i>, and staff training documents) and submit final versions of the member handbooks and <i>ORM</i> with HHS’ approval. • Revise processes to track, investigate, and resolve all expressions of dissatisfaction as grievances and provide updated process and staff training documents to HSAG.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	• SX_DQ3197 IA_Medicaid Adult (7.26) HBEN<Pg. 33-35> • SX_DQ4080 IA_Medicaid Child (7.26) HBEN<Pg. 34-36> • SX_DQ4081 IA_Medicaid Hawki (7.26) HBEN <Pg. 34-36> • Provider Reference Manual <Pg. 72-77> • SX_1_PEC04-INS-Provider Directory Maintenance and Ongoing Monitoring<Pg. 3-4> SX_1. CS05-INS-SOP-CS Call Handling-Incoming Complaints, Grievances, & Appeals<Entire Document>	
Individual(s) Responsible: [redacted]		

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
Completion Date: 05/11/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are not sufficient to demonstrate readiness with the requirements for this program area. While the PAHP submitted updated versions of the three member handbooks (i.e., DWP Adult, DWP Kids, and Hawki), the <i>CGA06-INS-Member Complaints and Grievances</i> policy, and the <i>Provider Reference Manual</i>, the definitions of inquiries, complaints, and grievances were still inconsistent, and it appears there is confusion regarding an inquiry versus a complaint/grievance and the requirements for tracking all expressions of dissatisfaction as grievances, regardless of the mode of reporting to the PAHP or the time frame for resolution. Therefore, the PAHP must submit a plan of correction, including all steps that will be taken, to remediate the continued deficiency, and the PAHP will also be required to meet with HSAG to ensure future compliance with the program area. These findings must be addressed: - The <i>CGA06-INS-Member Complaints and Grievances</i> policy defined a grievance as “an expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD)” and indicated that grievances may also be referred to as “complaints.” However, the <i>Provider Reference Manual</i> defined a grievance as “an expression of dissatisfaction about any matter other than an Adverse Benefit Determination” but identified complaints as “any oral or written expression of dissatisfaction by an enrollee submitted to DentaQuest or to a state agency and resolved by close of business the following day.” Additionally, the <i>CGA06-INS-Member Complaints and Grievances</i> policy indicated that an inquiry is “a written or verbal question or request for information posed to DentaQuest with regard to such issues as benefits, contracts, and organization rules,” whereas the <i>Provider Reference Manual</i> defined an inquiry as “the first contact with DentaQuest (verbal or written) expressing dissatisfaction from the Member or provider on behalf of the member, an attorney on behalf of a Member, a government agency or an authorized representative acting on behalf of the Enrolled Member and with the Enrolled Member’s written consent.” - The <i>Provider Reference Manual</i> also indicated that “[a] complaint is an informal component of the grievance system. A complaint is the lowest level of challenge and provides DentaQuest an opportunity to resolve a problem without it becoming a formal grievance. All expressions of dissatisfaction are tracked, investigated and resolved. Complaints must be resolved by close of business the day following receipt or be moved into the grievance system.” Additionally, the <i>CS05-INS-SOP-Call Handling-Incoming Complaints, Grievances & Appeals</i> document described the process for customer service representatives (CSRs) to follow when documenting “incoming inquiries, complaints/verbal grievances/1st contact complaint/grievances, and grievances,” which are different processes depending upon how the CSR designates the type of call. However, all expressions of dissatisfaction must be tracked, investigated, and resolved as grievances through the grievance process, regardless of whether the member wants to “file” a grievance or the amount of time it takes to resolve the issue.		☐ Accepted ☐ Accepted With Recommendations ☒ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
While the member handbooks included an appropriate definition of grievances, the definition must also specifically indicate that a dispute of an extension of time proposed by the PAHP to make an authorization decision qualifies as a grievance.		
Updated Remediation to Address CAP Not Accepted:		
Updated Plan to Remedy Deficiency (Include a narrative with all actions that will be taken to remediate deficiency):	DentaQuest has updated the grievance process. For grievances received verbally, the customer service representatives will send any dissatisfaction to the CG team to work through the grievance process. A letter will be generated to notify members of the resolution.	
Responsible Individual(s):	[redacted], [redacted]	
Timeline/Completion Date:	5/26/2026	
Evidence as Submitted by the PAHP to Address Deficiency:	- SX_1 CGA06-INS-Member Complaints and Grievances <pgs 8,9> - SX_1 CS05-INS-SOP-CS Call Handling-Incoming Complaints, Grievances, & Appeals - IA<pgs 1,2> - SX_1 IA Medicaid grievance resolution letter template <entire document> - SX_1_IA Provider Reference Manual_05.26.2026 <Pgs 72-77>	
HSAG Feedback on Updated Remediation: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. The <i>CS05–INS–SOP–Call Handling–Incoming Complaints, Grievances & Appeals</i> document, <i>CGA06-INS-Member Complaints and Grievances</i> policy, and <i>Provider Reference Manual</i> were updated appropriately to include correct reporting of expressions of dissatisfaction as grievances. However, the definition of grievances in the member handbooks still did not include the dispute of an extension of time proposed by the PAHP to make an authorization decision. To ensure future compliance with this element, HSAG recommends that the PAHP update its member handbooks to include the definition of grievances consistent with this element.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
Handling of Grievances		
5. The PAHP ensures that the individuals who make decisions on grievances are individuals: a. Who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual. b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease: i. A grievance regarding denial of expedited resolution of an appeal. ii. A grievance that involves clinical issues. c. Who take into account all comments, documents, records, and other information submitted by the member or their representative. 42 CFR §438.228 42 CFR §438.406(b)(2) 42 CFR §457.1260(d) Contract H.1.07 Contract H.1.08(b-c) Contract H.1.09	HSAG Required Evidence: • Policies and procedures • Organizational chart of grievance staff members, including credentials • Staff training materials • System screenshot of the field where the decision-maker (name and credentials) on grievances is documented • System screenshot of the field where the results of the review are documented • HSAG will also use the results of the system demonstration (i.e., mock case examples of a standard and expedited grievance) Evidence as Submitted by the PAHP: • Policies and procedures ○ SX_CGA06-INS-Member Complaints and Grievances <Pg 3 Procedure C, 5 a > • Organizational chart of grievance staff members, including credentials ○ SX_RRQ_Attachment 16_Grievances Org Chart ○ SX_RRQ_Attachment 17_Appeals Org Chart • Staff training materials ○ SX_2026 CG Training Syllabus ○ SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
	- System screenshot of the field where the decision-maker (name and credentials) on grievances is documented - SX_Decision Maker System Screenshots - System screenshot of the field where the results of the review are documented - SX_Resolution Date_Time and Letters Sent Date_Time	
PAHP Description of Process: N/A		
HSAG Findings: The PAHP’s policies and procedures and staff training documents did not indicate that individuals who make decisions on grievances are individuals who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual. Recommendations: Neither the <i>hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA</i> nor the <i>IA Medicaid Appeals Grievances Delegated CRD Process Draft</i> training documents explained how PAHP staff members will know who should resolve non-clinical grievances. The training documents also did not explain how staff members will take into account all comments, documents, records, and other information submitted by the member or their representative. HSAG recommends that the PAHP enhance its Iowa-specific training documents to ensure staff members have a strong understanding of not only the Iowa Medicaid requirements, but also how to track, investigate, and sufficiently resolve grievances.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Update and provide documentation to support that individuals who make decisions on grievances are individuals who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual. - Provide updated Iowa-specific staff training documents that detail how staff members will track, investigate, and sufficiently resolve grievances.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	- SX_5_Complaints_Investigation<Entire Video> - SX_5,26_CGA - Investigation_Extensions<Entire Document> - SX_5_6_8_9_CGA06-INS-Member Complaints and Grievances-Primary Delegation_IA<Pg. 5>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/09/2026		

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. The PAHP submitted the <i>CGA06-INS-Member Complaints and Grievances</i> policy, which met the requirements of this element. The PAHP also submitted the <i>Complaints_ Investigation</i> training video, which included most of the requirements of this element; however, HSAG recommends that the PAHP include in its training video or other training documentation how the PAHP staff member determines appropriate staff members for resolving grievances (e.g., clinical staff for clinical-related grievances).		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted
Timely Resolution and Notification of Grievances		
6. The PAHP resolves each grievance, and provides <i>written</i> notice, as expeditiously as the member’s health condition requires, within HHS-established timeframes that do not exceed the timeframes specified in 42 CFR §438.408. a. The PAHP resolves the grievance and sends notice to the affected parties within <i>30 calendar days</i> from the day the PAHP receives the grievance. b. <i>The PAHP resolves 100 percent of grievances within 30 days of receipt, or within 72 hours of receipt for expedited grievances.</i> 42 CFR §438.228 42 CFR §438.408(a) 42 CFR §438.408(b)(1) 42 CFR §457.1260(e)(12) Contract H.10.04 Contract H.10.07 Contract H.11.04	HSAG Required Evidence: • Policies and procedures • Grievance resolution notice template • Tracking and reporting mechanisms for timely grievance resolution (e.g., system tracking capabilities, mock timeliness report) • Staff training materials • System screenshot of the field where the date of receipt of the grievance is documented • System screenshot of the field where the date of written resolution and the resolution notice notes are documented • HSAG will also use the results of the system demonstration (i.e., mock case examples of a standard grievance) Evidence as Submitted by the PAHP: • Policies and procedures ◦ SX_CGA06-INS-Member Complaints and Grievances <Pg 5 Procedure D 1a-b> • Grievance resolution notice template -N/A	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
	- Tracking and reporting mechanisms for timely grievance resolution (e.g., system tracking capabilities, mock timeliness report) - SX_CGA05-INS-SOP-Monitoring Resolution Timeframes-No Exhibits 1.pdf - Staff training materials - SX_2026 CG Training Syllabus - SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA - System screenshot of the field where the date of receipt of the grievance is documented - SX_Member Grievance-Appeal Screenshot - System screenshot of the field where the date of written resolution and the resolution notice notes are documented - SX_Resolution Date_Time and Letters Sent Date Time	
PAHP Description of Process: The correspondence for Grievances and Appeals is currently in development. Drafts will be sent as soon as they are available.		
HSAG Findings: HSAG’s review identified the findings below: - During the system demonstration, staff members confirmed that the date and time documented in the Salesforce system for when a resolution notice is sent to the member is the date and time the staff member generated the notice rather than when the notice is actually sent to the member. HSAG asked staff members when a resolution notice would be sent in the mail, and PAHP staff members indicated that once the letter is generated in Salesforce, it will route to the mail room for printing and mailing. The mail room staff member will print the letter and prepare it for pickup. However, mail will be picked up at 10:00 a.m. and 2:00 p.m. seven days a week except on holidays. Therefore, if the letter is sent to the mail room after 2:00 p.m., the letter would be sent the next day, which could impact the time frame. - During the review, PAHP staff members indicated that the PAHP does not have a process to track time frames based on the mail date and will be developing that process. HSAG requested documentation that described the process of when mail is picked up and mailed the PAHP; however, this		

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
documentation was not provided after the review. Instead, the PAHP submitted the <i>INT-01-INS-GOV Inbound Mail–Government</i> policy and procedure, which outlined when incoming mail would be picked up and brought to the PAHP, but not when outgoing mail would be processed and mailed. Recommendations: The <i>CGA06-INS-Member Complaints and Grievances</i> policy indicated that grievances in which a delay would significantly increase risk to the member’s health will be resolved within one business day; however, the requirement is that these expedited grievances be resolved within 72 hours. Although the PAHP’s training documents included the correct time frame of 72 hours, HSAG recommends that the PAHP update its <i>CGA06-INS-Member Complaints and Grievances</i> policy to indicate expedited grievances will be resolved in 72 hours. One business day could be longer than 72 hours in the event that a holiday occurs consecutively with a weekend.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Implement a mechanism to use the date and time the PAHP received the grievance and the date and time the resolution notice entered the mailing stream (i.e., not the date and time the notice was sent to print and fulfillment) to calculate the TAT.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	SX_5_6_8_9_CGA06-INS-Member Complaints and Grievances-Primary Delegation_IA<Pg. 4>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/09/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. The PAHP updated its <i>CGA06-INS-Member Complaints and Grievances</i> policy to reflect the correct time frame of 72 hours for expedited grievance resolution. However, the required action was to implement a mechanism to use the date and time the PAHP received the grievance and the date and time the resolution notice entered the mailing stream (i.e., not the date and time the notice was sent to print and fulfillment) to calculate the TAT. The PAHP submitted its updated <i>CGA06-INS-Member Complaints and Grievances</i> policy, which indicated that to ensure communications are sent to members timely, the PAHP “will notate the same day the letter is processed for cases resolved before 2pm CST. For cases with letters processed after 2pm CST, DentaQuest will notate the date the case was resolved as the next business day.” While this option could be a temporary solution, HSAG strongly recommends that the PAHP implement a systematic process to calculate time frames based on the date and time the member notice is sent as this manual process could introduce human error causing time frames to be missed or miscalculated.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
8. If the PAHP extends the grievance resolution timeframe not at the request of the member, it completes all of the following: a. Makes reasonable efforts to give the member prompt oral notice of the delay. b. Within two calendar days gives the member written notice of the reason for the decision to extend the timeframe and informs the member of the right to file a grievance if he or she disagrees with that decision. 42 CFR §438.228 42 CFR §438.408(c)(2) 42 CFR §457.1260(e)(1) Contract H.10.06	HSAG Required Evidence: • Policies and procedures • Member materials, such as the member handbook • Grievance extension template letter • Staff training materials • System screenshot of field where oral notice of the extension is documented • System screenshot of field where written notice of the extension is documented, including the date of the notice • HSAG will also use the results of the system demonstration (i.e., mock grievance case examples) Evidence as Submitted by the PAHP: • Policies and procedures ○ SX_CGA06-INS-Member Complaints and Grievances <Pg 5 Procedure D 3> • Member materials, such as the member handbook ○ SX_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft_2.27.26 ○ SX_DQ4080 IA_Medicaid Child (7.26) HBEN_Draft_2.26.26 • Grievance extension template letter-N/A • Staff training materials ○ SX_2026 CG Training Syllabus ○ SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA • System screenshot of field where oral notice of the extension is documented-N/A	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
	- System screenshot of field where written notice of the extension is documented, including the date of the notice - SX_Grievance Extension Details	
PAHP Description of Process: DentaQuest does not have a field to document an oral notice of the extension. HSAG Findings: HSAG’s review identified the findings below: - The <i>CGA06-INS-Member Complaints and Grievances</i> policy indicated that the PAHP will give the provider prompt oral notice of the delay where the provider has agreed to be responsible for promptly notifying the member or authorized representative of the determination. However, this requirement is the PAHP’s responsibility and it cannot be delegated to the provider without appropriate delegation agreements and oversight in place; although this does not appear to be an appropriate function to delegate to providers. The policy must be updated to indicate that the PAHP staff members will provide the member or authorized representative prompt notification of the delay. - The PAHP submitted the <i>IA Medicaid Appeal Extension letter template</i>, which was specific to appeals and did not include language specific to grievances. Recommendations: HSAG’s review identified the recommendations below: - Neither the <i>hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA</i> nor the <i>IA Medicaid Appeals Grievances Delegated CRD Process Draft</i> training documents explained how PAHP staff members would take an extension, the reasons for the extension, and what process to follow to ensure the member is notified of the extension. HSAG strongly recommends including this information in the staff training documents so staff members understand the appropriate processes to follow for extensions and where to document the information in the information system. - The member handbooks indicated that the PAHP will notify the member by phone and in writing within two days; however, the requirement is that the PAHP <i>promptly</i> notify the member orally and provide notification in writing within two calendar days. HSAG recommends that the PAHP clarify this language in the member handbooks. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Update and submit its revised <i>CGA06-INS-Member Complaints and Grievances</i> policy to indicate that the PAHP staff members (rather than the provider) will provide the member or authorized representative prompt notification when the PAHP extends the grievance resolution time frame. - Develop and submit a grievance extension letter template.		

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	- SX_5_6_8_9_CGA06-INS-Member Complaints and Grievances-Primary Delegation_IA<Pg. 8-9> - SX_8_ IA Medicaid Grievance Extension Letter Template<Entire Document>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/09/2026		
HSAG Feedback: The PAHP's remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. The PAHP submitted its updated <i>CGA06-INS-Member Complaints and Grievances</i> policy with the <i>Exhibit Q-IA Medicaid</i> . While the policy exhibit included the correct information, it indicated that the section is in addition to Section C in the general policy. However, it should be in addition to Section D in the general policy. HSAG recommends that the PAHP correct this language in its <i>Exhibit Q-IA Medicaid</i> .		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted
9. The PAHP directs the following types of grievance requests to HHS: a. Enrolled member eligibility including termination of eligibility. b. Effective dates of coverage. c. Determinations of premium and copayment responsibilities. Contract H.1.03(a-c)	HSAG Required Evidence: - Policies and procedures - Grievance referral template to HHS - Staff training materials Evidence as Submitted by the PAHP: - Policies and procedures - SX_CGA06-INS-Member Complaints and Grievances <Pg 7 Exhibit Q Procedure A 7 a,b,c> - Grievance referral template to HHS-N/A - Staff training materials - SX_2026 CG Training Syllabus - SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA	☐ Met ☒ Not Met
PAHP Description of Process: The Grievance referral process is currently under discussion with HHS.		

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
HSAG Findings: The <i>CGA06-INS-Member Complaints and Grievances</i> policy indicated that the grievance types in this element would be directed to HHS; however, during the review, PAHP staff members explained that the process is still in development with HHS. After the review, the PAHP provided the <i>IA Medicaid Appeals Grievances Delegated CRD Process Draft</i> , which indicated that C&G Specialists would attempt to resolve the issue, but if it could not be resolved, the disenrollment request would be directed to HHS. The document included a placeholder indicating that the PAHP is awaiting feedback from HHS regarding how the disenrollment request would be provided to HHS. However, the disenrollment request from a member is different than Medicaid eligibility and coverage grievances. The document provided did not address how grievances regarding member eligibility, effective dates of coverage, and determinations of premium copayment responsibilities would be handled.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Develop a process to ensure grievances related to enrolled member eligibility, including termination of eligibility, effective dates of coverage, and determinations of premium and copayment responsibilities, are directed to HHS. - Clearly outline the process for handling these types of grievances in process and training documents and submit to HSAG.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	- SX_5_6_8_9_CGA06-INS-Member Complaints and Grievances-Primary Delegation_IA<Pg. 8> - SX_9. Eligibility Training<Entire Document>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/09/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. The PAHP resubmitted its <i>CGA06-INS-Member Complaints and Grievances</i> policy with the <i>Exhibit Q–IA Medicaid</i> , which indicated that the grievance types in this element would be directed to HHS. However, the PAHP also submitted the <i>Eligibility Training</i> document which did not address how grievances regarding member eligibility, effective dates of coverage, and determinations of premium copayment responsibilities would be submitted to HHS. As the PAHP indicated previously that it is collaborating with HHS to identify a process for these types of referrals, HSAG strongly recommends that the training document and any related procedures be updated to include these finalized expectations set forth by HHS.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
Handling of Appeals		
16. If the PAHP denies a request for expedited resolution of an appeal, it: - Transfers the appeal to the timeframe for standard resolution in accordance with 42 CFR §438.408(b)(2). - Follows the requirements in 42 CFR §438.408(c)(2), including: - Makes reasonable efforts to give the member prompt oral notice of the delay. - Within two calendar days, gives the member written notice of the reason for the decision to deny the expedited appeal resolution timeframe and informs the member of the right to file a grievance if the member disagrees with that decision. 42 CFR §438.228 42 CFR §438.408(b)(2) 42 CFR §438.408(c)(2) 42 CFR §438.410(c) 42 CFR §457.1260(f) Contract H.6.11	HSAG Required Evidence: - Policies and procedures - Member materials, such as the member handbook - Denied expedited resolution letter template - Staff training materials - System screenshot of the field where the type of appeal request is documented (i.e., standard versus expedited) - System screenshot of the field where the denial of an expedited appeal resolution time frame is documented - System screenshot of the field where oral and written notice of the denied request for an expedited appeal resolution time frame is documented - HSAG will also use the results of the system demonstration (i.e., mock appeal case examples) Evidence as Submitted by the PAHP: - Policies and procedures - SX_CGA01-INS-MCD-Member Appeals <Pg 4-5 Procedure B, 5d-g; Pg 7 Procedure C 5d (i-vii)> - Member materials, such as the member handbook - SX_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft_2.27.26 - SX_DQ4080 IA_Medicaid Child (7.26) HBEN Draft_2.26.26 - Denied expedited resolution letter template-N/A - Staff training materials	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
	○ SX_2026 CG Training Syllabus ○ SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA • System screenshot of the field where the type of appeal request is documented (i.e., standard versus expedited) ○ SX_Expedited Appeal System Screenshot • System screenshot of the field where the denial of an expedited appeal resolution time frame is documented ○ SX_Expedited Appeal System Screenshot • System screenshot of the field where oral and written notice of the denied request for an expedited appeal resolution time frame is documented ○ SX_Expedited Appeal System Screenshot	
PAHP Description of Process: The correspondence for Grievances and Appeals is currently in development. Drafts will be sent as soon as they are available.		
HSAG Findings: HSAG’s review identified the findings below: • The <i>CGA01-INS-MCD-Member Appeals</i> policy indicated that the PAHP will give the provider prompt oral notice of the delay where the provider has agreed to be responsible for promptly notifying the member or authorized representative of the determination. However, this requirement is the PAHP’s responsibility and it cannot be delegated to the provider without appropriate delegation agreements and oversight in place; although this does not appear to be an appropriate function to delegate to providers. The policy must be updated to indicate that the PAHP staff members will provide the member or authorized representative prompt notification of the delay. • The <i>CGA01-INS-MCD-Member Appeals</i> policy did not indicate that the written notice to the member will also include the member’s right to file a grievance if the member disagrees with the denial of an expedited appeal time frame. • During the review, HSAG requested that the PAHP provide the denied expedited resolution letter template. However, this document was not provided to HSAG as requested. Recommendations: Neither the <i>hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA</i> nor the <i>IA Medicaid Appeals Grievances Delegated CRD Process Draft</i> training documents included the process for transferring an expedited request to the standard appeal time frame when the		

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
request does not meet the criteria for expedited review. HSAG recommends that the PAHP enhance its training documents so staff members understand how to document and process these requests.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Update its <i>CGA01-INS-MCD-Member Appeals</i> policy to indicate that the PAHP staff members (rather than the provider) will provide the member or authorized representative prompt notification when the PAHP denies the request to handle an appeal as expedited. - Update its <i>CGA01-INS-MCD-Member Appeals</i> policy to indicate that the written notice to the member will also include the member's right to file a grievance if the member disagrees with the denial of an expedited appeal time frame. - Develop and submit a denied expedited resolution letter template that complies with these requirements.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	- SX_16_20_21_22_23_24_26.CGA01-INS-MCD-Member Appeals-Medicaid -IA<Pg. 7> - SX_16.IA Medicaid Deny to Expedite Appeal letter template<Entire Document>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/11/2026		
HSAG Feedback: The PAHP's remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
20. The PAHP provides the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The PAHP informs the member of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFR §438.408(b) and (c) in the case of expedited resolution.	HSAG Required Evidence: - Policies and procedures - Member communications, such as ABD notice template, member acknowledgment template, and/or call script - Staff training materials - HSAG will also use the results of the system demonstration (i.e., mock appeal case examples)	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
42 CFR §438.228 42 CFR §438.406(b)(4) 42 CFR §438.408(b-c) 42 CFR §457.1260(d) Contract H.6.05 Contract H.6.10	Evidence as Submitted by the PAHP: • Policies and procedures ○ SX_CGA01-INS-MCD-Member Appeals <Pg 3 Section B 2 b> • Member communications, such as ABD notice template, member acknowledgment template, and/or call script-N/A • Staff training materials ○ SX_2026 CG Training Syllabus ○ SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA	
PAHP Description of Process: The correspondence for Grievances and Appeals is currently in development. Drafts will be sent as soon as they are available.		
HSAG Findings: HSAG’s review identified the findings below: • The <i>CGA01-INS-MCD-Member Appeals</i> policy indicated that members would be informed of their right to submit documentation to support their appeal request as part of the acknowledgement letter. However, the policy also indicated that if an appeal request was resolved before the acknowledgement letter was to be sent to the member, the acknowledgement letter would not be sent. During the review, HSAG recommended that the PAHP update its ABD notice to include this information as well as include it in the acknowledgement notice. After the review, the PAHP submitted the <i>IA Medicaid Grievance Acknowledgement</i> letter template, which was not specific to appeals and did not include the statement that members would have the right to submit documentation to support their appeal and the time frame in which to submit the documentation. • After the review, the PAHP submitted the updated ABD notice, which also did not include that the member would have a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments, or the limited time frame in which members could submit the information in the case of an expedited appeal.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: • Provide evidence of the process that the PAHP will use to provide the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments and notify the member of the limited time available for this sufficiently in advance of the resolution time frame for appeals as specified in 42 CFR §438.408(b) and (c) in the case of expedited resolution.		

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
Update and submit written documentation (e.g., the ABD notice, appeal acknowledgement notice template, call script) that confirms the process and language used to inform members of this requirement.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	- SX_20. IA Medicaid Appeal Acknowledgement letter template<Entire Document, Pg. 2> - SX_16_20_21_22_23_24_26.CGA01-INS-MCD-Member Appeals-Medicaid -IA<Pg. 3-4>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/11/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are not sufficient to demonstrate readiness with the requirements for this program area. The <i>CGA01-INS-MCD-Member Appeals</i> policy still indicated that members would be informed of their right to submit documentation to support their appeal request as part of the acknowledgement letter. However, the policy also indicated that if an appeal request was resolved before the acknowledgement letter was to be sent to the member, the acknowledgement letter would not be sent. Therefore, for any appeals resolved prior to the due date for the acknowledgement letter, the member would not be informed of their right to a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. While the PAHP submitted the <i>IA Medicaid Appeal Acknowledgement letter template</i> , which included the member’s right to submit additional information, there is still a gap in members receiving this information when an acknowledgement letter is not provided to the member. Additionally, the <i>CGA01-INS-MCD-Member Appeals</i> policy also noted that “[i]f the information is received within 7 days of case resolution and the information provided would change the outcome of the appeal, DentaQuest will change its decision and issue a new resolution to the member.” This process is inappropriate as this would allow the member more than one level of appeal. The rule requires that the PAHP provide the member’s right to present evidence and testimony and make legal and factual arguments and the limited time available for this sufficiently in advance of the resolution time frame. The PAHP may not change the outcome of its appeal decision once the decision has been rendered, and the member must be referred to the SFH process after the PAHP’s one level of appeal is exhausted. Therefore, the PAHP must submit a plan of correction, including all steps that will be taken, to remediate the continued deficiency, and the PAHP will also be required to meet with HSAG to ensure future compliance with the program area.		☐ Accepted ☐ Accepted With Recommendations ☒ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
Updated Remediation to Address CAP Not Accepted:		
Updated Plan to Remedy Deficiency (Include a narrative with all actions that will be taken to remediate deficiency):	DentaQuest has removed the part of the appeal process previously indicated that the acknowledgement letter would not be sent in the instance in which the decision was made prior to the acknowledgement letter due date. DentaQuest will send acknowledgement letters for all appeals cases, thus communicating to the members their right to submit additional documentation and evidence for the appeal, and allowing time for that process to occur. This updated process will also remove the step previously noted if information is received within 7 days of case resolutions. Any activity following the internal appeal decision will be referred to the SFH process.	
Responsible Individual(s):	[redacted]	
Timeline/Completion Date:	5/21/2026	
Evidence as Submitted by the PAHP to Address Deficiency:	SX_20_21.CGA01-INS-MCD-Member Appeals-Medicaid -IA<Pg. 3-4>	
HSAG Feedback on Updated Remediation: The PAHP's remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
21. The PAHP provides the member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the PAHP (or at the direction of the PAHP) in connection with the appeal of the ABD. a. This information is provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFR §438.408(b) and (c). 42 CFR §438.228 42 CFR §438.406(b)(5) 42 CFR §438.408(b-c) 42 CFR §457.1260(d)	HSAG Required Evidence: - Policies and procedures - Member communications, such as ABD notice template, member acknowledgment template, and/or call script - Staff training materials - HSAG will also use the results of the system demonstration (i.e., mock appeal case examples)	☐ Met ☒ Not Met
Evidence as Submitted by the PAHP: Policies and procedures		

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
Contract H.6.06–H.6.07	○ SX_CGA01-INS-MCD-Member Appeals < Pg 3 Procedure B 2(c); Pg 8 Procedure C, 6c(viii)> • Member communications, such as ABD notice template, member acknowledgment template, and/or call script-N/A • Staff training materials ○ SX_2026 CG Training Syllabus ○ SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA	
PAHP Description of Process: The correspondence for Grievances and Appeals is currently in development. Drafts will be sent as soon as they are available.		
HSAG Findings: The <i>CGA01-INS-MCD-Member Appeals</i> policy indicated that the acknowledgement letter would include a copy of the appeal case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the PAHP, in connection with the appeal of the ABD. However, the <i>IA Medicaid Grievance Acknowledgement</i> notice template did not include this language. During the review, PAHP staff members indicated it would be included in the member handbooks; however, the updated member handbooks submitted after the review also did not include this information. Additionally, the information was not included in the updated ABD notice template submitted after the review.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: • Provide evidence of the process that the PAHP will use to provide the member and his or her representative the member’s case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the PAHP (or at the direction of the PAHP) in connection with the appeal of the ABD. This information must be provided free of charge and sufficiently in advance of the resolution time frame for appeals as specified in 42 CFR §438.408(b) and (c). • Update and submit written documentation (e.g., the ABD notice, appeal acknowledgement notice template, call script) that confirms the process and language used to inform members of this requirement.		
Plan to Remedy Deficiency: (Include all actions)	• SX_16_20_21_22_23_24_26.CGA01-INS-MCD-Member Appeals-Medicaid -IA<Pg. 3-4 > • SX_21. IA Medicaid Grievance Acknowledgement letter template<Entire Document, Pg. 2> • SX_21.IA Medicaid Appeal Acknowledgement letter template< Entire Document, Pg. 2>	

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
that will be taken to remediate deficiency.)		
Individual(s) Responsible: [redacted]		
Completion Date: 05/11/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are not sufficient to demonstrate readiness with the requirements for this program area. The <i>CGA01-INS-MCD-Member Appeals</i> policy indicated that the acknowledgement letter would include a copy of the appeal case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the PAHP, in connection with the appeal of the ABD and that the information would be provided free of charge and sufficiently in advance of the resolution time frame. The <i>Medicaid Appeal Acknowledgement letter template</i> indicated the following: “We will send you a copy of your case file. Your case file includes all information that we will review about your appeal.” It is unclear whether the PAHP is sending a case file to all members for all appeals and how that process will occur or if the PAHP is only sending the case file upon request. Additionally, the policy indicated that if an appeal request was resolved before the acknowledgement letter was to be sent to the member, the acknowledgement letter would not be sent. Therefore, for any appeals resolved prior to the due date for the acknowledgement letter, the member would not be informed of their right to receive the case file sufficiently in advance of the resolution time frame. The PAHP must submit a plan of correction, including all steps that will be taken, to remediate the continued deficiency and the PAHP will also be required to meet with HSAG to ensure future compliance with the program area.		☐ Accepted ☐ Accepted With Recommendations ☒ Not Accepted
Updated Remediation to Address CAP <i>Not Accepted</i> :		
Updated Plan to Remedy Deficiency (Include a narrative with all actions that will be taken to remediate deficiency):	DentaQuest has removed the part of the appeal process previously indicated that the acknowledgement letter would not be sent in the instance in which the decision was made prior to the acknowledgement letter due date. DentaQuest will send acknowledgement letters for all appeals cases, thus also including the appeal case file with the acknowledgement letter sent to the member, and sufficiently in advance of the resolution time frame. Updated the appeal acknowledgement letter to make it clear the case file is attached to the letter.	
Responsible Individual(s):	[redacted]	
Timeline/Completion Date:	5/21/2026	
Evidence as Submitted by the PAHP to Address Deficiency:	- SX_20_21.CGA01-INS-MCD-Member Appeals-Medicaid -IA<Pg. 3> - SX_21. IA Medicaid Grievance Acknowledgement letter template<Pg. 2>	

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
HSAG Feedback on Updated Remediation: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
22. <i>The PAHP directs the appeals related to exceptions to policy regarding services outside of State Plan Benefits to HHS.</i> Note: Waivers of administrative rules are also referred to as exceptions to policy. Contract F.16.09 Contract H.1.03(d)	HSAG Required Evidence: • Policies and procedures • Process to assist members in requesting an exception to policy • Exception to policy referral template to HHS • Staff training materials • Tracking and reporting mechanisms for exception to policy requests and HHS’ decision Evidence as Submitted by the PAHP: • Policies and procedures ○ SX_CGA01-INS-MCD-Member Appeals < Pg 5 Procedure B 6 a-c > • Process to assist members in requesting an exception to policy ○ SX_CGA01-INS-MCD-Member Appeals < Pg 13 > • Exception to policy referral template to HHS-N/A • Staff training materials ○ SX_2026 CG Training Syllabus ○ SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA • Tracking and reporting mechanisms for exception to policy requests and HHS’ decision ○ SX_CGA05-INS-SOP-Monitoring Resolution Timeframes-No Exhibits 1.pdf	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
PAHP Description of Process: The Exception to policy referral process is currently in discussion with HHS.		
HSAG Findings: Although the PAHP's <i>CGA01-INS-MCD-Member Appeals</i> policy included this information, during the review, PAHP staff members stated that the process for directing appeals related to exceptions to policy regarding services outside of State Plan Benefits to HHS is still in process. After the review, the PAHP submitted no additional evidence, indicating that this process is still in development with HHS.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must:		
Submit its process to direct appeals related to exceptions to policy regarding services outside of State Plan Benefits to HHS.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	SX_16_20_21_22_23_24_26.CGA01-INS-MCD-Member Appeals-Medicaid -IA<Pg. 13 >	
Individual(s) Responsible: [redacted]		
Completion Date: 05/11/2026		
HSAG Feedback: The PAHP's remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. Although the PAHP's <i>CGA01-INS-MCD-Member Appeals</i> policy included this information, there were no procedures for how these appeal types will be directed to HHS. PAHP staff members previously stated that the process for directing appeals related to exceptions to policy regarding services outside of State Plan Benefits to HHS is still in process. As the PAHP indicated previously that it is collaborating with HHS to identify a process for these types of referrals, HSAG strongly recommends that policies, procedures, and training documents be developed or updated to include these finalized expectations set forth by HHS.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted
Resolution and Notification of Appeals		
23. The PAHP resolves standard appeals and sends notice to the affected parties as expeditiously as the member's health condition requires, but no later than 30 calendar days from the day the PAHP receives the appeal.	HSAG Required Evidence: - Policies and procedures - Tracking and reporting mechanisms (e.g., system tracking capabilities, mock timeliness report) - Staff training materials	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
a. <i>The PAHP resolves 100 percent of appeals within 30 days of receipt for standard appeals.</i> 42 CFR §438.228 42 CFR §438.408(a) 42 CFR §438.408(b)(2) 42 CFR §457.1260(e)(1-2) Contract H.7.01 Contract H.11.05	- System screenshot of the field where the type of appeal request is documented (i.e., standard appeal) - System screenshot of the field where the date of receipt of the appeal is documented - System screenshot of the field where the date of the mailing of the resolution notice is documented - HSAG will also use the results of the system demonstration (i.e., mock appeal case examples) Evidence as Submitted by the PAHP: - Policies and procedures - SX_CGA01-INS-MCD-Member Appeals <Pg 6 Procedure C 2> - Tracking and reporting mechanisms (e.g., system tracking capabilities, mock timeliness report) - SX_CGA05-INS-SOP-Monitoring Resolution Timeframes-No Exhibits 1.pdf - Staff training materials - SX_2026 CG Training Syllabus - SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA - System screenshot of the field where the type of appeal request is documented (i.e., standard appeal) - SX_Member Grievance-Appeal Screenshot - System screenshot of the field where the date of receipt of the appeal is documented - SX_Member Grievance-Appeal Screenshot - System screenshot of the field where the date of the mailing of the resolution notice is documented-N/A	
PAHP Description of Process: The date of the mailing is noted on the letter. Please see policy CGA01-INS-MCD-Member Appeals.		

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
HSAG Findings: HSAG’s review identified the findings below: - During the system demonstration, staff members confirmed that the date and time documented in the Salesforce system for when a resolution notice is sent to the member is the date and time the staff member generated the notice rather than when the notice is actually sent to the member. HSAG asked staff members when a resolution notice would be sent in the mail, and PAHP staff members indicated that once the letter is generated in Salesforce, it will route to the mail room for printing and mailing. The mail room staff member will print the letter and prepare it for pickup. However, mail will be picked up at 10:00 a.m. and 2:00 p.m. seven days a week except on holidays. Therefore, if the letter is sent to the mail room after 2:00 p.m., the letter would be sent the next day, which could impact the time frame. - During the review, PAHP staff members indicated that the PAHP does not have a process to track time frames based on the mail date and will be developing that process. HSAG requested documentation that described the process of when mail is picked up and mailed the PAHP; however, this documentation was not provided after the review. Instead, the PAHP submitted the <i>INT-01-INS-GOV Inbound Mail–Government</i> policy and procedure, which outlined when incoming mail would be picked up and brought to the PAHP, but not when outgoing mail would be processed and mailed.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Implement a mechanism to use the date the PAHP received the appeal and the date the resolution notice entered the mailing stream (i.e., not the date the notice was sent to print and fulfillment) to calculate the TAT.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	SX_16_20_21_22_23_24_26.CGA01-INS-MCD-Member Appeals-Medicaid -IA<Pg. 6 >	
Individual(s) Responsible: [redacted]		
Completion Date: 05/11/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. The PAHP submitted its updated <i>CGA01-INS-MCD-Member Appeals</i> policy, which indicated that to ensure communications are sent to members timely, the PAHP “will notate the same day the letter is processed for cases resolved before 2pm CST. For cases with letters processed after 2pm CST, DentaQuest will notate the date the case was resolved as the next business day.” While this option could be a temporary solution, HSAG strongly recommends that the PAHP implement a systematic process to calculate time frames based on the date and time the member notice is sent as this manual process could introduce human error causing time frames to be missed or miscalculated.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
24. The PAHP resolves expedited appeals and sends notice to the affected parties no later than 72 hours after the PAHP receives the appeal. a. <i>The PAHP resolves 100 percent of appeals within 72 hours of receipt for expedited appeals.</i> 42 CFR §438.228 42 CFR §438.408(b)(3) 42 CFR §457.1260(e)(1) Contract H.7.04 Contract H.11.05	HSAG Required Evidence: • Policies and procedures • Tracking and reporting mechanisms (e.g., system tracking capabilities, mock timeliness report) • Staff training materials • System screenshot of the field where the type of appeal request is documented (i.e., expedited appeal) • System screenshot of the field where the date and time of receipt of the appeal is documented • System screenshot of the field where the date and time of the mailing of the resolution notice is documented • HSAG will also use the results of the system demonstration (i.e., mock appeal case examples) Evidence as Submitted by the PAHP: • Policies and procedures ○ SX_CGA01-INS-MCD-Member Appeals <Pg 6 Procedure C 1-2> • Tracking and reporting mechanisms (e.g., system tracking capabilities, mock timeliness report) ○ SX_CGA05-INS-SOP-Monitoring Resolution Timeframes-No Exhibits 1.pdf • Staff training materials ○ SX_2026 CG Training Syllabus ○ SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA • System screenshot of the field where the type of appeal request is documented (i.e., expedited appeal) ○ SX Expedited Appeal System Screenshot	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
	- System screenshot of the field where the date and time of receipt of the appeal is documented - SX_Expedited Appeal System Screenshot - System screenshot of the field where the date and time of the mailing of the resolution notice is documented - SX_Resolution Date_Time and Letters Sent Date_Time	
PAHP Description of Process: N/A		
HSAG Findings: HSAG’s review identified the findings below: - During the system demonstration, staff members confirmed that the date and time documented in the Salesforce system for when a resolution notice is sent to the member is the date and time the staff member generated the notice rather than when the notice is actually sent to the member. HSAG asked staff members when a resolution notice would be sent in the mail, and PAHP staff members indicated that once the letter is generated in Salesforce, it will route to the mail room for printing and mailing. The mail room staff member will print the letter and prepare it for pickup. However, mail will be picked up at 10:00 a.m. and 2:00 p.m. seven days a week except on holidays. Therefore, if the letter is sent to the mail room after 2:00 p.m., the letter would be sent the next day, which could impact the time frame. - During the review, PAHP staff members indicated that the PAHP does not have a process to track time frames based on the mail date and will be developing that process. HSAG requested documentation that described the process of when mail is picked up and mailed the PAHP; however, this documentation was not provided after the review. Instead, the PAHP submitted the <i>INT-01-INS-GOV Inbound Mail–Government</i> policy and procedure, which outlined when incoming mail would be picked up and brought to the PAHP, but not when outgoing mail would be processed and mailed.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Implement a mechanism to use the date and time the PAHP received the expedited appeal and the date and time the resolution notice entered the mailing stream (i.e., not the date and time the notice was sent to print and fulfillment) to calculate the TAT.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	SX_16_20_21_22_23_24_26.CGA01-INS-MCD-Member Appeals-Medicaid -IA<Pg. 6 >	

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
Individual(s) Responsible: [redacted]		
Completion Date: 05/11/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. The PAHP submitted its updated <i>CGA01-INS-MCD-Member Appeals</i> policy, which indicated that to ensure communications are sent to members timely, the PAHP “will notate the same day the letter is processed for cases resolved before 2 p.m. CST. For cases with letters processed after 2 p.m. CST, DentaQuest will notate the date the case was resolved as the next business day.” While this option could be a temporary solution, HSAG strongly recommends that the PAHP implement a systematic process to calculate time frames based on the date and time the member notice is sent as this manual process could introduce human error causing time frames to be missed or miscalculated.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted
26. If the PAHP extends the standard or expedited appeal resolution timeframes not at the request of the member, it completes all of the following: - Makes reasonable efforts to give the member prompt oral notice of the delay. - Within two calendar days gives the member written notice of the reason for the decision to extend the timeframe and informs the member of the right to file a grievance if he or she disagrees with that decision. - Resolves the appeal as expeditiously as the member’s health condition requires and no later than the date the extension expires.	HSAG Required Evidence: - Policies and procedures - Member materials, such as the member handbook - Appeal extension template letter - Staff training materials - System screenshot of the field where oral notice of the extension is documented - System screenshot of the field where written notice of the extension is documented, including the date of the notice - HSAG will also use the results of the system demonstration (i.e., mock appeal case examples)	☐ Met ☒ Not Met
42 CFR §438.228 42 CFR §438.408(c)(2) 42 CFR §457.1260(e)(1-2) Contract H.7.03 Contract H.7.06	Evidence as Submitted by the PAHP: - Policies and procedures - SX_CGA01-INS-MCD-Member Appeals <Pg 7 Procedure C 5d (i-vii)> - Member materials, such as the member handbook - SX_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft 2.27.26	

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
	○ SX_DQ4080 IA Medicaid Child (7.26) HBEN_Draft_2.26.26 • Appeal extension template letter-N/A • Staff training materials ○ SX_2026 CG Training Syllabus ○ SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA • System screenshot of the field where oral notice of the extension is documented-N/A • System screenshot of the field where written notice of the extension is documented, including the date of the notice ○ SX_Expedited Appeal System Screenshot	
PAHP Description of Process: The correspondence for Grievances and Appeals is currently in development. Drafts will be sent as soon as they are available.		
HSAG Findings: The <i>CGA01-INS-MCD-Member Appeals</i> policy indicated that the PAHP will give the provider prompt oral notice of the delay where the provider has agreed to be responsible for promptly notifying the member or authorized representative of the determination. However, this requirement is the PAHP's responsibility and it cannot be delegated to the provider without appropriate delegation agreements and oversight in place; although this does not appear to be an appropriate function to delegate to providers. The policy must be updated to indicate that the PAHP staff members will provide the member or authorized representative prompt notification of the delay. Recommendations: HSAG's review identified the recommendations below: • Neither the <i>hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA</i> nor the <i>IA Medicaid Appeals Grievances Delegated CRD Process Draft</i> training documents explained how the staff members would take an extension, the reasons for the extension, and what process to follow to ensure the member is notified of the extension. HSAG strongly recommends including this information in the staff training documents so staff members understand the appropriate processes to follow for extensions and where to document the information in the information system. • The three member handbooks indicated that the PAHP will notify the member by phone and in writing within two days; however, the requirement is that the PAHP <i>promptly</i> notify the member orally and provide notification in writing within two calendar days. HSAG recommends clarifying this language in the member handbooks.		

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
The <i>IA Medicaid Appeal Extension letter template</i> implied that the member would be required to provide additional information to the PAHP; however, normally it is the provider who needs to submit the additional information. HSAG recommends that the PAHP revise its extension letter template to advise that the PAHP requested additional information from the provider.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Update its policy to indicate that the PAHP staff members (rather than the provider) will provide the member or authorized representative prompt notification of the delay.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	- SX_16_20_21_22_23_24_26.CGA01-INS-MCD-Member Appeals-Medicaid -IA<Pg. 7 > - SX_5,26_CGA - Investigation_Extensions<Entire Document>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/11/2026		
HSAG Feedback: The PAHP's remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
28. For all appeals, the PAHP provides written notice of the appeal resolution that includes: - The results of the resolution process and the date it was completed. - For appeals not resolved wholly in favor of the member: - The right to request a SFH, and how to do so. - The right to request and receive benefits while the hearing is pending, and how to make the request.	HSAG Required Evidence: - Policies and procedures - Appeal resolution notice template - Staff training materials - System screenshot of the field where the appeal resolution notice is maintained - HSAG will also use the results of the system demonstration (i.e., mock appeal case examples)	☐ Met ☒ Not Met
Evidence as Submitted by the PAHP: Policies and procedures		

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
iii. That the member may be held liable for the cost of those benefits if the hearing decision upholds the PAHP's ABD related to the appeal. 42 CFR §438.228 42 CFR §438.408(e)(1-2) 42 CFR §457.1260(e)(1) 42 CFR §457.1260(e)(4) Contract H.8.01 Contract H.9.04	○ SX_CGA01-INS-MCD-Member Appeals <Pg 7-8 Procedure C, Item 6(c)(i-ix)> • Appeal resolution notice template-N/A • Staff training materials ○ SX_2026 CG Training Syllabus ○ SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA • System screenshot of the field where the appeal resolution notice is maintained ○ SX_Expedited Appeal System Screenshot	
PAHP Description of Process: The correspondence for Grievances and Appeals is currently in development. Drafts will be sent as soon as they are available.		
HSAG Findings: HSAG's review identified the findings below: • The <i>CGA01-INS-MCD-Member Appeals</i> policy did not include that the resolution notice will indicate that the member may be held liable for the cost of continued benefits if the hearing decision upholds the PAHP's ABD related to the appeal. • During the review, HSAG requested that the appeal resolution notice template be provided in follow-up documents; however, this template letter was not submitted as requested. • During the review, HSAG requested a policy or process document explaining how the appeal upheld reason (i.e., denial reason for appeals) would be generated in the appeal resolution notice; however, this evidence was not submitted as requested. Recommendations: The <i>CGA01-INS-MCD-Member Appeals</i> policy outlined a process for member external appeals and indicated that the resolution notice would include information related to this process. During the review, PAHP staff members explained that this is a Medicare process used only for members who have Medicare coverage. HSAG recommends that the PAHP remove this section from the <i>CGA01-INS-MCD-Member Appeals</i> policy or include in its Iowa exhibit for this policy that the process does not apply to Iowa Medicaid and that it would not be included in the resolution notice.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: • Develop and submit an appeal resolution notice template, including that the member may be held liable for the cost of continued benefits if the hearing decision upholds the PAHP's ABD related to the appeal. • Develop and submit a policy, process, or training document explaining how the appeal upheld reason (i.e., denial reason for appeals) will be generated in the appeal resolution notice.		

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	- SX_28.IA Medicaid Appeal Resolution Upheld letter template<Entire Document, Pg. 2> - SX_1._27, CGA - Resolution<Entire Document>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/09/2026		
HSAG Feedback: The PAHP's remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. However, the PAHP must refer to Element 32 for additional recommendations.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted
State Fair Hearings and State External Review		
31. The member has no more than <i>120 calendar days</i> from the date of the PAHP's notice of appeal resolution to request a SFH. 42 CFR §438.228 42 CFR §438.408(f)(2) 42 CFR §457.1260(e)(5) HHS.Iowa.Gov—How to Appeal IAC 441—7.4(b)	HSAG Required Evidence: - Policies and procedures - Appeal resolution notice template - Member materials, such as the member handbook and/or ABD notice - Staff training materials Evidence as Submitted by the PAHP: - Policies and procedures - SX_CGA01-INS-MCD-Member Appeals <Pg 9 Procedure E 1> - Appeal resolution notice template-N/A - Member materials, such as the member handbook and/or ABD notice - SX_DQ3197 IA_Medicaid Adult (7.26) HBEN Draft 2.27.26	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
	○ SX_DQ4080 IA Medicaid Child (7.26) HBEN_Draft_2.26.26 • Staff training materials ○ SX_2026 CG Training Syllabus ○ SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA	
PAHP Description of Process: The correspondence for Grievances and Appeals is currently in development. Drafts will be sent as soon as they are available.		
HSAG Findings: Although the PAHP's policies and procedures, training documentation, and member handbooks included that the member had 120 days to submit an SFH request after receipt of the appeal resolution notice, during the review, HSAG requested that the PAHP submit the appeal resolution notice template. However, this evidence was not submitted as requested.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: • Develop and submit an appeal resolution notice template, which must indicate that the member has no more than <i>120 calendar days</i> from the date of the PAHP's notice of appeal resolution to request an SFH.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	• SX_31.IA Medicaid Appeal Resolution Upheld letter template<Entire Document, Pg. 2>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/09/2026		
HSAG Feedback: The PAHP's remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
Continuation of Benefits		
32. The PAHP continues the member’s benefits if all of the following occur: - The member files the request for an appeal timely (within 60 calendar days from the date on the ABD notice). - The appeal involves the termination, suspension, or reduction of previously authorized services. - The services were ordered by an authorized provider. - The period covered by the original authorization has not expired. - The member timely files for continuation of benefits. <i>Timely files</i> means on or before the later of the following: within 10 calendar days of the PAHP sending the notice of ABD, or the intended effective date of the PAHP’s proposed ABD. 42 CFR §438.228 42 CFR §438.420(a-b) Contract H.9.01–H.9.02	HSAG Required Evidence: - Policies and procedures - ABD notice template - Appeal resolution notice template - Staff training materials - Process to continue benefits when requested by a member - System screenshot of the field for where a member request to continue benefits is documented - HSAG will also use the results of the system demonstration Evidence as Submitted by the PAHP: - Policies and procedures - SX_CGA01-INS-MCD-Member Appeals <Pg 10-11 Procedure F 1-2> - ABD notice template-N/A - Appeal resolution notice template-N/A - Staff training materials - SX_2026 CG Training Syllabus - SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA - Process to continue benefits when requested by a member - SX_CGA01-INS-MCD-Member Appeals <Pg 10-11 Procedure F 1-2> - System screenshot of the field for where a member request to continue benefits is documented	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
	SX_Member Grievance-Appeal Screenshot	
PAHP Description of Process: The correspondence for Grievances and Appeals is currently in development. Drafts will be sent as soon as they are available.		
HSAG Findings: Although the PAHP’s <i>CGA01-INS-MCD-Member Appeals</i> policy included the information related to the continuation of benefits, during the review, HSAG requested that the PAHP submit the appeal resolution notice template. However, this evidence was not submitted as requested. Recommendations: HSAG’s review identified the recommendations below: - The <i>IA Medicaid NABD letter template with RGL</i> submitted by the PAHP indicated that members must ask for the benefits to be continued within 10 days of receiving the notice that the PAHP is reducing, ending, or denying previously authorized services; however, it did not notify the member that the period covered by the original authorization must not be expired for the services to continue during the appeal. HSAG recommends that the PAHP include this language in the ABD notice template. - Neither the <i>hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA</i> nor the <i>IA Medicaid Appeals Grievances Delegated CRD Process Draft</i> training documents described how staff members would process the continuation of benefits, if requested, during the appeal or SFH. HSAG recommends that the PAHP ensure its training documentation includes how staff members will process the continuation of benefits and where to document information in the information system.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Develop an appeal resolution notice template, which must inform members of their right to continue benefits.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	SX_32.IA Medicaid appeal upheld resolution letter template<Entire Document, Pg. 2>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/09/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. The PAHP provided an appeal upheld resolution letter template, which included a statement that “you may be able to keep getting your services while a State Fair Hearing is being reviewed.” Therefore, this evidence was <i>Accepted</i> to remediate the previously noted deficiency. However, instructions within the template explained that this section should only be included “when this letter resolves an adverse benefit determination.” Although the intent of “resolves an adverse		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
benefit determination” is not clear, HSAG strongly recommends that the PAHP ensure that PAHP staff members responsible for developing appeal notices are aware that benefits can only be continued if the appeal/SFH involves the termination, suspension, or reduction of previously authorized services and the original authorization has not expired. The PAHP should update the instructions within the notice template for its staff members to include detailed steps for determining when the continuation of benefits section should be included or removed. HSAG also recommends that the PAHP update its notice template to include all of the requirements that must be met for a member to receive continued services when the notice template includes a continuation of benefits section.		
Reinstatement of Services		
36. If the PAHP or the SFH officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the PAHP authorizes or provides the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. 42 CFR §438.228 42 CFR §438.424(a) 42 CFR §457.1260(i) Contract H.9.05	HSAG Required Evidence: • Policies and procedures • Workflow for authorizing or providing services within 72 hours of decision to reverse determination • Tracking and reporting mechanisms (e.g., system tracking capabilities, mock timeliness report) • Staff training materials Evidence as Submitted by the PAHP: • Policies and procedures ○ SX_CGA01-INS-MCD-Member Appeals <Pg 10 Procedure E 12> • Workflow for authorizing or providing services within 72 hours of decision to reverse determination ○ SX_CGA - Expedited Cases • Tracking and reporting mechanisms (e.g., system tracking capabilities, mock timeliness report) ○ SX_CGA05-INS-SOP-Monitoring Resolution Timeframes-No Exhibits 1.pdf • Staff training materials ○ SX_2026 CG Training Syllabus	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
	SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA	
PAHP Description of Process: HSAG Findings: The PAHP’s policy stipulated these requirements verbatim. However, during the review, the PAHP could not demonstrate systematically how the timeliness will be tracked. The PAHP explained that to reinstate services after an SFH reversal decision, the PAHP will use a ticketing system within Service Now to initiate the process and route the request to reinstate the services to the appropriate department (i.e., claims or UM). HSAG requested screenshots of this ticketing system to confirm how the PAHP will ensure the services are reinstated timely. However, after the review, the PAHP noted that this could not be demonstrated via screenshots.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Provide evidence (e.g., screenshots) for how it documents and tracks that it authorizes or provides the disputed services within 72 hours.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	SX_36. Hearing Overturn Effectuation System Documentation<Entire Document>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/06/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are not sufficient to demonstrate readiness with the requirements for this program area. The PAHP provided a screenshot from Salesforce with two case comments; the first case comment was added on 4/1/26 at 8:32 a.m. and indicated, “4.1 – Attaching Decision: OVERTURNED – see linked cases for SFH request,” and the second comment was added on 4/1/26 at 8:33 a.m. and indicated, “4.1 – Completed overturn. Waiting on new PDL to generate.” The PAHP also provided a screenshot of its Windward system that included two line items. The first line had a stamp date of 4/1/26 at 9:30 a.m. and indicated a status of “Reversed,” while the second line item had a date stamp of 4/1/26 at 9:32 a.m. with a status of “Determined.” The documentation provided by the PAHP indicated that the Windward system operates on Eastern time zone, which accounts for the one hour difference from the case notes and associated times in Salesforce. Although the “Reversed” line comes prior to a “Determined” line, HSAG is assuming that the “Determined” line relates to the overturned decision and not to the initial decision (i.e., service denial). Documentation provided by the PAHP also included a screenshot of an email from a complaints and grievance specialist that indicates, “Please see the attached information for member		☐ Accepted ☐ Accepted With Recommendations ☒ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
[redacted]. Please let me know if you need further information.” The documentation explained that the screenshot is an example of an email that was sent to a plan regarding the overturn effectuation. This email screenshot did not have an email date sent, and it was unclear why the email from the complaints and grievance specialist would be sent to a plan, when the PAHP is a plan that is responsible for completing the effectuation in Iowa. Further, based on the documentation provided in support of the remediation, it is not clear when the PAHP was notified by the SFH officer of the overturned decision; therefore, HSAG could not determine whether the effectuation (i.e., PA decision was changed from denied to approved, or member received the services) occurred within 72 hours of the overturned decision by the SFH officer. Further, the documentation submitted did not address the timeliness for authorizing or providing the disputed services, when the decision is overturned during an appeal instead of an SFH. Therefore, the PAHP must submit a plan of correction, including all steps that will be taken, to remediate the continued deficiency, and the PAHP will also be required to meet with HSAG to ensure future compliance with the program area.		
Updated Remediation to Address CAP Not Accepted:		
Updated Plan to Remedy Deficiency (Include a narrative with all actions that will be taken to remediate deficiency):	DentaQuest has provided updated fair hearing documentation to illustrate the timing of the effectuation and notification of the fair hearing decision when the decision was to overturn the previous adverse determination.	
Responsible Individual(s):	[redacted]	
Timeline/Completion Date:	5/22/2026	
Evidence as Submitted by the PAHP to Address Deficiency:	SX_36_Hearing Overturn Effectuation System Documentation<Entire Document>	
HSAG Feedback on Updated Remediation: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. However, HSAG recommends that the PAHP ensure its system has the capability to effectively track the date and time the decision was made by the PAHP appeals department or the SFH officer and the date and time the PAHP effectuates the overturned decision (e.g., through PA status [e.g., approved, open] and/or through claims payment/documentation of services rendered).		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
Grievances, Appeals, and State Fair Hearings		
39. The PAHP provides written notice of the grievance and appeal resolution in a format and language that, at a minimum, meets the requirements in accordance with 42 CFR §438.10. 42 CFR §438.10 42 CFR §438.228 42 CFR §438.408(d)(1) 42 CFR §438.408(d)(2)(i) 42 CFR §457.1260(e)(1) Contract H.8.01(a) Contract H.10.07	HSAG Required Evidence: • Policies and procedures • Grievance and appeal resolution templates, including taglines • Staff training materials • Quality assurance process to monitor resolution notices (e.g., required content, easily understood, grammatical/ typographical errors) • HSAG will also use the results of the system demonstration (i.e., mock case examples) Evidence as Submitted by the PAHP: • Policies and procedures ○ SX_CGA01-INS-MCD-Member Appeals <Pg 7-8 Procedure C 6(c)> ○ SX_CGA06-INS-Member Complaints and Grievances <Pg 5-6 Procedure D 5> • Grievance and appeal resolution templates, including taglines-N/A • Staff training materials ○ SX_2026 CG Training Syllabus ○ SX_hp-cga-complaints-grievances-and-appeals-department-overview-9Duy9QHA • Quality assurance process to monitor resolution notices (e.g., required content, easily understood, grammatical/ typographical errors) ○ SX_QA10-INS-Complaints Grievances and Appeals Audit <Full Document>	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard X—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
PAHP Description of Process: The correspondence for Grievances and Appeals is currently in development. Drafts will be sent as soon as they are available.		
HSAG Findings: While the requirements of this element were outlined in the PAHP’s policies and procedures, HSAG did not receive the appeal resolution notice template to confirm that the written notice will comply with 42 CFR §438.10. Although requested during the review, this evidence was not submitted.		
Recommendations: During the review, PAHP staff members indicated that the PAHP will audit each specialist every week and that part of the audit will include a review of the member notices that were sent. HSAG strongly recommends that the PAHP implement a quality assurance process to review member notices before they are mailed to the member to ensure accuracy and quality, at least for a specified period and when there are new staff members.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must:		
Develop and submit an appeal resolution notice template.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	- SX_39.IA Medicaid appeal overturn resolution letter template<Entire Document> - SX_39. IA Medicaid appeal upheld resolution letter template<Entire Document>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/09/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. However, although the appeal resolution letter templates were at a 6.7 reading grade level according to the Flesch-Kincaid readability test, HSAG recommends that the PAHP ensure that all completed appeal resolution letters (i.e., those being sent to members) also pass the readability test prior to sending the notice to the member. The PAHP’s staff members should document the statistics for the readability assessment within its information system as this process will be assessed during future compliance reviews. Further, although the appeal resolution templates did not include taglines as required by 42 CFR §438.10(d), HSAG assumes that the taglines will be included as a separate attachment to the notices prior to mailing to members. Therefore, HSAG also recommends that the PAHP ensure it has a quality assurance process in place to confirm that all notices include the appropriate taglines document as an attachment to the completed notices.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted

Standard XI—Subcontractual Relationships and Delegation

Operational Readiness Review Standards Remediation Plan		
Standard XI—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
Monitoring and Auditing		
10. <i>The PAHP monitors the subcontractor’s performance on an ongoing basis.</i> a. <i>Formal reviews are conducted by the PAHP at least quarterly.</i> b. <i>Whenever deficiencies or areas of improvement are identified, the PAHP and subcontractor take corrective action.</i> c. <i>The PAHP provides to HHS the findings of all subcontractor performance monitoring and reviews upon request and notifies HHS any time a subcontractor is placed on corrective action.</i> 42 CFR §438.230 42 CFR §457.1233(b) Contract J.3.05	HSAG Required Evidence: • Policies and procedures • Staff training materials • HSAG will use the data from the Delegation Universe File • HSAG will use the results from the Delegation File Review Evidence as Submitted by the PAHP: • SXI_Regulatory Compliance Addendum Template <Pg 6, Article IV Section 4.3 Pg 4, Article III Section 3.2> • SXI_Vendor Management Program Page 14 – Vendor oversight, ongoing monitoring, data review, reporting evaluation, and escalation processes • SXI_COM11-ENT Delegation Oversight Policy <Pg 3, Section B> • SXI_COM07-ENT Training & Education Policy <Pg 1–4>	☐ Met ☒ Not Met
PAHP Description of Process:		
HSAG Findings: While the PAHP’s <i>COM11-ENT-SOP-Subcontractor Oversight</i> SOP included language about its standardized process for monitoring and oversight of its delegated entities, stating “the Delegation Oversight Subcommittee maintains the ultimate responsibility for monitoring subcontractor compliance with applicable contract requirements, rules and regulations,” this statement did not sufficiently address the requirements of sub-element (c). During the review, HSAG requested that the state-specific contract requirements be included in its policies and procedures to ensure PAHP staff were aware of and can adhere to the contract requirements, but evidence to support this requirement was not submitted.		

Operational Readiness Review Standards Remediation Plan		
Standard XI—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Update its procedure or other written documentation to include state-specific contract requirements outlined in sub-element (c), and provide confirmation that staff have been trained on state-specific contract requirements.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	Standard Operating Procedure NET30-INS-SOP-Iowa Medicaid CHIP Client Notification Requirements was created to include the state-specific contract requirements outlined in sub-element (c). - SXI_NET30-INS-SOP-Iowa Medicaid CHIP Client Notification Requirements<Pg.2-3> - SXI_Iowa DHHS Contract - Annual Training<Entire Document> - SXI_Email_ACTION REQUIRED_Iowa DHHS Contract - Annual Training<Entire Document> - SXI_Iowa All Staff Annual Training Schedule<Entire Document>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/11/2026		
HSAG Feedback: The PAHP's remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
Additional State Requirements		
11. <i>The PAHP notifies HHS in writing of all subcontracts relating to deliverables to be provided under its Contract prior to the time the subcontract(s) become effective.</i>	HSAG Required Evidence: - Policies and procedures - Copies of the notification to HHS of subcontractors responsible for deliverables	☐ Met ☒ Not Met
42 CFR §438.230 42 CFR §457.1233(b) Contract J.3.03	Evidence as Submitted by the PAHP: - SXI_Regulatory Compliance Addendum Template <Pg 6, Article IV Section 4.3> - SXI_Vendor Management Program <Pg 3-4> - SXI_COM11-ENT Delegation Oversight <Pg 2-3>	

Operational Readiness Review Standards Remediation Plan		
Standard XI—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
	SXI_IA Sub-Del Vendor List <Entire Document>	
PAHP Description of Process: We have established processes to notify HHS of subcontractors responsible for deliverables. As we are still in the pre-go-live phase for 7/1/26, the required HHS notifications have not yet been triggered but will be submitted once subcontract agreements are finalized.		
HSAG Findings: Although the PAHP indicated in the <i>Description of Process</i> that the PAHP had established processes to notify HHS of subcontractors responsible for contract deliverables, the PAHP did not submit documentation to support this. Further, the PAHP indicated on the <i>Post-Site Review Tracker</i> that “DentaQuest will be developing a process with HHS to ensure the process is documented.”		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Submit a documented process (e.g., policy, procedure, SOP) that includes the process for how and when the PAHP notifies HHS in writing of all subcontracts relating to deliverables to be provided under its Contract prior to the time the subcontract(s) becomes effective.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	SXI_NET30-INS-SOP-Iowa Medicaid CHIP Client Notification Requirements <Pg. 1 - Release Management>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/07/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard XII—Practice Guidelines

Operational Readiness Review Standards Remediation Plan		
Standard XII—Practice Guidelines		
Requirement	Supporting Documentation	Score
Adoption of Practice Guidelines		
2. The PAHP adopts practice guidelines that consider the needs of the PAHP's members. 42 CFR §438.236(b)(2) 42 CFR §457.1233(c) Contract G.4.02	HSAG Required Evidence: • Policies and procedures • Analysis of the needs of the PAHP's membership (i.e., using Iowa demographics and/or other published data) • List of adopted practice guidelines specific to Iowa, or list of practice guidelines the PAHP plans to adopt • Iowa-specific meeting minutes documenting committee review/approval, and/or planned meeting schedule and agenda • Staff training materials Evidence as Submitted by the PAHP: • SXII_UM01-INS-Clinical Algorithms <pages 1-4, Procedure A. Formulation/Establishment, B. Adoption, D. Ongoing and Annual Assessment> • SXII_Member Handbook Prev Implementation DRAFT	☐ Met ☒ Not Met
PAHP Description of Process: Staff Training materials are currently under development. They will be submitted by May 1, 2026.		
HSAG Findings: HSAG's review identified the findings below: • While the PAHP could speak to processes to consider member needs when adopting CPGs, this requirement and the PAHP's process were not documented within its policy.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: • Update its policy to include how the PAHP adopts CPGs that consider the needs of its members.		

Operational Readiness Review Standards Remediation Plan		
Standard XII—Practice Guidelines		
Requirement	Supporting Documentation	Score
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	The Dental Advisory Committee Charter demonstrates structured provider and stakeholder involvement in the review and adoption of clinical practice guidelines, ensuring alignment with member needs. The Dental Practice Guidelines and Prior Authorization Policy has been updated to clearly describe how clinical practice guidelines are adopted, including consideration of member demographics, utilization, and access needs, along with incorporation of evidence-based sources and stakeholder input. Additionally, the Process to Communicate Clinical Criteria supports consistent implementation of these guidelines within utilization management processes. - SXII_Iowa Dental Advisory Committee Charter<Entire Document> - SXII_UM01-INS-IA-Dental Practice Guidelines and Prior Authorization<Pg. 1 & 23> - SXII_SOP Process to Communicate Clinical Criteria Develop Iowa Decision Documents<Pg. 2>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/08/2026		
HSAG Feedback: The PAHP's remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
3. The PAHP adopts practice guidelines that are adopted in consultation with network providers.	HSAG Required Evidence: - Policies and procedures - List of adopted practice guidelines specific to Iowa, or list of practice guidelines the PAHP plans to adopt - Iowa-specific meeting minutes documenting committee review/approval, and/or planned meeting schedule and agenda - Evidence of consultation with network providers in Iowa, or plan/timeline to consult with network providers	☐ Met ☒ Not Met
42 CFR §438.236(b)(3) 42 CFR §457.1233(c) Contract G.4.03	Evidence as Submitted by the PAHP:	

Operational Readiness Review Standards Remediation Plan		
Standard XII—Practice Guidelines		
Requirement	Supporting Documentation	Score
	SXII_UM01-INS-Clinical Algorithms <pages 1-4, Procedure A. Formulation/Establishment, B. Adoption, D. Ongoing and Annual Assessment>	
PAHP Description of Process: N/A		
HSAG Findings: While the PAHP's <i>UM01-INS-Clinical Algorithms</i> policy indicated that its utilization criteria and guidelines are reviewed and adopted through the UM Committee and the Peer Review Committee, its policy did not specifically address how it consulted with contracted network providers for the Iowa Medicaid managed care program. Further, the PAHP provided attendees of the UM committee and Peer Review Committee; however, HSAG could not determine that any Iowa-contracted network providers were included on these committees. While PAHP staff members mentioned processes to solicit feedback from the provider community in Iowa and Iowa organizations, these processes were not documented to confirm that the PAHP had appropriate mechanisms to ensure network providers are included in the CPG adoption process.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Update its policy to describe the mechanisms to consult with Iowa network providers as part of the CPG adoption process. - Provide evidence (e.g., committee charter) to confirm that CPGs will be adopted by a local (i.e., Iowa) committee.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	The Iowa Dental Advisory Committee Charter has been provided to demonstrate a formal Iowa-based structure for the review and adoption of clinical practice guidelines, including participation from Iowa network providers and stakeholders. This committee serves as the mechanism for incorporating provider input into the clinical practice guideline adoption process. The UM01 Dental Practice Guidelines and Prior Authorization Policy has been updated to clearly describe the process for consulting with Iowa network providers during guideline adoption, including use of committee review, provider feedback, and stakeholder engagement. - SXII_Iowa Dental Advisory Committee Charter<Entire Document> - SXII_UM01-INS-IA – Dental Practice Guidelines and Prior Authorization <Pg. 1 & 23>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/08/2026		
HSAG Feedback: The PAHP's remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Operational Readiness Review Standards Remediation Plan		
Standard XII—Practice Guidelines		
Requirement	Supporting Documentation	Score
Application of Guidelines		
6. 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) 42 CFR §457.1233(c) Contract G.4.05	HSAG Required Evidence: • Policies and procedures • Hierarchy of coverage criteria • Coverage guidelines/criteria • Plan (including mechanisms) and timeline for monitoring the consistent application of clinical and practice guidelines for service authorization decisions • Plan to incorporate clinical and practice guidelines into member education materials (e.g., dental disease management materials, member newsletters) • Member materials (i.e., member handbook, member newsletters) • Staff training materials Evidence as Submitted by the PAHP: • SXII_UM01-INS-Clinical Algorithms <pages 1-4, Procedure A. Formulation/Establishment, B. Adoption, D. Ongoing and Annual Assessment> • SXII_Sample Provider Newsletter • SXII_Member Handbook Prev Implementation DRAFT	☐ Met ☒ Not Met
PAHP Description of Process: Staff Training materials are currently under development. They will be submitted by May 1, 2026.		
HSAG Findings: HSAG’s review identified the findings below: Although the <i>UM01-INS-Clinical Algorithms</i> policy included its utilization review guidelines and criteria and their associated reference (e.g., ADA, American Academy of Pediatric Dentistry), it did not describe the PAHP’s mechanisms for ensuring member education aligns with its adopted CPGs for the Iowa Medicaid managed care program. While HSAG provided examples for how the PAHP could meet this requirement and requested additional evidence, no documentation was submitted in follow-up.		

Operational Readiness Review Standards Remediation Plan		
Standard XII—Practice Guidelines		
Requirement	Supporting Documentation	Score
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Update its policy and develop a process to describe how the PAHP ensures its member education is aligned with its adopted CPGs.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	The UM01 Dental Practice Guidelines and Prior Authorization Policy has been updated to describe the process for ensuring member and provider education materials are aligned with adopted clinical practice guidelines. This includes review and approval by clinical leadership, including the Iowa Dental Director, to ensure consistency with evidence-based guidelines and state requirements. SXII_UM01-INS-IA – Dental Practice Guidelines and Prior Authorization <Pg. 1 & 23>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/08/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard XIV—Quality Assessment and Performance Improvement Program

Operational Readiness Review Standards Remediation Plan		
Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	Supporting Documentation	Score
Organizational Structure and Staffing		
28. The PAHP provides an initial operational staffing plan to HHS following the requirements in Section A of the Contract. In its staffing plan, the PAHP: - Ensures that staff delivering in-person services are based in Iowa as appropriate. - Includes no less than the staffing areas suggestion in Table 1 under Contract Section A.07. - Encourages a local presence in Iowa, particularly in relation to the delivery of member and provider services. - Includes key personnel positions included on the Staffing Checklist. - Includes a resume for each key personnel member. - Describes what functions are proposed to be conducted outside of Iowa and how out-of-State staff will be supervised to ensure compliance with Contract requirements. - Has more than 50 percent of all work under the Contract in each functional area performed locally in Iowa, with less than 50 percent of all work performed under the Contract performed by PAHP's other corporate locations, unless otherwise approved by HHS. - Onboards in excess of 50 percent of local staff in each functional area of contract performance within 120 days of contract execution. Contract A.04-A.07 Contract A.11 Contract A.14	HSAG Required Evidence: - Policies and procedures - Job descriptions for all personnel defined in the Staffing Checklist - Operational Staffing Plan (as requested via the Questionnaire) - Resume for all key personnel - HSAG will also use the results of the Staffing Checklist Evidence as Submitted by the PAHP: - SXIV_IA Staffing Plan <full document> - SXIV_Iowa Key Personnel Resumes <full document> - SXIV_DentaQuest Iowa Office <full document>	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	Supporting Documentation	Score
PAHP Description of Process: HSAG Findings: HSAG’s review identified the findings below: - The PAHP did not demonstrate adequate staffing to ensure a local presence in Iowa, including a sufficient percentage of staff in each functional area to meet the requirements under sub-element (g). For example, the updated staffing plan indicated a total of seven Contract Center Representatives who are responsible for both member and provider calls. Based on the expected call volume, it is not clear how the PAHP will effectively respond to member and provider calls. Additionally, as the management positions for member and provider services are separate positions (i.e., Member Services Manager and Provider Services Director) and both positions are not located in Iowa, it is unclear how the PAHP will effectively oversee staff members responsible for member and provider support. - The PAHP provided the <i>Iowa Key Personnel Resumes</i> and the <i>IA Staffing Plan</i> Microsoft Excel (Excel) workbook; however, the <i>IA Staffing Plan</i> Excel workbook only included the “Inclusions in Staffing Plan,” listed verbatim from HHS’ contract in column D, which did not provide clarity on the qualifications needed for the key personnel for the PAHP program. - The rows in the <i>IA Staffing Plan</i> Excel workbook that correlated with Requirements 16–24 of HSAG’s <i>Staffing Checklist</i> did not align the positions with the required responsibilities (e.g., responds to member inquiries via a member services helpline as well as written and electronic correspondence; ensures timely and accurate processing of claims; responds to provider inquiries and disputes; and provides outreach on provider policies and procedures). - The PAHP did not provide job postings as requested to confirm that existing staff and staff to be hired have the appropriate qualifications to fulfill the role(s) for the key personnel positions. - Please refer to HSAG Findings, Recommendations, and Required Actions (as applicable to staffing requirements) as noted within other Standard tools (e.g., refer to Standard VII regarding Requirements 3 and 8 of HSAG’s <i>Staffing Checklist</i>).		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must have an adequate staffing plan and sufficient documentation that: - Ensures that staff delivering in-person services are based in Iowa as appropriate. - Includes a sufficient number of staffing in each functional area to comply with Contract Section A.07. - Encourages a local presence in Iowa, particularly in relation to the delivery of member and provider services. - Includes a resume for each key personnel member that demonstrates appropriate qualifications for the filled roles. - Has more than 50 percent of all work under the Contract in each functional area performed locally in Iowa, with less than 50 percent of all work performed under the Contract performed by the PAHP’s other corporate locations, unless otherwise approved by HHS. - Onboards in excess of 50 percent of local staff in each functional area of contract performance within 120 days of contract execution.		

Operational Readiness Review Standards Remediation Plan		
Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	Supporting Documentation	Score
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	- SXIV_DentaQuest- Iowa Key Staff Combined Job Descriptions- 05.11.2026<Entire Document> - SXIV_DentaQuest- Iowa Key Staff Combined Resumes<Entire Document> - SXIV_DentaQuest- Claims and UM Staffing Justification<Entire Document> - SXIV_DentaQuest- Contact Center Staffing Justification<Entire Document> - SXIV_DentaQuest- Supervision of Out-of-State Staff<Entire Document> - SXIV_DentaQuest- Iowa Key Staff Combined Resumes<Entire Document> - SXIV_DentaQuest- Iowa Personnel Organizational Structure- 05.11.2026<Entire Document> - SXIV_DentaQuest- Iowa Staffing Plan- 05.11.2026<Entire Document> - IA HHS Approval – A_11 Initial Staff (120 Day) Onboarding Supporting Documents: - SXIV_11799_DentaQuest - Document Review - A_11 Initial Staff Onboarding<Entire Document> - SXIV_Aproved (11799 - RE_ Changes Needed - DENTAQUEST)<Entire Document> - SXIV_Changes Needed (11799 - DentaQuest - Document Review - DENTAQUEST)<Entire Document>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/11/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
29. The PAHP’s staffing plan includes a backup personnel plan, including a discussion of the staffing contingency plan for: a. The process for replacement of personnel in the event of a loss of key personnel or others before or after signing the Contract. b. Allocation of additional resources to the Contract in the event of an inability to meet a performance standard.	HSAG Required Evidence: - Policies and procedures - Operational Staffing Plan (as requested via the Questionnaire)	☐ Met ☒ Not Met
	Evidence as Submitted by the PAHP: SXIV_IA Staffing Plan <full document>	

Operational Readiness Review Standards Remediation Plan		
Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	Supporting Documentation	Score
c. Replacement of staff with key qualifications and experience and new staff with similar qualifications and experience. d. The time frame necessary for obtaining replacements. e. The method of bringing replacements or additions up to date regarding the Contract. Contract A.07(d)		
PAHP Description of Process: In the event of a loss or vacancy of Key Personnel, DentaQuest will promptly assign a qualified internal employee to assume the responsibilities of the role on an interim basis, ensuring continuity of operations. The recruitment and replacement process may take up to eight weeks to allow sufficient time to identify and secure the most qualified candidate. Once onboarded, the new Key Staff member will receive comprehensive role-specific training from a designated Subject Matter Expert (SME) within the department to ensure full alignment with contract requirements, operational processes, and performance expectations.		
HSAG Findings: The PAHP provided the <i>IA Staffing Plan</i> Excel spreadsheet, which did not include information related to a backup personnel plan. While the PAHP did include a short description of its process within the <i>PAHP Description of Process</i> for this element, HSAG did not receive policies and procedures and/or a contingency plan. During the review, HSAG requested that the PAHP include a backup plan within a policy and procedure and/or a workplan; however, this was not provided as a follow-up item. Instead, the PAHP provided a <i>DentaQuest- Iowa Staffing Plan- 3.25.2026</i> spreadsheet and <i>DentaQuest- Iowa Personnel Organizational Structure- 03.25.2026 1</i>, which did not satisfy the intent of this element.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Provide a backup personnel plan that addresses all components under Contract A.07(d).		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	The Staffing Contingency and Backup Personnel SOP was updated to address all components under Contract A.07(d). It explains the process behind our staffing plan that ensures back-up coverage aligns with all expectations. SXIV_IA-SOP-Staffing Contingency and Backup Personnel<Entire Document>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/08/2026		

Operational Readiness Review Standards Remediation Plan		
Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	Supporting Documentation	Score
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
30. <i>The PAHP provides initial and ongoing training and ensures all staff are trained in the areas listed in the Staff Training Checklist.</i> a. <i>The PAHP maintains documentation to confirm staff training, curriculum, schedules, and attendance.</i> Contract A.13	HSAG Required Evidence: • Policies and procedures • Staff training tracking mechanisms • Staff Training Plan (as requested via the Questionnaire) • HSAG will also use the results of the Staff Training Checklist Evidence as Submitted by the PAHP: • SXIV_COM07-ENT - Training and Education <Page 1> • SXIV_2025 DQ Compliance Training Completion Status Report (sample) <Pages 1-2>	☐ Met ☒ Not Met
PAHP Description of Process:		
HSAG Findings: While the PAHP provided some training materials and the <i>DentaQuest SOP_Iowa Medicaid CHIP Training Requirements_03.31.2026</i> SOP, these materials and the SOP did not provide specific details on the PAHP’s plan to ensure all applicable staff receive education and training to ensure compliance with all program-related requirements. The SOP only indicated that “[a]ll staff and subcontracted staff must complete training that includes, but not limited to:…Iowa Medicaid and CHIP Contract components [and] Iowa-specific providers and non-Medicaid Resources.” Additionally, HSAG noted the following deficiencies: • Requirement #7 required the PAHP to provide “[t]raining regarding interpretation and application of UM guidelines for all UM staff”; however, the PAHP provided a <i>UM Initial and Ongoing Training Clinical Criteria</i> document that only contained two brief paragraphs on the “Inter-Rater Reliability Program” and “New Hire Training,” as well as a <i>Sample Clinical Training Materials</i> PowerPoint slide deck, which did not include Iowa-specific training for the UM staff. However, the PAHP confirmed that staff training materials will not be available until May 2026 as reported under Standard VII and the <i>Post-Site Review Tracker</i>.		

Operational Readiness Review Standards Remediation Plan		
Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	Supporting Documentation	Score
- Requirement #8 required the PAHP to provide “[t]raining and education to understand abuse, neglect, exploitation, and prevention including the detection, mandatory reporting, investigation, and remediation procedures and requirements.” While the <i>2025 Abuse-Neglect-Exploitation Training Final</i> PowerPoint deck included training and education to understand abuse, neglect, and exploitation, HSAG found a brief procedure list on page 20 that included: “1. Staff identifies a potential critical incident. This could be on a call, patient visit or any other type of interaction. 2. Staff notifies their Supervisor/Manager of the nature of the incident. 3. Supervisor/Manager will contact the appropriate Client Services Partner. Depending on the specific details of the incident, the Client, local authorities, etc., may be contacted. 4. If an immediate threat is made to DentaQuest and/or its employees, HR will be notified and potentially the appropriate authorities.” However, HSAG expected to see a workflow and/or procedure to document the steps that the staff member would take to report and investigate, and remediate abuse, neglect, and exploitation similar to what the PAHP provided for Requirement #2 (i.e., <i>Initial training–CGA–Quality of Care_Critical Incidents_Site visits</i> document), which outlined the process to create and investigate quality of care issues. During the review, HSAG requested the PAHP to provide a procedure document; however, the PAHP submitted the <i>DentaQuest SOP_Iowa Medicaid CHIP Training Requirements_03.31.2026</i> SOP, which only included “[a]buse, neglect, and exploitation prevention (including detection, mandatory reporting, investigation, and remediation)” with no additional details such as a procedure document. - Requirement #9 required the PAHP to provide “[t]raining specific to Iowa providers and non-Medicaid resources”; however, the PAHP provided the <i>NET03-INS-Provider Partner Staffing and Training-FINAL</i> policy and procedure, which was labeled as “All States” and “All lines of business” and did not include a specific Iowa Exhibit or Addendum. During the review, HSAG requested specific training and/or an Iowa Exhibit or Addendum for its Iowa providers; however, this was not provided after the review.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Provide an adequate training plan and documentation that addresses all operational program areas, including expected completion dates for department-specific trainings. - Refer to <i>HSAG Findings</i> within each Standard tool, as applicable, to address any program-related findings related to training. Of note, the PAHP will be required to attest that all training materials are Iowa-specific and will be provided to all hired staff prior to July 1, 2026, through a follow-up session that will occur with HSAG. Any failure to demonstrate sufficient training may result in a <i>Not Ready</i> status.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	- SXIV_IA All Staff Annual Training<Entire Document> - SXIV_Iowa All Staff Annual Training Schedule<Entire Document>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/08/2026		



Operational Readiness Review Standards Remediation Plan		
Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	Supporting Documentation	Score
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. However, HSAG recommends that the PAHP ensure all staff are trained on Iowa program requirements by June 19, 2026, according to the <i>Iowa All Staff Annual Training Schedule</i> .		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted

Standard XV—Program Integrity

Operational Readiness Review Standards Remediation Plan		
Standard XV—Program Integrity		
Requirement	Supporting Documentation	Score
Provider Disclosures/Provider Applications for Program Integrity Reasons		
17. <i>The PAHP implements in its provider enrollment processes the obligation of providers to disclose the identity of any person described in 42 CFR §1001.1001(a)(1) as well as other permissible exclusions that would impact the integrity of the provider enrollment.</i> a. <i>The PAHP forwards such disclosures to HHS.</i> b. <i>The PAHP abides by any direction provided by HHS on whether or not to permit the applicant to be a provider in the program.</i> i. <i>Specifically, the PAHP does not permit the provider to become a network provider if HHS or the PAHP determines that any person who has ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the Title XX Services program, or if HHS or the PAHP determines that the provider did not fully and accurately make any disclosure pursuant to 42 CFR §1001.1001(a)(1).</i> 42 CFR §1001.1001(a)(1) Contract I.11.06	HSAG Required Evidence: • Policies and procedures • Provider contract template • Disclosure of ownership and control notice template • Reporting mechanisms • Staff training materials Evidence as Submitted by the PAHP: • SXV_PEC01-INS-Credentialing Guidelines Redacted 5–6 • SXV_COM12-ENT – OIG/GSA Exclusion Review – Pages 1–4 • SXV_Disclosure of Ownership & Control Form Pages 1–5 (Entire Document) • SXV_Disclosure of Ownership – Instructions – Pages 1–5 (Entire Document)	☐ Met ☒ Not Met
PAHP Description of Process: NA		

Operational Readiness Review Standards Remediation Plan		
Standard XV—Program Integrity		
Requirement	Supporting Documentation	Score
HSAG Findings: The documents submitted did not include the requirements of this element. HSAG requested that the PAHP include the Iowa-specific requirements in its appropriate program integrity policy and/or procedure. However, the PAHP did not provide a revised policy inclusive of the Iowa-specific requirements as requested.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Revise its appropriate policy(ies), procedure(s), templates, etc., to include the Iowa-specific requirements of this element.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	SXV_17,19_PEC01-INS-Credentialing Guidelines_IA <Pg. 16 Bullet 2>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/11/2026		
HSAG Feedback: The PAHP's remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
Medicaid Excluded Providers		
18. <i>The PAHP may not employ or contract with providers excluded from participation in Federal and State health care programs under either section 1128 or section 1128A of the Social Security Act.</i> a. <i>The PAHP checks employees and subcontractors every month against the Office of Inspector General's (OIG's) List of Excluded Individuals/Entities (LEIE), the General</i>	HSAG Required Evidence: - Policies and procedures - Three consecutive examples of documentation supporting the monthly screening of employees for sanctions/exclusions (proof of sources must be included) - Three consecutive examples of documentation supporting the monthly screening of providers for	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard XV—Program Integrity		
Requirement	Supporting Documentation	Score
<i>Services Administration (GSA) System of Aware Management (SAM; formerly known as the GSA Excluded Parties List System [EPLS]), the Social Security Administration Death Master File (SSDMF), the National Plan and Provider Enumeration System (NPPES), and the Iowa Medicaid exclusion list to ensure that no employee or subcontractor has been excluded.</i> b. <i>The PAHP checks the lists of providers currently excluded by the State and the federal government every 30 days. In addition, the PAHP checks the SSDMF, the NPPES, the SAM, the Medicare Exclusion Database (MED) and any such other databases as the Secretary of DHHS may prescribe.</i> 42 CFR §438.214(d)(1) 42 CFR §457.1233(a) Contract E.3.03 Contract I.1.01–I.1.02 Contract I.1.07 Contract I.2.16	sanctions/exclusions (proof of sources must be included) - Plan for ongoing monitoring of sanctions/exclusions - Written agreement with the delegated entity if ongoing monitoring of sanctions/exclusions will be completed by the delegated entity - Staff training materials Evidence as Submitted by the PAHP: - SXV_COM12-ENT-OIG-GSA Exclusion Review Pages 1–4 - SXV_PEC01-INS-Credentialing Guidelines_Redacted Pages 5–6 - SXV_PEC04-INS-Provider Maintenance and Ongoing Monitoring Page 3-6 - SXV_PEC05-INS-Provider Disciplinary Action CAP and Appeal Policy-FINAL_Redacted Pages 2–4 - SXV_HRDQ1-ENT - Background Checks_Redacted 1–3	
PAHP Description of Process: NA		
HSAG Findings: The PAHP did not provide documentation to demonstrate it will conduct monthly checks against the Social Security Administration Death Master File (SSDMF) and National Plan and Provider Enumeration System (NPPES) for PAHP employees. HSAG requested that the PAHP include the Iowa-specific requirements in its appropriate program integrity policy and/or procedure. However, although the PAHP provided additional supporting evidence under Standard VIII—Provider Selection, the PAHP did not provide additional evidence that confirmed the process for monitoring employees monthly. Recommendations: HSAG strongly recommends that the PAHP develop a monitoring mechanism to demonstrate compliance with monthly checks. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Revise the appropriate policy(ies) to include the SSDMF and NPPES monthly checks for PAHP employees (e.g., licensed dental staff).		

Operational Readiness Review Standards Remediation Plan		
Standard XV—Program Integrity		
Requirement	Supporting Documentation	Score
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	Policy COM12-ENT-OIG-GSA Exclusion Review has been updated to include the required language. The department executive responsible has reviewed and approved the required policy and is available for download and review. The employee exclusions screening process, which is managed by the Human Resources department will be monitored for accuracy and compliance. SXV_COM12-ENT-OIG-GSA Exclusion Review<Pg. 2-4 & 6>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/11/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
Reporting Obligations for Adverse Actions Taken on a Provider		
19. <i>The PAHP notifies HHS and the Office of the Inspector General (OIG) of provider decredentialing for program integrity reasons and in compliance with 42 CFR Part 1001.</i> 42 CFR Part 1001 Contract I.11.05	HSAG Required Evidence: - Policies and procedures - Provider termination workflow (for program integrity reasons) - Program integrity/fraud, waste, abuse plan - Identification and reporting mechanisms - Staff training materials Evidence as Submitted by the PAHP: - SXV_PEC05-INS-Provider Disciplinary Action CAP and Appeal Policy-FINAL_Redacted Pages 2–4 - SXV_Program Integrity Compliance Plan – Pages 4 and 7 - SXV_FPR01-INS-DENT-FPR Program-FINAL 2018_Redacted 1–4	☐ Met ☒ Not Met

Operational Readiness Review Standards Remediation Plan		
Standard XV—Program Integrity		
Requirement	Supporting Documentation	Score
PAHP Description of Process: DentaQuest has been informed that Program Integrity (PI) training with the state is scheduled to begin in May. At this time, DentaQuest does not have access to the reporting manual or the reporting templates for this section, as these materials are expected to be provided and discussed during the training.		
HSAG Findings: The PAHP did not submit documentation to demonstrate that it will report to HHS and OIG after the decredentialing of a provider due to program integrity reasons. During the review, HSAG requested that the PAHP include the Iowa-specific requirements in its appropriate program integrity policy and/or procedure. However, a revised policy was not submitted as requested. Recommendations: HSAG strongly recommends that the PAHP develop a tracking and reporting mechanism to demonstrate compliance with the requirements of this element.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Revise and submit written documentation (e.g., policy, procedure, program integrity plan) that outlines the steps that occur after the decredentialing of a provider due to program integrity reasons, including the entities that require notification.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	SXV_17, 19_PEC01-INS-Credentialing Guidelines_IA <Pg. 16 Bullet 3>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/11/2026		
HSAG Feedback: The PAHP's remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Appendix C. Information Systems Readiness Review Standards

Standard XIII—Health Information Systems

Standard XIII—Health Information Systems		
Requirement	Supporting Documentation	Score
General Rule		
1. The PAHP maintains a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of Medicaid managed care requirements. The systems provide information on areas including, but not limited to: a. Utilization b. Claims c. Grievances and appeals d. Disenrollments for other than loss of Medicaid eligibility 42 CFR §438.242(a) 42 CFR §457.1233(d) Contract K.02 Contract K.03 Contract K.12(a)(f)(i)(j)	HSAG Required Evidence: • Policies, procedures, and workflows • Systems integration mapping documentation • Current Information Systems Capabilities Assessment Tool (ISCAT), if available • Technical manual(s) • List of disenrollment codes (i.e., reasons for disenrollment) provided by HHS • Screenshot of disenrollment codes available in the disenrollment system • HSAG will use the results from the information systems demonstration, including reporting capabilities • HSAG will use the results from the systems demonstrations included as part of the Disenrollment Requirements and Limitations Standard, Coverage and Authorization of Services Standard, and the Grievance and Appeal Systems Standard Evidence as Submitted by the PAHP: • SXIII_ENR01-INS-Member Enrollment<Entire Document> • SXIII_Windward High-Level Workflow<Entire Document> • SXIII_Enrollment and eligibility subsystem High Level Workflow<Entire Document>	☐ Met ☒ Not Met

Standard XIII—Health Information Systems		
Requirement	Supporting Documentation	Score
	- SXIII_Information Security Plan <Entire Document – technical manual> - SXIII_CL01-INS-Claims Processing<Entire Document>	
PAHP Description of Process: Disenrollment codes are typically received from the State via the Companion Guide; however DentaQuest has not yet received them. Once received, our teams input the codes to the system for eligibility. This can be demonstrated in the systems demonstration, proper screenshots will be provided after the virtual review.		
HSAG Findings: HSAG’s review identified the findings below: - Based on the PAHP-submitted implementation plan, the PAHP indicated it received the companion guide from HHS as of 12/25/2025. However, during the interviews, the PAHP staff members stated that they still had not received the companion guide and therefore did not have the member disenrollment codes. The PAHP also updated the <i>ENR01-INS-MemberEnrollment</i> policy with Exhibit K to include member disenrollment codes. Based on the documentation submitted, and discussions with the PAHP, there is a disconnect between the PAHP-submitted documentation and information shared by the PAHP during the interviews. - Per HHS, disenrollment codes are not included in 834 files. The update made in the policy, “DentaQuest will store the following disenrollment codes as provided on the 834 member enrollment file for downstream reporting,” does not align with the HHS guidance.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Provide a copy of the HHS companion guide as well as a documented policy on how the PAHP identifies and incorporates disenrollment codes within Windward.		
Basic Elements of a Health Information System		
2. The Information Systems (IS) implemented by the PAHP shall include the following general system requirements but may not necessarily be limited to these requirements: (i) on-line access; (ii) on-line access to all major files and data elements within the IS; (iii) timely processing; (iv) daily file updates of enrolled member, provider, prior authorization and claims to be processed; and (v) weekly file updates of reference files and claim payments. a. Edits, Audits and Error Tracking: The PAHP shall employ comprehensive automated edits and audits to ensure that data are valid and that Contract requirements are met. The IS shall	HSAG Required Evidence: - Policies, procedures, and workflows - Completed ISCAT - Information system continuity and contingency plans - HSAG will use the results from the information systems demonstration	☐ Met ☒ Not Met
	Evidence as Submitted by the PAHP: SXIII_DentaQuest DRP v51 TOC<Entire Document>	

Standard XIII—Health Information Systems		
Requirement	Supporting Documentation	Score
track errors by type and frequency and maintain adequate audit trails to allow for the reconstruction of processing events. b. <i>System Controls and Balancing: The IS shall have an adequate system of controls and balancing to ensure that all data input can be accounted for and that all outputs can be validated.</i> c. <i>Back-Up of Processing and Transaction Files: The PAHP shall employ the following back-up timelines: (i) 24- hour back-up of eligibility verification, enrollment/eligibility update process, and prior authorization processing; (ii) 72-hour back-up of claims processing; and (iii) two weeks back-up of all other processes.</i> Contract K.13		
PAHP Description of Process: N/A		
HSAG Findings: HSAG’s review identified the findings below: - After the review, the PAHP provided a <i>2025 DentaQuest Dental Benefit Plan SOC 1 Report 1</i>. The report provided information that the PAHP has policies and procedures in place, but it was not clear for Requirement 2.a, how the PAHP’s information systems track errors by type and frequency and maintain adequate audit trails to allow for the reconstruction of processing events. - HSAG was unable to identify if the PAHP is able to employ backup timelines based on Requirement 2.c.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Update applicable documents and implement appropriate processes to address Requirements 2.a and c. The documentation should include clearly stated policies and procedures or desktop process documents that outline how the PAHP ensures accuracy and completeness of input and output data, as well as established backup processing procedures and timelines.		
3. The PAHP shall perform the following IS functions through a system that integrates the PAHP’s clinical record information, authorization, and claims payment data:	HSAG Required Evidence: - Policies, procedures, and workflows - Completed ISCAT - HSAG will use the results from the information systems demonstration	☐ Met ☒ Not Met

Standard XIII—Health Information Systems		
Requirement	Supporting Documentation	Score
a. Reporting. Maintain information and generate reports required by the performance indicators established to assess the PAHP’s performance. b. Capitation Payment. Maintain data documenting receipt and distribution of the capitation payment. c. Clinical Data. Maintain clinical and functional outcomes data and data to support quality activities. i. <i>The PAHP will use the clinical data to appropriately manage the care being provided to members.</i> ii. <i>The PAHP will use the data in its management of providers, assessment of care being provided to members, to develop new services that will increase access and improve cost-effectiveness of the program, and to implement evidence-based practices across the provider network.</i> d. Ad Hoc Reporting. Maintain the capacity to perform ad hoc reporting on an “as needed” basis, with a turnaround time as determined by HHS. Contract K.12(d)(e)(h)(k) Contract K.14	Evidence as Submitted by the PAHP: SXIII_CL01-INS-Claims Processing<Entire Document>	
PAHP Description of Process: N/A		
HSAG Findings: The documents provided by the PAHP did not include the evidence supporting Requirements 3.b–d. HSAG requested that the PAHP include the requirements in its Iowa-specific description. The PAHP submitted <i>SXIII_CL01-INS-Claims Processing_Exhibit Q_Iowa Medicaid</i> after the review; however, HSAG was unable to locate the PAHP’s processes related to Requirements 3.b–d.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Provide policies or desktop procedures to address Requirements 3.b–d.		

Standard XIII—Health Information Systems		
Requirement	Supporting Documentation	Score
Application Programming Interface		
4. The PAHP implements an Application Programming Interface (API) as specified in 42 CFR §431.60 (member access to and exchange of data) as if such requirements applied directly to the PAHP. Information is made accessible to its current members or the members’ personal representatives through the API as follows: a. <i>Data concerning adjudicated Claims, including Claims data for payment decisions that may be Appealed, were Appealed, or are in the process of Appeal, and provider remittances and beneficiary cost-sharing pertaining to such Claims, no later than one (1) business day after a Claim is processed;</i> b. <i>Encounter data, including encounter data from any Network Providers the Contractor is compensating on the basis of Capitation Payments and adjudicated Claims and encounter data from any subcontractors no later than one (1) business day after receiving the data from Providers;</i> c. <i>Clinical data, including laboratory results, if the Contractor maintains any such data, no later than one (1) business day after the data is received by the State; and</i> d. <i>Implementation and maintenance of a publicly accessible standards-based API as described in 42 CFR 431.70, which must include all of the provider directory information specified in 42 CFR 438.10(h)(1) and (2).</i> 42 CFR §438.242(b)(5-6) 42 CFR §431.60 42 CFR §457.1233(d) (2-3) Contract K.48	HSAG Required Evidence: • Policies, procedures, and workflows • API documentation, such as project plan(s), testing plan/results member educational materials, website materials, etc. • List of registered third-party applications • HSAG will use the results from the API demonstration Evidence as Submitted by the PAHP: • SXIII_DS02-ENT-Salesforce Portal Data Maintenance.pdf <Entire Document>	☐ Met ☒ Not Met
PAHP Description of Process: The system is still being configured, and materials are still being developed. Documentation and materials will be available closer to the go live of 7/1.		
HSAG Findings: HSAG’s review identified the findings below:		

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Requirement	Supporting Documentation	Score
- While the PAHP staff members were able to articulate appropriate processes for the implementation of the Application Programming Interface (API), the <i>DS02-ENT-Salesforce Portal Data Maintenance</i> policy originally cited by the PAHP as evidence of compliance pertained to the member and provider portals, which are not interchangeable with the Patient Access API and no other documentation was submitted to support compliance. - During the review, HSAG requested the API workflow that was demonstrated to be updated to include the PAHP’s process to ensure updated information is accessible to members within one business day (daily refresh); the links to information on the PAHP’s website for developers and members; and a crosswalk of the United States Core Data for Interoperability (USCDI) elements, and whether the PAHP maintains that information in its system and therefore should be accessible to members via the API. Based on the documentation submitted after the review, HSAG identified the following concerns: - The <i>FHIR Interoperability_WF</i> document was not updated to include the PAHP’s process to ensure updated information is accessible to members within one business day (daily refresh) as requested by HSAG. - The PAHP resubmitted the same policy that was submitted for HSAG’s desk review that pertained to the member and provider portals and are not synonymous to the Patient Access API. Therefore, while the PAHP indicated that “APIs allows Provider and Member Portal to display close to real-time data,” HSAG could not determine the applicability of the statement and the member and provider portals to the Patient Access API. - While the PAHP suggested that the <i>DS02-ENT</i> policy resubmitted after the review included the “listed data” accessible via the API, the policy applied to the member and provider portals, which are not synonymous to the Patient Access API. Therefore, HSAG could not determine the applicability to the Patient Access API. Additionally, while HSAG reviewed the “FHIR Patient Access” webpage for developers, HSAG could not determine the specific data elements associated with the USCDI. Further, HSAG specifically requested a crosswalk of all USCDI data elements and whether the PAHP maintains that information in its system and it therefore should be accessible to members via the API. This was not provided as requested. During the review, HSAG acknowledged that the PAHP may not maintain a large amount of data that is associated with the USCDI; therefore, a crosswalk could have easily been created and submitted. - The information for members regarding the API was included on the PAHP’s corporate website; therefore, HSAG requested how members would be informed of the Patient Access API and where to locate this information. During the review, while PAHP staff members initially suggested that including API information on plan-specific websites is not required, PAHP staff members later clarified that the PAHP can include a link on its Iowa Medicaid managed care program’s website and demonstrated an “Interoperability API” footer link that can be included on the PAHP’s website. Please note that the PAHP is required to provide members with resources via an “accessible location on its public website and through other appropriate mechanisms through which it ordinarily communicates with current and former beneficiaries seeking to access their health information held by the State Medicaid agency, educational resources in non-technical, simple and easy-to-understand language....” While the PAHP’s corporate website, with an “Interoperability API” footer link, included a pathway for members to search for a specific dental plan, Iowa members were accessing an Iowa-specific landing page to access information on their dental plan (e.g., where members can access the Iowa Medicaid managed care member handbook, member newsletters, and other member resources for Iowa). Therefore, the PAHP must proceed with including a footer link on its Iowa-specific member		

Standard XIII—Health Information Systems		
Requirement	Supporting Documentation	Score
website. Further, the language “Interoperability API” would not meet the information requirements under 42 CFR §438.10(d)(6)(i), which requires the PAHP to provide all written member materials in an easily understood language and format, nor does “Interoperability API” appear to meet the PAHP’s required reading grade level. Examples of member friendly language for footer links may include “Access to your records” and “Click here to learn how you can access your health information” (please note that these are examples only, and the PAHP must decide which language to use). Lastly, while the narrative under the “Your Privacy Rights” section informed members that they can submit a complaint to the Office for Civil Rights (OCR), it did not inform members that they can also submit a complaint to the Federal Trade Commission (FTC). Recommendations: During the review, the PAHP staff members confirmed that they have no third-party developers registered with the PAHP to make an application available to members to access their health information via the Patient Access API. The PAHP indicated that the PAHP’s responsibility is to implement the API in accordance with CMS’ technical standards and that there is a lack of developer interest in the API. However, it is unclear to HSAG why the PAHP has not proactively outreached to developers in an attempt to make a registered application available to members. Further, the PAHP confirmed awareness of multiple third-party developers by posting a link to “My Health Application.” Lastly, HSAG has conducted multiple compliance reviews with MCPs across several states and not only do most MCPs have one or more registered developers, several are able to provide system demonstrations of the applications through a sandbox environment. As such, HSAG recommends that the PAHP proactively make efforts to onboard a third-party developer, especially as CMS continues to enhance the interoperability requirements. HSAG also recommends that the PAHP ensure it implements the Provider Access, Payer-to-Payer Access, and Prior Authorization APIs by the required implementation dates. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Develop and submit a policy specific to CMS’ interoperability requirements. This policy should not only include the federal requirements but include a description for how the PAHP has implemented the APIs. - Update the <i>FHIR_Interoperability_WF</i> and/or the PAHP’s newly created interoperability policy to explain how the PAHP ensures it provides member access to updated information within one business day of receipt of new or updated information. - Create a crosswalk of USCDI elements, and which elements the PAHP maintains in its system and are accessible via the API.		
5. The PAHP maintains a publicly accessible standards-based API described in 42 CFR §431.70 (access to published provider directory information), which must include all information specified in 42 CFR §438.10(h)(1) and (2). 42 CFR §438.242(b)(6) 42 CFR §431.70 42 CFR §438.10(h)(1-2) 42 CFR §457.1233(d)	HSAG Required Evidence: - Policies, procedures, and workflows - API documentation, such as project plan(s), testing plans/results, stakeholder educational materials, website materials, etc. - List of registered third-party applications - HSAG will use the results from the web-based provider directory demonstration	☐ Met ☒ Not Met

Standard XIII—Health Information Systems		
Requirement	Supporting Documentation	Score
Contract K.48	Evidence as Submitted by the PAHP: SXIII_MKT05-INS-SOP-Website Accessibility <Entire Document>	
PAHP Description of Process: The system is still being configured, and materials are still being developed. Documentation and materials will be available closer to the go live of 7/1.		
HSAG Findings: HSAG’s review identified the findings below: - While the PAHP staff members were able to articulate appropriate processes for the implementation of the API, the <i>DS02-ENT-Salesforce Portal Data Maintenance</i> policy originally cited by the PAHP as evidence of compliance pertained to the member and provider portals, which are not interchangeable with the Provider Directory API, and no other documentation was submitted to support compliance. - The PAHP did not have an online provider directory; therefore, HSAG is unable to confirm the Provider Directory API complied with 42 CFR §438.10(h)(1-2). - Discussion during the review suggested that stakeholders would need to request permission from the PAHP to access the Provider Directory API. However, while the federal rule does not prohibit the PAHP from requiring developers to register with the PAHP, the Provider Directory API must be publicly accessible and does not require user authentication, authorization, or any other protocols that restrict the availability of the information (i.e., “...excluding the security protocols related to user authentication and authorization, or any other protocols that restrict the availability of this information to anyone wishing to access...”). CMS further clarified that the requirement to make provider directory information available without authentication or authorization applies to the user and not the application. Therefore, based on discussion during the review, HSAG could not confirm that the PAHP’s Provider Directory API was readily accessible to any member of the public without having to request access from the PAHP.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Develop and submit a policy specific to CMS’ interoperability requirements. This policy should not only include the federal requirements but include a description for how the PAHP has implemented the APIs. - Provide confirmation that users can access provider directory information via the API without authorization or permission from the PAHP. - Provide a response file(s) for an Iowa-contracted network provider and the corresponding link to the provider’s profile in the online provider directory. The response file must confirm that all provider details required under 42 CFR §438.10(d)(1) are accessible via the API.		
Data Exchange and Management		
6. <i>The PAHP’s information system/IS shall support and maintain compliance with current and future versions of the Health Insurance Portability and Accountability Act (HIPAA)</i>	HSAG Required Evidence: - Policies, procedures, and workflows - Data exchange guidelines	☒ Met ☐ Not Met

Standard XIII—Health Information Systems		
Requirement	Supporting Documentation	Score
<i>Transaction and Code Set requirements for electronic health information data exchange and Privacy and Security Rule standards as specified in 45 CFR Parts 160, 162 and 164.</i> a. <i>The PAHP's IS plans for privacy and security shall include, but not be limited to: (i) administrative procedures and safeguards (45 CFR §164.308); (ii) physical safeguards (45 CFR §164.310); and (iii) technical safeguards (45 CFR §164.312).</i> Contract K.18	- HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities Evidence as Submitted by the PAHP: - SXIII_Information Security Plan <Pg 35 Network Security Standard and Pg 37 Physical Security Standard> - SXIII_CDM04-INS-EDI HIPAA Compliance <Entire document>	
PAHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
7. <i>All data shared by the PAHP with HHS uses the format specified by HHS, including use of valid values that will be accepted by each code field.</i> Contract K.38	HSAG Required Evidence: - Policies, procedures, and workflows - Data exchange guidelines - HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities Evidence as Submitted by the PAHP: - SXIII_CDM02-INS-Encounter Submissions-FINAL<Entire Document>	☒ Met ☐ Not Met
PAHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Recommendations: While the evidence generally meets the element, HSAG recommends that the PAHP update its policy to include more specifics related to the HHS-specified format including use of valid values that will be accepted by each code field.		

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Requirement	Supporting Documentation	Score
Required Actions: None.		
8. The PAHP submits provider network information via electronic file to HHS in the timeframe and manner defined by HHS. a. The PAHP keeps provider enrollment and disenrollment information up to date. Contract K.40	HSAG Required Evidence: - Policies, procedures, and workflows	☐ Met ☒ Not Met
	Evidence as Submitted by the PAHP: SXIII_NET01-INS-Network Development Maintenance and Use<Pg. 4 Directories>	
PAHP Description of Process: N/A		
HSAG Findings: The documents provided by the PAHP did not include the requirements of this element. The PAHP submitted <i>SXIII_IA Provider Master List Instructions</i> <Entire Document> after the review; however, this file contained instructions on how to properly set up a provider in Windward but did not speak to how the PAHP will submit provider network information via an electronic file to HHS in the time frame or manner defined by HHS. Additionally, HSAG was unable to locate documentation (e.g., desktop procedure, policy) to support the PAHP’s processes to ensure that provider enrollment and disenrollment information is up to date. In review of the submitted policy, <i>Provider Directory Maintenance and Ongoing Monitoring</i> , HSAG was able to ascertain how provider enrollments and updates to existing providers would be completed; however HSAG was unable to identify how disenrollments would be updated in the PAHP’s source system and the provider directory.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Provide updated documentation and implement appropriate processes to address Requirement 8. The PAHP should include an example of the file format that will be utilized to submit provider network information to HHS, as well as the frequency in which this file will be shared with HHS. Additionally, the PAHP should provide updated documentation on how the PAHP will ensure that provider enrollment and disenrollment information is maintained and information is kept up to date within the source system and the provider directory. This can be presented in the form of a policy, procedural document, or desktop process.		

Standard XIII—Health Information Systems		
Requirement	Supporting Documentation	Score
Third Party Liability		
9. <i>The PAHP exercises full assignment rights as applicable and makes every reasonable effort to determine the liability of third parties to pay for services rendered to members under the Contract and cost avoid and/or recover any such liability from the third party.</i> a. <i>The PAHP develops, implements, and adheres to policies and procedures to meet its obligations regarding third-party liability (TPL) when the third party pays a cash benefit to the member for medical claim expenses, regardless of services used, or does not allow the member to assign their benefits.</i> b. <i>When there is a liable third party, the PAHP pays the member's coinsurance, deductibles, co-payments, and other cost-sharing expenses up to the PAHP's allowed amount.</i> c. <i>The PAHP's total liability does not exceed the PAHP's allowed amount minus the amount paid by the primary payer.</i> d. <i>The PAHP follows all activities laid out in the most recent HHS Medicaid TPL Action Plan, and most recent CMS handbook called Coordination of Benefits and Third-Party Liability (COB/TPL) In Medicaid.</i> Contract J.4.02	HSAG Required Evidence: • Policies, procedures, and workflows • TPL processing guidelines • HSAG will use the completed ISCAT and results from the claims testing Evidence as Submitted by the PAHP: • SXIII_CL01-INS-Claims Processing<Entire Document>	☒ Met ☐ Not Met
PAHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		

Standard XIII—Health Information Systems		
Requirement	Supporting Documentation	Score
Continuity and Contingency Planning		
10. <i>The PAHP develops plans for system problem resolution that do not rise to the level of disaster and document such in its global Policies and Procedures Manual (PPM.)</i> a. <i>The PAHP notifies HHS immediately upon identification of network hardware or software failures and sub-standard performance and shall conduct triage with HHS to determine the severity level or deficiencies or defects and determine timelines for fixes.</i> b. <i>The PAHP develops, implements, and adheres to procedures defining the methods for notifying HHS and other applicable stakeholders regarding system problems that do not rise to the level of disaster as defined in Section K.35.</i> Contract K.31 Contract K.32 Contract K.35	HSAG Required Evidence: - Policies, procedures, and workflows - Information system contingency and continuity plans Evidence as Submitted by the PAHP: - SXIII_DQ BCDR Letter of Readiness Feb2026<Entire Document>	☐ Met ☒ Not Met
PAHP Description of Process: N/A HSAG Findings: The PAHP submitted <i>SXIII_DQ BCDR Letter of Readiness Jan2026<Entire Document></i> and <i>SXIII_DentaQuest DRP v51 Redacted<Pg. 15></i>, which included all the requirements but did not include the critical Requirement 10.a. Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Provide an updated policy that addresses Requirement 10.a.		
11. <i>The PAHP develops and submits contingency and continuity planning documents and documents such in its PPM. In addition, the PAHP ensures ongoing maintenance and execution of the HHS-accepted contingency and continuity plans. The PAHP's contingency and continuity planning responsibilities include, but are not limited to:</i>	HSAG Required Evidence: - Policies, procedures, and workflows - Information system contingency and continuity plans Evidence as Submitted by the PAHP: - SXIII Information Security Plan<Pg. 21 Business Continuity, Pg. 31 Encryption & Pg. 44-46 #4>	☒ Met ☐ Not Met

Standard XIII—Health Information Systems		
Requirement	Supporting Documentation	Score
a. <i>Notifying HHS of any disruptions in normal business operations with a plan for resuming normal operations.</i> b. <i>Ensuring members continue to receive services with minimal interruption.</i> c. <i>Ensuring data is safeguarded and accessible.</i> d. <i>Training PAHP staff and stakeholders on the requirements of the information system contingency and continuity plans.</i> e. <i>Conducting annual exercises to test current versions of information system contingency and continuity plans.</i> i. <i>The scope of the annual exercises are approved by HHS.</i> ii. <i>The PAHP provides a report of activities performed, results of the activities, corrective actions identified, and modifications to plans based on results of the exercises.</i> Contract K.35(b)	SXIII_DQ BCDR Letter of Readiness Feb2026<Entire Document>	
PAHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: Although this requirement is considered <i>Met</i> for the purposes of readiness review under Standard XIII—Health Information Systems, HSAG strongly recommends that the PAHP develop a workflow to elaborate on its step-by-step processes to ensure members continue to receive services with minimal interruptions, in the case of a system outage (e.g., call center operations). Please also refer to findings under Standard II—Member Rights and Member Information.		
Required Actions: None.		
12. <i>The PAHP develops IS contingency planning in accordance with 45 CFR §164.308. Contingency plans include:</i> a. <i>Data backup plans;</i> b. <i>Disaster recovery plans;</i> c. <i>Emergency mode of operation plans.</i> Contract K.36	HSAG Required Evidence: - Policies, procedures, and workflows - Information system contingency plans Evidence as Submitted by the PAHP: - SXIII_Information Security Plan <pg. 21> - DQ BCDR Letter of Readiness Feb2026 <Entire Document>	☒ Met ☐ Not Met

Standard XIII—Health Information Systems		
Requirement	Supporting Documentation	Score
	- DentaQuest DRP v51 TOC<Entire Document> - DQ System Data Backup Procedures v1.3 TOC <Entire Document>	
PAHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
13. <i>The PAHP's Application and Data Criticality Analysis and Testing and Revisions procedures are addressed within the required contingency plans.</i> a. <i>The PAHP executes all activities needed to recover and restore operation of information systems, data, and software at an existing or alternate location under emergency conditions within 24 hours of identification or a declaration of a disaster.</i> b. <i>The PAHP protects against hardware, software, and human error.</i> c. <i>The PAHP maintains appropriate checkpoint and restart capabilities and other features necessary to ensure reliability and recovery, including telecommunications reliability, file back-ups, and disaster recovery.</i> Contract K.36	HSAG Required Evidence: - Policies, procedures, and workflows - Information system contingency plans Evidence as Submitted by the PAHP: - SXIII_Information Security Plan<pg. 21> - DentaQuest DRP v51 TOC<Entire Document>	☒ Met ☐ Not Met
PAHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		

Standard XIII—Health Information Systems		
Requirement	Supporting Documentation	Score
14. <i>The PAHP maintains full and complete back-up copies of data and software in accordance with the timelines described in Section K.13 of the Contract.</i> a. <i>The PAHP maintains a back-up log to verify the back-ups were successfully run and back-up status reports are provided to HHS upon request.</i> b. <i>The PAHP stores its data in an off-site location approved by HHS.</i> Contract K.37	HSAG Required Evidence: • Policies, procedures, and workflows • Information system contingency plans	☒ Met ☐ Not Met
	Evidence as Submitted by the PAHP: • SXIII_DQ System Data Backup Procedures v1.3 TOC <Entire Document>	
PAHP Description of Process: N/A		
HSAG Findings: HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.		
Required Actions: None.		
15. <i>The PAHP must develop processes for development, testing, and promotion of system changes and maintenance.</i> a. <i>The PAHP notifies HHS at least 30 days prior to the installation or implementation of “minor” software and hardware upgrades, modifications, or replacements, and 90 days prior to the installation or implementation of “major” software and hardware upgrades, modifications, or replacements.</i> b. <i>The PAHP ensures that system changes or system upgrades are accompanied by a plan that includes a timeline, milestones, and adequate testing to be completed before implementation.</i> i. <i>The PAHP notifies and provide such plans to the HHS upon request in the timeframe and manner specified by HHS.</i>	HSAG Required Evidence: • Policies, procedures, and workflows • Information system testing plan • Technical manual(s) • HSAG will use the results from the information systems demonstration	☐ Met ☒ Not Met
	Evidence as Submitted by the PAHP: • SXIII_ADS03-INS-DENT-WW System Enhancement-FINAL <Entire Document> • SXIII_Information Security Plan <pg. 44>	

Standard XIII—Health Information Systems		
Requirement	Supporting Documentation	Score
ii. The PAHP develops and submits the plan required under this section in its PPM. c. The Contractor ensures the environment for development, system testing, and user acceptance testing is separate from the production environment. Contract K.33 Contract K.34		
PAHP Description of Process: N/A		
HSAG Findings: The PAHP submitted the <i>SXIII_DentaQuest DRP v51 Redacted<Pg. 4-5 & 68></i> policy, which included most of the requirements; however, HSAG was unable to locate any policies and procedures addressing requirement 15.a.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Update applicable policies and implement appropriate processes to address Requirement 15.a.		

Standard XIII—Health Information Systems						
Met	=	7	X	1	=	7
Not Met	=	8	X	0	=	0
Total	=	15	Total Score	=		7
Total Score ÷ Total					=	47%

Standard II—Claims and Encounter Systems

Standard II—Claims and Encounter Systems

Requirement 1: Claims Processing and Encounter Systems—The PAHP must have a claims processing system and Medicaid Management Information System (MMIS) that:

- Collects data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of section 1903(r)(1)(F) of the Social Security Act (electronic claims submission) and in accordance with section 6504(a) of the Affordable Care Act. The PAHP must provide electronic remittance advice and transfers claims payment electronically. The PAHP must have the capacity to process paper claims and track electronic versus paper claim submissions over time to measure success in increasing electronic submissions. The PAHP shall provide electronic remittance advice and transfer claims payment electronically. The PAHP must be able to maintain data on incurred but not yet reimbursed claims and data on the time required to process and mail claims payment.
- Enables the PAHP to manage and monitor its system to ensure collection of data received from providers is accurate and timely; screen the data for completeness, logic, and consistency; and collect data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts in accordance with 42 CFR 438.242(b) and (c). The PAHP shall verify the accuracy and timeliness of data reported by network providers for whom the PAHP is responsible for compensating on the basis of capitation payments.
- Collects and maintains data on member and provider characteristics as specified by HHS, and on services furnished to the recipients through an encounter data system or other method as may be specified by HHS. The PAHP collects and maintains sufficient member encounter data to identify the provider who delivers any item(s) or services(s) to enrolled members. The PAHP shall make all collected data available to HHS and upon request to CMS.
- Accommodates billing of specified enrolled members a cost sharing amount and reduce the payment it makes to a provider by the amount of the member's cost sharing obligation. The PAHP must implement a mechanism to notify providers of an enrolled member's financial participation or cost sharing requirement.

The PAHP should provide a description of its systems for managing the claims processing and encounter data requirements. Evidence includes process flows, policies and procedures, system manuals, process manuals, claims submission requirements documents, claims validation processes, claim timeliness reports, etc.

Reference—42 CFR 438.242; 42 CFR 457.1233; Affordable Care Act, Section 6504(a); Social Security Act, Section 1903(r)(1)(F); HHS Contract Sections K.04, K.05, K.06, K.07, K.08, K.09, K.10(a), K.12(f)(g) and K.41

Score:	☐ Met	☒ Not Met—Action Required
Findings:	HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness of the elements within this requirement with the exception of Requirement 3.d. The PAHP indicated Requirement 3.d is not applicable, as there are no member cost-sharing obligations for this contract. However, the Iowa PAHP contract includes references for member cost-sharing; therefore, the PAHP should have addressed cost-sharing in its written documentation.	
Required Action:	The PAHP should update and submit its policy to align with the member cost-sharing language within its Iowa PAHP Contract.	

Information Submitted as Evidence by the PAHP	
Documents Submitted	Description of the Process
SXIII_CDM02-INS-Encounter Submissions-FINAL SXIII_CL01-INS-Claims Processing SXIII_CL02-INS-Claims Payment	DentaQuest submits encounter data (unaltered claims data) for all services in the format prescribed by the health plan. Claims data is extracted from Windward and submitted in encounter files accurately, completely, and truthfully. There is no member cost sharing for this contract. There is no member cost sharing for this contract.

Standard II—Claims and Encounter Systems

Requirement 2: Claims Submission and Payment Requirements—The PAHP shall:

- Have a claims processing system for both in- and out-of-network providers capable of processing all claims types. The PAHP shall allow in-state network providers to submit claims for reimbursement no more than 180 days from the date of service and shall allow out-of-state providers to submit claims 12 months from the date of service without requiring a PAHP-specified provider number to receive payment.
- Accurately price specific procedures or encounters and maintain detailed records of remittances to providers. Regardless of participating provider status, the PAHP must be able to reimburse Indian Health Care Providers the applicable encounter rates published annually in the Federal Register by the Indian Health Service (IHS), the FQHC rate the providers would receive in Fee-For-Service (FFS) if enrolled in Medicaid as an FQHC, or the amount they would receive if the services were provided under the State Plan's FFS payment methodology.
- Pay 90 percent of all clean claims within 14 days of receipt, 95 percent of all clean claims from providers within 21 calendar days of the date of receipt and pay 99 percent of all clean claims from providers within 90 calendar days of the date of receipt. The PAHP shall accurately adjudicate 90 percent of all clean identified adjustments including reprocessed claims within 30 business days of receipt, and 99 percent within 90 days of receipt. The PAHP shall reprocess all claims processed in error within 30 business days of identification of the error or upon a schedule approved by HHS.
- Develop, implement, and adhere to written policies and procedures, subject to HHS review and approval, to monitor claims adjudication accuracy and for registering and responding to claim disputes from in- and out-of-network providers.
- Obtain HHS approval for any claims forms or payment methodology developed by the PAHP for use by providers and ensure they are in such a format as to assure the submission of encounter data as required under the contract. The PAHP shall comply with any applicable federal regulations, including HIPAA regulations related to transactions, code sets, confidentiality, and submission requirements for protected health information (PHI).
- Require each physician providing services to enrolled members to have a standard unique health identifier in compliance with 42 U.S.C. § 1396u-2(d)(4).
- Require that all providers that submit claims to the PAHP have a National Provider Identifier (NPI) number unless otherwise directed to the Agency in accordance with 45 C.F.R. § 162.410.

The PAHP should provide its policies and procedures for managing the claims processing and payment requirements. Evidence includes process flows, policies and procedures, sample reports, etc.

Reference—42 CFR 447.45, 45 CFR 162.410, 42 USC 1396u-2(d)(4), Iowa Admin. Code r. 441-80.2, HHS Contract Section D.5, D.6, K.41

Score:	☐ Met	☒ Not Met—Action Required
Findings:	Although some elements of this requirement were met, the PAHP submitted SXIII_CL01-INS-Claims Processing_Exhibit Q_Iowa Medicaid after the review, which did not include documentation to meet Requirements 2.b and 2.d.	
Required Action:	In order to receive a Met score for this element, the PAHP must: Provide a policy or desktop procedure to include the PAHP's process to address Requirements 2.b and 2.d.	

Information Submitted as Evidence by the PAHP	
Documents Submitted	Description of the Process
SXIII_CL01-INS-Claims Processing	Windward is DentaQuest’s proprietary core operating system. The claims systems has the ability to process claims both in and out of network. Once a provider has entered into an agreement and credentialed they are entered into the Windward system. Once in Windward the providers can be searched via the find-the-dentist feature on the website and their NPI will be used to process claims. DentaQuest submits encounter data (unaltered claims data) for all services in the format prescribed by the health plan. Claims data is extracted from Windward and submitted in encounter files accurately, completely, and truthfully. Error rates can only be calculated and adhered to when DentaQuest receives a HIPAA compliant response file from the health plan. Errors are addressed by specific department and subsequently resubmitted.

Standard II—Claims and Encounter Systems

Requirement 3: Encounter Data—The PAHP shall have the capacity to submit encounter data to the Agency’s MMIS in accordance with the HHS contract including, but not limited to, the following:

- Submit encounter data, including prescribed data fields, to HHS by the twentieth (20th) of the following month (i.e., subsequent to the month for which data are reflected). The PAHP shall comply with standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate. The PAHP shall obtain Agency approval of policies and procedures, to support encounter claim reporting and shall strictly adhere to the Agency-approved policies and procedures as well as standards defined by the Agency for items such as the file structure and content definitions.
- Submit an encounter claim to HHS, or its designee, for every service rendered to an enrolled member for which the PAHP either paid or denied reimbursement and ensure encounter data provides reports of individual patient encounters with the PAHP’s provider network. The PAHP must ensure these claims contain FFS equivalent detail as to procedures, diagnoses, place of service, units of service, billed amounts, reimbursed amounts, and provider identification numbers. The PAHP shall ensure that all encounter data reflects the amount allowed and the amount actually paid to the Provider, including but not limited to the amount paid by any Subcontractor.
- Implement policies and procedures to ensure that encounter claims submissions are accurate. The PAHP must submit timely and accurate reports in the format and timeframe designated by HHS, with an error rate for encounter data that shall not exceed one percent (1%). The PAHP must investigate root cause of report inaccuracies and submit a revised report in the timeframe designated by HHS. All corrections to the monthly encounter data submission must be finalized within forty-five (45) days from the date the initial error report for the month was sent to the PAHP or fifty-nine (59) days from the date the initial encounter data were due.
- Implement a system for monitoring and reporting the completeness of claims and encounter data received from providers. The PAHP shall have in place a system for verifying and ensuring that providers are not submitting claims or encounter data for services that were not provided. The PAHP shall demonstrate its internal standards for measuring completeness, the results of any completeness studies, and any corrective action plans developed to address areas of non-compliance.

The PAHP should describe, in detail, its policies and procedures for preparing and submitting encounter data files. Evidence includes process flows, policies and procedures, system manuals, sample reports, etc.

Reference—42 CFR 438.14(c)(1); 42 CFR 438.242; 42 CFR 438.818; 42 CFR 457.1209; 42 CFR 457.1233; HHS Contract Section K.10(a-d), K.11, K.26, K.42, K.43, K.44 and K.45

Score:	☐ Met	☒ Not Met—Action Required
Findings:	The PAHP submitted SXIII_CDM02-INS-Encounter Submissions-FINAL after the review; however, HSAG was unable to locate sufficient documentation to indicate readiness. The documents provided by the PAHP did not include Requirements 3.a-d.	
Required Action:	In order to receive a Met score for this element, the PAHP must: Provide evidence, such as policies, procedures, system manuals, sample reports, etc. that demonstrate the PAHP’s process to address the elements of Requirements 3.a-d.	

Information Submitted as Evidence by the PAHP	
Documents Submitted	Description of the Process
SXIII_CDM02-INS-Encounter Submissions-FINAL	DentaQuest submits encounter data (unaltered claims data) for all services in the format prescribed by the health plan. Claims data is extracted from Windward and submitted in encounter files accurately, completely, and truthfully. Error rates can only be calculated and adhered to when DentaQuest receives a HIPAA compliant

Standard II—Claims and Encounter Systems

Requirement 4: Information System Plan and IS Staff—The PAHP shall:

- a. Have policies and procedures for receiving, creating, accessing, storing, and transmitting health information data in a manner that is compliant with HIPAA standards for electronic exchange, privacy, and security requirements (45 C.F.R. Parts 160, 162 and 164 and the HIPAA Security Rule at 45 C.F.R. § 164.308). The plan shall identify the steps to be taken and include a timeline with target dates. The plan shall include, but may not be limited to, a detailed explanation of the following:
 - i. Planning, developing, testing, and implementing new operating rules, new or updated versions of electronic transaction standards, and new or updated national standard code sets.
 - ii. Concurrent use of multiple versions of electronic transaction standards and codes sets.
 - iii. Registration and certification of new and existing trading partners.
 - iv. Creation, maintenance, and distribution of transaction companion guides for trading partners.
 - v. Staffing plan for electronic data interchange (EDI) help desk to monitor data exchange activities, coordinate corrective actions for failed records or transactions, and support trading partners and business associates.
 - vi. Compliance with all aspects of HIPAA Privacy and Security rules.
 - vii. Strategies for maintaining up-to-date knowledge of HIPAA-related mandates with defined or expected future compliance deadlines.
- b. Assign dedicated resources to staff a technical helpdesk to monitor system performance, identify and troubleshoot system issues, monitor data exchange activities, coordinate corrective actions for failed records or transactions and support trading partners and business associates.

The PAHP should describe, in detail, its plan for maintaining compliance with HIPAA standards for claims transactions and staffing requirements. Evidence includes process flows, policies and procedures, system manuals, sample reports, etc.

Reference—42 CFR 438.818, HHS Contract Section K.16, K.17

Score:	☒ Met	☐ Not Met—Action Required
Findings:	HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.	
Required Action:	None.	

Information Submitted as Evidence by the PAHP

Documents Submitted	Description of the Process
SXIII_CDM04-INS-EDI HIPAA Compliance SXIII_Information Security Plan	DentaQuest is compliant with HIPAA security requirements and recertifies annually through HITRUST. Policies and Standards for the handling, transmission and storage of HIPAA related information are maintained within the DentaQuest Information Security Plan provided. Policies are reviewed, updated and approved annually through the Cyber Committee.

Results for Standard II—Claims and Encounter Systems			
Total Elements	4	Required Action: Process-related Elements	- The PAHP must provide a policy or desktop procedure to include the PAHP’s process to address Requirements 2.b and 2.d. - The PAHP must provide evidence, such as policies, procedures, system manuals, sample reports, etc., that demonstrate the PAHP’s process to address the elements of Requirements 3.a-d.
Met	1		
Not Met	3	Required Action: System-related Elements	None.

Standard I—Enrollment Systems

Standard I—Enrollment Systems		
Requirement 1: Health Information System and Required Functions—The PAHP shall maintain an enrolled member database, using Medicaid State ID numbers, on a county-by-county basis which contains eligibility begin and end dates, enrollment history, utilization and expenditure information, and county of legal residency. The PAHP should describe in detail its systems for managing enrollment and the dissemination of enrollment information to downstream systems (e.g., claims processing, authorizations, referral information, and/or clinical/treatment notes). Types of evidence include process flows, policies and procedures, process manuals, sample reports, etc.		
Reference—42 CFR 438.242(a), HHS Contract Sections K.03. and K.12.		
Score:	☒ Met	☐ Not Met—Action Required
Findings:	HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.	
Required Action:	None.	
Information Submitted as Evidence by the PAHP		
Documents Submitted	Description of the Process	
SXIII_ENR01-INS-Member Enrollment	DentaQuest uses a proprietary member enrollment platform to enroll members in the Windward system. We include any data that the client sends on the file and map the data to appropriate fields within Windward including the Medicaid State ID numbers. County information submitted on the file is mapped to the county fields in Windward. Eligibility begin and end dates are mapped to the coverage effective and termination dates in Windward. All required information from the client is mapped to various fields in Windward.	
	DentaQuest applies standard and client specific business rules to identify and execute “new add” transactions into the claims processing system, Windward.	

Standard I—Enrollment Systems

Requirement 2: Interface with State Systems and Member Enrollment Data—The PAHP’s information systems shall have the capacity to electronically receive HIPAA-compliant 834 enrollment files through a file transfer process with the Agency’s Title XIX eligibility system in a manner, timeframe, and frequency determined by HHS.

- Extraction, transformation, and load (ETL) processes used by the PAHP shall be documented in detail and approved by HHS.
- The PAHP shall report inability to retrieve or load eligibility data for any reason to the sending trading partner and the Agency on the same business day as transmission.
- The PAHP shall not modify Enrolled Member identifiers, eligibility categories, or other Enrolled Member data elements without written approval from the Agency.

The PAHP should describe, in detail, how it processes enrollment, disenrollment, and changes to the recipient’s enrollment information in the PAHP’s systems from the daily and monthly enrollment files provided by HHS. Types of evidence include process flows, policies and procedures, process manuals, sample reports, etc.

Reference—HHS Contract Sections K.26. and K.39(a)

Score:	☒ Met	☐ Not Met—Action Required
Findings:	HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element. Recommendations: Although the requirement is met, HSAG recommends that the PAHP update applicable policies and procedures to include the requirement to obtain HHS approval.	
Required Action:	None.	

Information Submitted as Evidence by the PAHP

Documents Submitted	Description of the Process
SXIII_ENR01-INS-Member Enrollment SXIII_ENR01-INS-COMM-SOP-EE Testing- FINAL	DentaQuest is capable of receiving 834 enrollment files from the clients via sFTP. The file is detected and picked up for further processing. The process performs validity checks, compare and load the eligibility data to Windward system.

Standard I—Enrollment Systems

Requirement 3: Member Enrollment Data—The PAHP shall reconcile its eligibility and capitation records for each eligible enrolled member monthly.

- If the PAHP discovers a discrepancy in eligibility or capitation, the PAHP shall provide notification in a manner specified by the Agency.
- The PAHP shall return any capitation or overpayments to the Agency within sixty (60) days of discovering the discrepancy via procedures determined by the Agency.
- If the PAHP receives either enrollment information or capitation for an enrolled member, the PAHP is financially responsible for the enrolled member unless the PAHP has not received capitation for that enrolled member ninety (90) days following notification to the Agency that a capitation was not received.

The PAHP should describe, in detail, monthly enrollment reconciliation processes. Types of evidence include process flows, policies and procedures, process manuals, sample reports, etc.

Reference—HHS Contract Section K.39(b)

Score:	☐ Met	☒ Not Met—Action Required
Findings:	The PAHP provided a description of the process within the Enrollment Tool related to how the PAHP will reconcile its eligibility with the capitation records (820 file), however, the PAHP did not submit any evidence that supported implemented processes related to Requirements 3.a–c.	
Required Action:	In order to receive a Met score for this element, the PAHP must: Provide policies, procedures, and/or workflows that addresses Requirements 3.a–c as they relate to its reconciliation of eligibility and capitation records.	

Information Submitted as Evidence by the PAHP

Documents Submitted	Description of the Process
	DQ has an internal system which pulls in the billed membership at the invoice level. When received, the 820 file is also uploaded to the database. The data within the 820 is analyzed at a member level to determine variances between internal and client values. 820 capitation payment data is to be reconciled against Enrollment data and internal rate data. Variances are to be broken down and analyzed for root causes including, but not limited to: timing issues, rate discrepancies, membership/enrollment discrepancies.

Standard I—Enrollment Systems

Requirement 4: Use of a Common Identifier—The PAHP may use a common identifier, including enrolled members’ Social Security numbers, to link databases and computer systems as required in the contract. However, the PAHP shall not publish, distribute, or otherwise make available the Social Security numbers of enrolled members.

The PAHP should provide its policies, procedures, and a description of its systems for managing this requirement. Types of evidence include process flows, policies and procedures, process manuals, sample reports, etc.

Reference—HHS Contract Section K.27.

Score:	☒ Met	☐ Not Met—Action Required
Findings:	HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness requirements for this element.	
Required Action:	None.	
Information Submitted as Evidence by the PAHP		
Documents Submitted		Description of the Process
		DentaQuest will the member identification number provided by HHS to create a membership file within DentaQuest. That unique member identification number will be used in Windward and adjunct applications. We do not request or use social security numbers

Standard I—Enrollment Systems

Requirement 5: Managed Care Excluded Populations—The populations in this section are excluded from enrollment in the Medicaid Managed Care program.

- a. Non-qualified aliens receiving time-limited coverage of certain emergency medical conditions.
- b. Beneficiaries who have a Medicaid eligibility period that is retroactive.
- c. Persons eligible for the Program of All-Inclusive Care for the Elderly (PACE) who voluntarily elect PACE coverage.
- d. Persons enrolled in Health Insurance Premium Payment Program (HIPP).
- e. Persons deemed medically needy.
- f. Persons incarcerated and ineligible for full Medicaid benefits.
- g. Persons presumed eligible for services (i.e., presumptive eligibility).
- h. Persons residing in the Iowa Veteran’s Home.
- i. Effective July 1, 2017, beneficiaries who are eligible only for the Family Planning Waiver.
- j. Persons eligible only for the Medicare Savings Program.
- k. Alaskan Native and American Indian populations shall be enrolled voluntarily.

The PAHP should describe its processes for ensuring that enrollment data received and processed into its enrollment data system is for populations eligible for the Managed Care Program only and should describe its process for communicating any issues with or discrepancies in enrollment data to HHS. Types of evidence include process flows, policies and procedures, process manuals, sample reports, etc.

Reference—HHS Contract Exhibit D.02

Score:	☐ Met	☒ Not Met—Action Required
Findings:	The PAHP did not provide any evidence or documentation addressing Requirements 5.a–k.	
Required Action:	In order to receive a Met score for this element, the PAHP must: Update applicable documents and implement appropriate processes to address Requirements 5.a–k as they relate to managed care excluded populations.	

Information Submitted as Evidence by the PAHP

Documents Submitted	Description of the Process
	We map data into Windward based on client submitted codes that identify populations eligible and not eligible for benefits. The populations listed above will not be mapped into Windward based on the codes associated with them on the client enrollment file.

Results for Standard I—Enrollment Systems			
Total Elements	5	Required Action: Process-related Elements	- The PAHP must provide policies, procedures, and/or workflows that address Requirements 3.a–c as they relate to its reconciliation of eligibility and capitation records. - The PAHP must update applicable documents and implement appropriate processes to address Requirements 5.a–k as they relate to managed care excluded populations.
Met	3		
Not Met	2	Required Action: System-related Elements	None.

Appendix D. Information Systems Test Claim Scenarios

Test Claims Scenarios for Dental Services							
Scenario	Member #	Claim Scenario	Date of Service	Provider Name	Claim Type	Suggested Service Code(s)	Suggested Place of Treatment Code
1	1	Parent presented with member for a routine oral evaluation of a child under 3 years of age.	11/7/2025	Wesley Williams, DDS	ADA Dental Claim form	D0145	11
2	2	Member presented for a comprehensive oral evaluation with imaging and fluoride treatment. After paying the claim, the PAHP discovered that they overpaid this provider for a past visit in the amount of \$200.00. The dental plan previously requested a refund for the \$200.00 but did not received the refund within the required timeframe. Claim was submitted electronically.	10/27/2025	Leo Spaceman, DDS	ADA Dental Claim form	D0150, D0272, D1206	11
3	4	Member presented with mild sensitivity while eating in two teeth. A limited oral evaluation with application of sealant on two teeth was performed. Claim was submitted via the provider portal.	11/10/2025	Wesley Williams, DDS	ADA Dental Claim form	D0140, D1351 (2)	11

Test Claims Scenarios for Dental Services							
Scenario	Member #	Claim Scenario	Date of Service	Provider Name	Claim Type	Suggested Service Code(s)	Suggested Place of Treatment Code
4	3	Member's guardian enrolled the patient in a new PAHP after the patient began orthodontic treatment with a provider in a different PAHP. Member presented for an office visit for comprehensive orthodontic treatment. After claim processing it is discovered by the PAHP that the patient's father although absent, was court ordered to pay for all dental and orthodontic treatment via a dental plan through his employment.	11/20/2025	Spencer Reid, DDS	ADA Dental Claim form	D8080	11
5	3	Member presents for repair of damaged lower jaw retainer. Dr. Reid submits a claim with D8704 indicating that a replacement retainer was provided. PAHP requests documentation and documentation supports repair and not replacement indicating that D8702 is a more appropriate code for the service provided.	12/15/2025	Beverly Marsh, DMD	ADA Dental Claim form	D8704	11
6	5	Member was referred to an oral surgeon for an urgent evaluation after being discharged from the Emergency Department. Prior authorization was not obtained from the health plan. Claim was submitted via paper. Provider is out of network.	10/3/2025	Spencer Reid, DDS	ADA Dental Claim form	D0150, D0210	11

Test Claims Scenarios for Dental Services							
Scenario	Member #	Claim Scenario	Date of Service	Provider Name	Claim Type	Suggested Service Code(s)	Suggested Place of Treatment Code
7	8	Member presented for removal of one impacted tooth (tooth number 5). Provider's office submits a claim for two units of D7240 for tooth number 5.	10/6/2025	Beverly Marsh, DMD	ADA Dental Claim form	D7240 (2), D9222, D9223	22
8	6	Member presented for a comprehensive oral examination with imaging. The claim was submitted electronically.	11/28/2025	iSmile Clinic	ADA Dental Claim form	D0150, D0210	50
9	6	Member presented with new onset sensitivity while eating in two teeth as well as return of sensitivity in a previously sealed tooth.	10/16/2025	ABC Health Center	ADA Dental Claim form	D1351 (4), D1353	50
10	7	Member presented to a periodontist for a consultation due to the potential need for a root canal. The claim was submitted via provider portal.	12/2/2025	Jeffrey John, DDS	ADA Dental Claim form	D0180	11
11	7	Member presented for a gingivectomy after diagnosis with extensive gum disease.	10/14/2025	Jeffrey John, DDS	ADA Dental Claim form	D4211	11
12	9	Member presented for a periodic oral evaluation and teeth whitening.	12/18/2025	Leo Spaceman, DDS	ADA Dental Claim form	D0120, D9973	11
13	10	Member was found to have a cavity on two surfaces during a routine visit and presented for repair.	11/10/2025	Annie Cavanero, DDS	ADA Dental Claim form	D2331	11

Test Claims Scenarios for Dental Services							
Scenario	Member #	Claim Scenario	Date of Service	Provider Name	Claim Type	Suggested Service Code(s)	Suggested Place of Treatment Code
14	12	Member presented for evaluation and treatment of a suspected broken crown.	11/21/2025	Leo Spaceman, DDS	ADA Dental Claim form	D0140, D0270, D2980	11
15	7	Member presented for periodontal maintenance after a previous periodontal service. A paper claim was submitted.	12/17/2025	Jeffrey John, DDS	ADA Dental Claim form	D4910	11
16	8	Member presented for a complete maxillary denture after removal of applicable teeth.	12/5/2025	Nancy Zimmerman, DDS	ADA Dental Claim form	D5110	11
17	11	Member presented for placement of a partial resin based denture.	12/9/2025	Nancy Zimmerman, DDS	ADA Dental Claim form	D5212	11
18	11	Member presented for evaluation and partial repair of damaged dentures.	11/20/2025	Nancy Zimmerman, DDS	ADA Dental Claim form	D6980	11
19	13	Member presented for a root canal after evaluation by a periodontist.	12/16/2025	Leo Spaceman, DDS	ADA Dental Claim form	D3330	11
20	13	Member presented to a new provider for retreatment of a previously completed root canal.	10/17/2025	Annie Cavanero, DDS	ADA Dental Claim form	D3348	11
21	6	Member presented with severe right lower molar pain, swelling, and was unable to sleep or work. Member walked into a dental office with no prior appointment on an emergency basis. Member had already met the annual benefit max at the time of service.	10/6/2025	Nancy Zimmerman, DDS	ADA Dental Claim form	D9110, D0140	11

Test Claims Scenarios <i>for</i> Dental Services							
Scenario	Member #	Claim Scenario	Date of Service	Provider Name	Claim Type	Suggested Service Code(s)	Suggested Place of Treatment Code
22	11	Member presented to an out of network dental office for a suspected abscess and severe tooth pain on an emergency basis.	11/14/2025	Bruce Ruby, DDS	ADA Dental Claim form	D7510, D9110, D0140	11

Appendix E. Information Systems Readiness Review Remediation Plan

Standard XIII—Health Information Systems

Information Systems Readiness Review Standards Remediation Plan		
Standard XIII—Health Information Systems		
Requirement	Supporting Documentation	Score
General Rule		
1. The PAHP maintains a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of Medicaid managed care requirements. The systems provide information on areas including, but not limited to: - Utilization - Claims - Grievances and appeals - Disenrollments for other than loss of Medicaid eligibility 42 CFR §438.242(a) 42 CFR §457.1233(d) Contract K.02 Contract K.03 Contract K.12(a)(f)(i)(j)	HSAG Required Evidence: - Policies, procedures, and workflows - Systems integration mapping documentation - Current Information Systems Capabilities Assessment Tool (ISCAT), if available - Technical manual(s) - List of disenrollment codes (i.e., reasons for disenrollment) provided by HHS - Screenshot of disenrollment codes available in the disenrollment system - HSAG will use the results from the information systems demonstration, including reporting capabilities - HSAG will use the results from the systems demonstrations included as part of the Disenrollment Requirements and Limitations Standard, Coverage and Authorization of Services Standard, and the Grievance and Appeal Systems Standard Evidence as Submitted by the PAHP: - SXIII_ENR01-INS-Member Enrollment<Entire Document>	☐ Met ☒ Not Met

Information Systems Readiness Review Standards Remediation Plan		
Standard XIII—Health Information Systems		
Requirement	Supporting Documentation	Score
	- SXIII_Windward High-Level Workflow<Entire Document> - SXIII_Enrollment and eligibility subsystem High Level Workflow<Entire Document> - SXIII_Information Security Plan <Entire Document – technical manual> - SXIII_CL01-INS-Claims Processing<Entire Document>	
PAHP Description of Process: Disenrollment codes are typically received from the State via the Companion Guide; however DentaQuest has not yet received them. Once received, our teams input the codes to the system for eligibility. This can be demonstrated in the systems demonstration, proper screenshots will be provided after the virtual review.		
HSAG Findings: HSAG’s review identified the findings below: - Based on the PAHP-submitted implementation plan, the PAHP indicated it received the companion guide from HHS as of 12/25/2025. However, during the interviews, the PAHP staff members stated that they still had not received the companion guide and therefore did not have the member disenrollment codes. The PAHP also updated the <i>ENR01-INS-MemberEnrollment</i> policy with Exhibit K to include member disenrollment codes. Based on the documentation submitted, and discussions with the PAHP, there is a disconnect between the PAHP-submitted documentation and information shared by the PAHP during the interviews. - Per HHS, disenrollment codes are not included in 834 files. The update made in the policy, “DentaQuest will store the following disenrollment codes as provided on the 834 member enrollment file for downstream reporting,” does not align with the HHS guidance.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Provide a copy of the HHS companion guide as well as a documented policy on how the PAHP identifies and incorporates disenrollment codes within Windward.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	IA HHS confirmed on 05/11/2026 that the 834 file will not contain disenrollment reasons. The 2300 – HEALTH COVERAGE loop will contain information of members who will be disenrolled due to events such as death or incarceration. - SXIII_ENR01-INS-Member Enrollment IA.pdf <Pg. 4-5> - SXIII_Member Enrollment Email No Disenrollment codes on 834.pdf<Entire Document> - SXIII_Iowa Medicaid Companion Guide – 834 – Dental Guide V4.00.pdf<Entire Document>	

Information Systems Readiness Review Standards Remediation Plan		
Standard XIII—Health Information Systems		
Requirement	Supporting Documentation	Score
Individual(s) Responsible: [redacted]		
Completion Date: 05/08/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
Basic Elements of a Health Information System		
2. The Information Systems (IS) implemented by the PAHP shall include the following general system requirements but may not necessarily be limited to these requirements: (i) on-line access; (ii) on-line access to all major files and data elements within the IS; (iii) timely processing; (iv) daily file updates of enrolled member, provider, prior authorization and claims to be processed; and (v) weekly file updates of reference files and claim payments. a. <i>Edits, Audits and Error Tracking:</i> The PAHP shall employ comprehensive automated edits and audits to ensure that data are valid and that Contract requirements are met. The IS shall track errors by type and frequency and maintain adequate audit trails to allow for the reconstruction of processing events. b. <i>System Controls and Balancing:</i> The IS shall have an adequate system of controls and balancing to ensure that all data input can be accounted for and that all outputs can be validated. c. <i>Back-Up of Processing and Transaction Files:</i> The PAHP shall employ the following back-up timelines: (i) 24- hour back-up of eligibility verification, enrollment/eligibility	HSAG Required Evidence: • Policies, procedures, and workflows • Completed ISCAT • IS continuity and contingency plans • HSAG will use the results from the information systems demonstration Evidence as Submitted by the PAHP: • SXIII _DentaQuest DRP v51 TOC<Entire Document>	☐ Met ☒ Not Met

Information Systems Readiness Review Standards Remediation Plan		
Standard XIII—Health Information Systems		
Requirement	Supporting Documentation	Score
<i>update process, and prior authorization processing; (ii) 72-hour back-up of claims processing; and (iii) two weeks back-up of all other processes.</i> Contract K.13		
PAHP Description of Process: N/A		
HSAG Findings: HSAG’s review identified the findings below: - After the review, the PAHP provided a <i>2025 DentaQuest Dental Benefit Plan SOC 1 Report 1</i>. The report provided information that the PAHP has policies and procedures in place, but it was not clear for Requirement 2.a, how the PAHP’s information systems track errors by type and frequency and maintain adequate audit trails to allow for the reconstruction of processing events. - HSAG was unable to identify if the PAHP is able to employ backup timelines based on Requirement 2.c.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Update applicable documents and implement appropriate processes to address Requirements 2.a and c. The documentation should include clearly stated policies and procedures or desktop process documents that outline how the PAHP ensures accuracy and completeness of input and output data, as well as established backup processing procedures and timelines.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	2.a.The Systems and File Integrity Policy serves to comply with applicable files and system transaction audit requirements. The policy document identifies the responsible areas, files and corresponding policies. - SXIII_SystemandFileIntegrityPolicy<Entire Document> - SXIII DQ BCDR Letter of Readiness <Entire Document> - SXIII DQ System Data Backup Procedures <Pg. 5-6> - SXIII 02_DQ EDR High Level Workflow <Pg.1> - SXIII_ENR02-INS-SOP Electronic Enrollment File Processing<Entire Document> - SXIII_CL01-INS-Claims Processing<pg.1;3-4;Exhibit Q> - SXIII_SOP for OCR Inbound File Monitoring<Entire Document> - SXIII_SOP Data Tool-File Intake Monitoring<Entire Document> - SXIII_SOP Inbound Portal Monitoring<Entire Document> - SXIII_DentaQuest - SOP - Prior Auth Process<Entire Document>	

Information Systems Readiness Review Standards Remediation Plan		
Standard XIII—Health Information Systems		
Requirement	Supporting Documentation	Score
	- SXIII_DentaQuest - SOP - New Process Implementation<Entire Document> - SXIII_DentaQuest - SOP - Clinical History Process<Entire Document> - SXIII_Client Data Integration - Process Overview<Entire Document> - SXIII_Client Data Integration - ETL Process Overview<Entire Document> - SXIII_Data Migration - DentaQuest - Data Integration Support Document<Entire Document> - SXIII_SOP-CIS-DOC-ASCIX12-820-Remittance<Entire Document> - SXIII_CDM01-INS-SOP-DentaQuest-Encounters_Supplemental-Files<Entire Document> 2.c. Backup documentation for systems are updated in uploaded documentation displaying backup timings for systems. - SXIII DQ BCDR Letter of Readiness <Entire Document> - SXIII DQ System Data Backup Procedures <Pg. 5-6> - SXIII 02 DQ EDR High Level Workflow <Pg. 1>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/08/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
3. The PAHP shall perform the following IS functions through a system that integrates the PAHP’s clinical record information, authorization, and claims payment data: - Reporting. Maintain information and generate reports required by the performance indicators established to assess the PAHP’s performance. - Capitation Payment. Maintain data documenting receipt and distribution of the capitation payment. - Clinical Data. Maintain clinical and functional outcomes data and data to support quality activities.	HSAG Required Evidence: - Policies, procedures, and workflows - Completed ISCAT - HSAG will use the results from the information systems demonstration Evidence as Submitted by the PAHP: - SXIII_CL01-INS-Claims Processing<Entire Document>	☐ Met ☒ Not Met

Information Systems Readiness Review Standards Remediation Plan		
Standard XIII—Health Information Systems		
Requirement	Supporting Documentation	Score
i. <i>The PAHP will use the clinical data to appropriately manage the care being provided to members.</i> ii. <i>The PAHP will use the data in its management of providers, assessment of care being provided to members, to develop new services that will increase access and improve cost-effectiveness of the program, and to implement evidence-based practices across the provider network.</i> d. Ad Hoc Reporting. Maintain the capacity to perform ad hoc reporting on an “as needed” basis, with a turnaround time as determined by HHS. Contract K.12(d)(e)(h)(k) Contract K.14		
PAHP Description of Process: N/A		
HSAG Findings: The documents provided by the PAHP did not include the evidence supporting Requirements 3.b–d. HSAG requested that the PAHP include the requirements in its Iowa-specific description. The PAHP submitted <i>SXIII_CL01-INS-Claims Processing_Exhibit Q_Iowa Medicaid</i> after the review; however, HSAG was unable to locate the PAHP’s processes related to Requirements 3.b–d.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Provide policies or desktop procedures to address Requirements 3.b–d.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	DentaQuest has fully remediated requirement (b) by implementing processes to document the receipt of payments through bank reporting, reconciliation, and application within the AR subledger. Incoming payments are tracked and recorded in the Bank Running Reconciliation file and Oracle AR system to ensure accuracy and traceability. These processes also support the tracking and management of payment distribution through controlled payment cycles and provider payment release activities. DentaQuest has fully remediated requirement c(i)(ii) through implementation of its Quality Assessment and Performance Improvement (QAPI) Program and Clinical Quality Management processes, which collect, maintain, and analyze clinical, utilization, and outcomes data. This data is used to manage member care, identify quality of care issues, and implement targeted interventions through provider engagement and care coordination activities. Additionally, data is used to monitor provider performance, support quality improvement initiatives, and drive the implementation of evidence-based practices across the provider network to improve	

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Requirement	Supporting Documentation	Score
access, quality, and cost-effectiveness. - SXIII FIN03-INS-SOP-Provider Release Payment Process <Entire Document> - SXIII Finance Payment Identification Process <Entire Document> - SXIII CQM01-INS-SOP-Intake and Case Review National SOP <Entire Document> - SXIII_1_Quality Management_Quality Improvement Program_Iowa <Pg. 4-7, 13, 15-17, 21-23> - SXIII BI-IT01 INS-SOP BI Reporting Process <Entire Document>		
Individual(s) Responsible: [redacted]		
Completion Date: 05/08/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
Application Programming Interface		
4. The PAHP implements an Application Programming Interface (API) as specified in 42 CFR §431.60 (member access to and exchange of data) as if such requirements applied directly to the PAHP. Information is made accessible to its current members or the members’ personal representatives through the API as follows: a. <i>Data concerning adjudicated Claims, including Claims data for payment decisions that may be Appealed, were Appealed, or are in the process of Appeal, and provider remittances and beneficiary cost-sharing pertaining to such Claims, no later than one (1) business day after a Claim is processed;</i> b. <i>Encounter data, including encounter data from any Network Providers the Contractor is compensating on the basis of</i>	HSAG Required Evidence: - Policies, procedures, and workflows - API documentation, such as project plan(s), testing plan/results member educational materials, website materials, etc. - List of registered third-party applications - HSAG will use the results from the API demonstration Evidence as Submitted by the PAHP: - SXIII_DS02-ENT-Salesforce Portal Data Maintenance.pdf <Entire Document>	☐ Met ☒ Not Met

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Requirement	Supporting Documentation	Score
<i>Capitation Payments and adjudicated Claims and encounter data from any subcontractors no later than one (1) business day after receiving the data from Providers;</i> c. <i>Clinical data, including laboratory results, if the Contractor maintains any such data, no later than one (1) business day after the data is received by the State; and</i> d. <i>Implementation and maintenance of a publicly accessible standards-based API as described in 42 CFR 431.70, which must include all of the provider directory information specified in 42 CFR 438.10(h)(1) and (2).</i> 42 CFR §438.242(b)(5-6) 42 CFR §431.60 42 CFR §457.1233(d) (2-3) Contract K.48		
PAHP Description of Process: The system is still being configured, and materials are still being developed. Documentation and materials will be available closer to the go live of 7/1.		
HSAG Findings: HSAG’s review identified the findings below: - While the PAHP staff members were able to articulate appropriate processes for the implementation of the Application Programming Interface (API), the <i>DS02-ENT-Salesforce Portal Data Maintenance</i> policy originally cited by the PAHP as evidence of compliance pertained to the member and provider portals, which are not interchangeable with the Patient Access API and no other documentation was submitted to support compliance. - During the review, HSAG requested the API workflow that was demonstrated to be updated to include the PAHP’s process to ensure updated information is accessible to members within one business day (daily refresh); the links to information on the PAHP’s website for developers and members; and a crosswalk of the United States Core Data for Interoperability (USCDI) elements, and whether the PAHP maintains that information in its system and therefore should be accessible to members via the API. Based on the documentation submitted after the review, HSAG identified the following concerns: - The <i>FHIR_Interoperability_WF</i> document was not updated to include the PAHP’s process to ensure updated information is accessible to members within one business day (daily refresh) as requested by HSAG.		

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Requirement	Supporting Documentation	Score
– The PAHP resubmitted the same policy that was submitted for HSAG’s desk review that pertained to the member and provider portals and are not synonymous to the Patient Access API. Therefore, while the PAHP indicated that “APIs allows Provider and Member Portal to display close to real-time data,” HSAG could not determine the applicability of the statement and the member and provider portals to the Patient Access API. – While the PAHP suggested that the <i>DS02-ENT</i> policy resubmitted after the review included the “listed data” accessible via the API, the policy applied to the member and provider portals, which are not synonymous to the Patient Access API. Therefore, HSAG could not determine the applicability to the Patient Access API. Additionally, while HSAG reviewed the “FHIR Patient Access” webpage for developers, HSAG could not determine the specific data elements associated with the USCDI. Further, HSAG specifically requested a crosswalk of all USCDI data elements and whether the PAHP maintains that information in its system and it therefore should be accessible to members via the API. This was not provided as requested. During the review, HSAG acknowledged that the PAHP may not maintain a large amount of data that is associated with the USCDI; therefore, a crosswalk could have easily been created and submitted. • The information for members regarding the API was included on the PAHP’s corporate website; therefore, HSAG requested how members would be informed of the Patient Access API and where to locate this information. During the review, while PAHP staff members initially suggested that including API information on plan-specific websites is not required, PAHP staff members later clarified that the PAHP can include a link on its Iowa Medicaid managed care program’s website and demonstrated an “Interoperability API” footer link that can be included on the PAHP’s website. Please note that the PAHP is required to provide members with resources via an “accessible location on its public website and through other appropriate mechanisms through which it ordinarily communicates with current and former beneficiaries seeking to access their health information held by the State Medicaid agency, educational resources in non-technical, simple and easy-to-understand language....” While the PAHP’s corporate website, with an “Interoperability API” footer link, included a pathway for members to search for a specific dental plan, Iowa members were accessing an Iowa-specific landing page to access information on their dental plan (e.g., where members can access the Iowa Medicaid managed care member handbook, member newsletters, and other member resources for Iowa). Therefore, the PAHP must proceed with including a footer link on its Iowa-specific member website. Further, the language “Interoperability API” would not meet the information requirements under 42 CFR §438.10(d)(6)(i), which requires the PAHP to provide all written member materials in an easily understood language and format, nor does “Interoperability API” appear to meet the PAHP’s required reading grade level. Examples of member friendly language for footer links may include “Access to your records” and “Click here to learn how you can access your health information” (please note that these are examples only, and the PAHP must decide which language to use). Lastly, while the narrative under the “Your Privacy Rights” section informed members that they can submit a complaint to the Office for Civil Rights (OCR), it did not inform members that they can also submit a complaint to the Federal Trade Commission (FTC). Recommendations: During the review, the PAHP staff members confirmed that they have no third-party developers registered with the PAHP to make an application available to members to access their health information via the Patient Access API. The PAHP indicated that the PAHP’s responsibility is to implement the API in accordance with CMS’ technical standards and that there is a lack of developer interest in the API. However, it is unclear to HSAG why the PAHP has not proactively outreached to developers in an attempt to make a registered application available to members. Further, the PAHP		

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Requirement	Supporting Documentation	Score
confirmed awareness of multiple third-party developers by posting a link to “My Health Application.” Lastly, HSAG has conducted multiple compliance reviews with MCPs across several states and not only do most MCPs have one or more registered developers, several are able to provide system demonstrations of the applications through a sandbox environment. As such, HSAG recommends that the PAHP proactively make efforts to onboard a third-party developer, especially as CMS continues to enhance the interoperability requirements. HSAG also recommends that the PAHP ensure it implements the Provider Access, Payer-to-Payer Access, and Prior Authorization APIs by the required implementation dates.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: - Develop and submit a policy specific to CMS’ interoperability requirements. This policy should not only include the federal requirements but include a description for how the PAHP has implemented the APIs. - Update the <i>FHIR_Interoperability_WF</i> and/or the PAHP’s newly created interoperability policy to explain how the PAHP ensures it provides member access to updated information within one business day of receipt of new or updated information. - Create a crosswalk of USCDI elements, and which elements the PAHP maintains in its system and are accessible via the API.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	- SXIII_ADS07-INS-Interoperability<Entire Document> - SXIII_USCDI_WS_ProfileAvailability<Entire Document> - SXIII_ProviderDirectoryAPI_Mapping<Entire Document> - SXIII_PatientAccessAPI_Mapping<Entire Document> - SXIII_Interoperability API Access Request Process – SOP<Entire Document>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/06/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to ensure readiness with the requirements for this program area with the expectation that the PAHP will address the previously communicated findings and recommendations: While the PAHP’s Iowa Medicaid member website had an “Interoperability API” footer link, the language “Interoperability API” did not meet the information requirements under 42 CFR §438.10(d)(6)(i), which requires the PAHP to provide all written member materials in an easily understood language and format, nor did “Interoperability API” appear to meet the PAHP’s required reading grade level. Examples of member-friendly language for footer links may include “Access to your records” and “Click here to learn how you can access your health information” (please note that these are examples only, and the PAHP must decide which language to use).		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted

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Requirement	Supporting Documentation	Score
During the review, the PAHP staff members confirmed that they have no third-party developers registered with the PAHP to make an application available to members to access their health information via the Patient Access API. The PAHP indicated that the PAHP’s responsibility is to implement the API in accordance with CMS’ technical standards and that there is a lack of developer interest in the API. However, it is unclear to HSAG why the PAHP has not proactively outreached to developers in an attempt to make a registered application available to members. Further, the PAHP confirmed awareness of multiple third-party developers by posting a link to “My Health Application.” Lastly, HSAG has conducted multiple compliance reviews with MCPs across several states and not only do most MCPs have one or more registered developers, several are able to provide system demonstrations of the applications through a sandbox environment. As such, HSAG recommends that the PAHP proactively make efforts to onboard a third-party developer, especially as CMS continues to enhance the interoperability requirements. HSAG also recommends that the PAHP ensure it implements the Provider Access, Payer-to-Payer Access, and Prior Authorization APIs by the required implementation dates.		
5. The PAHP maintains a publicly accessible standards-based API described in 42 CFR §431.70 (access to published provider directory information), which must include all information specified in 42 CFR §438.10(h)(1) and (2). 42 CFR §438.242(b)(6) 42 CFR §431.70 42 CFR §438.10(h)(1-2) 42 CFR §457.1233(d) Contract K.48	HSAG Required Evidence: - Policies, procedures, and workflows - API documentation, such as project plan(s), testing plans/results, stakeholder educational materials, website materials, etc. - List of registered third-party applications - HSAG will use the results from the web-based provider directory demonstration Evidence as Submitted by the PAHP: - SXIII_MKT05-INS-SOP-Website Accessibility <Entire Document>	☐ Met ☒ Not Met
PAHP Description of Process: The system is still being configured, and materials are still being developed. Documentation and materials will be available closer to the go live of 7/1.		
HSAG Findings: HSAG’s review identified the findings below: While the PAHP staff members were able to articulate appropriate processes for the implementation of the API, the <i>DS02-ENT-Salesforce Portal Data Maintenance</i> policy originally cited by the PAHP as evidence of compliance pertained to the member and provider portals, which are not interchangeable with the Provider Directory API, and no other documentation was submitted to support compliance.		

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Requirement	Supporting Documentation	Score
• The PAHP did not have an online provider directory; therefore, HSAG is unable to confirm the Provider Directory API complied with 42 CFR §438.10(h)(1-2). • Discussion during the review suggested that stakeholders would need to request permission from the PAHP to access the Provider Directory API. However, while the federal rule does not prohibit the PAHP from requiring developers to register with the PAHP, the Provider Directory API must be publicly accessible and does not require user authentication, authorization, or any other protocols that restrict the availability of the information (i.e., “...excluding the security protocols related to user authentication and authorization, or any other protocols that restrict the availability of this information to anyone wishing to access...”). CMS further clarified that the requirement to make provider directory information available without authentication or authorization applies to the user and not the application. Therefore, based on discussion during the review, HSAG could not confirm that the PAHP’s Provider Directory API was readily accessible to any member of the public without having to request access from the PAHP.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: • Develop and submit a policy specific to CMS’ interoperability requirements. This policy should not only include the federal requirements but include a description for how the PAHP has implemented the APIs. • Provide confirmation that users can access provider directory information via the API without authorization or permission from the PAHP. • Provide a response file(s) for an Iowa-contracted network provider and the corresponding link to the provider’s profile in the online provider directory. The response file must confirm that all provider details required under 42 CFR §438.10(d)(1) are accessible via the API.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	Updated Policy and Procedure for interoperability (XIII_ADS07-INS-Interoperability.pdf) providing clarification on third party access and availability of APIs. Addition of JSON response files for provider and screen shot of FAD tool information for requested sample FADEExample and PDFHIR_JSON.zip • SXIII_ADS07-INS-Interoperability.pdf <Pg. 1-3> • SXIII_USCDI_WS_ProfileAvailability<Entire Document> • SXIII_ProviderDirectoryAPI_Mapping<Entire Document> • SXIII_PatientAccessAPI_Mapping<Entire Document> • SXIII_Interoperability API Access Request Process – SOP<Entire Document> • SXIII_Element5_PDFHIR_JSON.zip<Entire Document> • SXIII_Element5_FADEExample<Entire Document>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/08/2026		

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Requirement	Supporting Documentation	Score
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to ensure readiness with the requirements for this program area with the expectation that the PAHP will address the findings below: - The JSON files were associated with a provider with no accessibility accommodations listed on the online provider directory. Therefore, HSAG could not confirm accessibility accommodations, when available, would be shared via the API. - The associated provider profile from the PAHP’s online provider directory had multiple “Plans Accepted” (e.g., from other states, including Arizona, Florida, Georgia, Illinois, Indiana, Mississippi, Nevada, Oklahoma, Oregon, Pennsylvania, and Tennessee). Therefore, HSAG is under the assumption that this provider provides teledentistry. HSAG was unable to locate teledentistry in the JSON files. - While the JSON files (i.e., network and practitioner role) confirmed the provider was associated with the Iowa Medicaid managed care program, the remaining two JSON files (i.e., organization and practitioner) pertained to Nevada and did not include Iowa-specific information (e.g., the file contained a Nevada address as opposed to the Iowa address listed on the provider’s profile in the online provider directory).		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted
Data Exchange and Management		
8. <i>The PAHP submits provider network information via electronic file to HHS in the timeframe and manner defined by HHS.</i> a. <i>The PAHP keeps provider enrollment and disenrollment information up to date.</i> Contract K.40	HSAG Required Evidence: - Policies, procedures, and workflows Evidence as Submitted by the PAHP: - SXIII_NET01-INS-Network Development Maintenance and Use<Pg. 4 Directories>	☐ Met ☒ Not Met
PAHP Description of Process: N/A		
HSAG Findings: The documents provided by the PAHP did not include the requirements of this element. The PAHP submitted <i>SXIII_IA Provider Master List Instructions</i><Entire Document> after the review; however, this file contained instructions on how to properly set up a provider in Windward but did not speak to how the PAHP will submit provider network information via an electronic file to HHS in the time frame or manner defined by HHS. Additionally, HSAG was unable to locate documentation (e.g., desktop procedure, policy) to support the PAHP’s processes to ensure that provider enrollment and disenrollment information is up to date. In review of the submitted policy, <i>Provider Directory Maintenance and Ongoing Monitoring</i>, HSAG was able to ascertain how provider enrollments and updates to existing providers would be completed; however HSAG was unable to identify how disenrollments would be updated in the PAHP’s source system and the provider directory.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must:		

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Requirement	Supporting Documentation	Score
Provide updated documentation and implement appropriate processes to address Requirement 8. The PAHP should include an example of the file format that will be utilized to submit provider network information to HHS, as well as the frequency in which this file will be shared with HHS. Additionally, the PAHP should provide updated documentation on how the PAHP will ensure that provider enrollment and disenrollment information is maintained and information is kept up to date within the source system and the provider directory. This can be presented in the form of a policy, procedural document, or desktop process.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	According to the PAHP Guide (Dental PAHP Guide - V12.2), the outbound file is not a requirement. SXIII_DentalPAHPGuide_IMESS_MedFile<Entire Document>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/11/2026		
HSAG Feedback: The PAHP's remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. However, based on the PAHP's statement that the outbound file is not currently a requirement, HSAG strongly recommends that the PAHP consult with HHS to confirm applicability of the Contract requirements and, as applicable, the time frame and the manner in which HHS will require the electronic provider network information file.		☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted
Continuity and Contingency Planning		
10. <i>The PAHP develops plans for system problem resolution that do not rise to the level of disaster and document such in its global Policies and Procedures Manual (PPM.)</i> <i>The PAHP notifies HHS immediately upon identification of network hardware or software failures and sub-standard performance and shall conduct triage with HHS to determine the severity level or deficiencies or defects and determine timelines for fixes.</i> <i>The PAHP develops, implements, and adheres to procedures defining the methods for notifying HHS and other applicable</i>	HSAG Required Evidence: - Policies, procedures, and workflows - IS contingency and continuity plans Evidence as Submitted by the PAHP: - SXIII_DQ BCDR Letter of Readiness Feb2026<Entire Document>	☐ Met ☒ Not Met

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Requirement	Supporting Documentation	Score
<i>stakeholders regarding system problems that do not rise to the level of disaster as defined in Section K.35.</i> Contract K.31 Contract K.32 Contract K.35		
PAHP Description of Process: N/A		
HSAG Findings: The PAHP submitted <i>SXIII_DQ BCDR Letter of Readiness Jan2026</i> <Entire Document> and <i>SXIII_DentaQuest DRP v51 Redacted</i> <Pg. 15>, which included all the requirements but did not include the critical Requirement 10.a.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: Provide an updated policy that addresses Requirement 10.a.		
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	DentaQuest has fully remediated this requirement by implementing policies and procedures within its PPM that address system issues that do not rise to the level of a disaster, which are managed separately under the organization’s disaster recovery program. These procedures define the identification, triage, and resolution of system issues, including requirements to notify HHS immediately upon identification of system failures or performance issues and to collaborate on severity determination and resolution timelines. Additionally, the procedures establish standardized methods and responsible parties for notifying HHS and applicable stakeholders of system issues to ensure timely communication and coordination. - SXIII MIM Process Document <Pg. 3-5 & 7> - SXIII_NET30-INS-SOP-Iowa Medicaid CHIP Client Notification Requirements <Pg.1>	
Individual(s) Responsible: [redacted]		
Completion Date: 5/7/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Information Systems Readiness Review Standards Remediation Plan		
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Requirement	Supporting Documentation	Score
15. <i>The PAHP must develop processes for development, testing, and promotion of system changes and maintenance.</i> a. <i>The PAHP notifies HHS at least 30 days prior to the installation or implementation of “minor” software and hardware upgrades, modifications, or replacements, and 90 days prior to the installation or implementation of “major” software and hardware upgrades, modifications, or replacements.</i> b. <i>The PAHP ensures that system changes or system upgrades are accompanied by a plan that includes a timeline, milestones, and adequate testing to be completed before implementation.</i> i. <i>The PAHP notifies and provide such plans to the HHS upon request in the timeframe and manner specified by HHS.</i> ii. <i>The PAHP develops and submits the plan required under this section in its PPM.</i> c. <i>The Contractor ensures the environment for development, system testing, and user acceptance testing is separate from the production environment.</i> Contract K.33 Contract K.34	HSAG Required Evidence: • Policies, procedures, and workflows • IS testing plan • Technical manual(s) • HSAG will use the results from the information systems demonstration Evidence as Submitted by the PAHP: • SXIII_ADS03-INS-DENT-WW System Enhancement-FINAL <Entire Document> • SXIII_Information Security Plan <pg. 44>	☐ Met ☒ Not Met
PAHP Description of Process: N/A		
HSAG Findings: The PAHP submitted the <i>SXIII_DentaQuest DRP v51 Redacted</i> <Pg. 4-5 & 68> policy, which included most of the requirements; however, HSAG was unable to locate any policies and procedures addressing requirement 15.a.		
Required Actions: In order to receive a <i>Met</i> score for this element, the PAHP must: • Update applicable policies and implement appropriate processes to address Requirement 15.a.		

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Requirement	Supporting Documentation	Score
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	DentaQuest has fully remediated this requirement by incorporating the required notification timeframes into the SXIII_NET30-INS-SOP-Iowa Medicaid CHIP Client Notification Requirements policy. The policy explicitly requires notification to HHS at least 30 days prior to minor system changes and 90 days prior to major system changes, in accordance with contractual requirements. These procedures ensure standardized and timely communication to HHS for all applicable system upgrades, modifications, and replacements. - SXIII_NET30-INS-SOP-Iowa Medicaid CHIP Client Notification Requirements <Pg. 1 Release Management> - SXIII ADS03-INS-DENT-WW System Enhancement<Entire Document>	
Individual(s) Responsible: [redacted]		
Completion Date: 05/07/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard II—Claims and Encounter Systems

Information Systems Readiness Review Standards Remediation Plan		
Standard II—Claims and Encounter Systems		
Requirement 1: Claims Processing and Encounter Systems—The PAHP must have a claims processing system and Medicaid Management Information System (MMIS) that: - Collects data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of section 1903(r)(1)(F) of the Social Security Act (electronic claims submission) and in accordance with section 6504(a) of the Affordable Care Act. The PAHP must provide electronic remittance advice and transfers claims payment electronically. The PAHP must have the capacity to process paper claims and track electronic versus paper claim submissions over time to measure success in increasing electronic submissions. The PAHP shall provide electronic remittance advice and transfer claims payment electronically. The PAHP must be able to maintain data on incurred but not yet reimbursed claims and data on the time required to process and mail claims payment. - Enables the PAHP to manage and monitor its system to ensure collection of data received from providers is accurate and timely; screen the data for completeness, logic, and consistency; and collect data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts in accordance with 42 CFR 438.242(b) and (c). The PAHP shall verify the accuracy and timeliness of data reported by network providers for whom the PAHP is responsible for compensating on the basis of capitation payments. - Collects and maintains data on member and provider characteristics as specified by HHS, and on services furnished to the recipients through an encounter data system or other method as may be specified by HHS. The PAHP collects and maintains sufficient member encounter data to identify the provider who delivers any item(s) or services(s) to enrolled members. The PAHP shall make all collected data available to HHS and upon request to CMS. - Accommodates billing of specified enrolled members a cost sharing amount and reduce the payment it makes to a provider by the amount of the member's cost sharing obligation. The PAHP must implement a mechanism to notify providers of an enrolled member's financial participation or cost sharing requirement. <i>The PAHP should provide a description of its systems for managing the claims processing and encounter data requirements. Evidence includes process flows, policies and procedures, system manuals, process manuals, claims submission requirements documents, claims validation processes, claim timeliness reports, etc.</i>		
Reference—42 CFR 438.242; 42 CFR 457.1233; Affordable Care Act, Section 6504(a); Social Security Act, Section 1903(r)(1)(F); HHS Contract Sections K.04, K.05, K.06, K.07, K.08, K.09, K.10(a), K.12(f)(g) and K.41		
Score:	☐ Met	☒ Not Met—Action Required
Findings:	HSAG has determined that the PAHP has sufficient policies, procedures, and/or plans in place to meet readiness of the elements within this requirement with the exception of Requirement 3.d. The PAHP indicated Requirement 3.d is not applicable, as there are no member cost-sharing obligations for this contract. However, the Iowa PAHP contract includes references for member cost-sharing; therefore, the PAHP should have addressed cost-sharing in its written documentation.	

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Standard II—Claims and Encounter Systems			
Required Action:		The PAHP should update and submit its policy to align with the member cost-sharing language within its Iowa PAHP Contract.	
Information Submitted as Evidence by the PAHP			
Documents Submitted		Description of the Process	
SXIII_CDM02-INS-Encounter Submissions-FINAL SXIII_CL01-INS-Claims Processing SXIII_CL02-INS-Claims Payment		DentaQuest submits encounter data (unaltered claims data) for all services in the format prescribed by the health plan. Claims data is extracted from Windward and submitted in encounter files accurately, completely, and truthfully. There is no member cost sharing for this contract. There is no member cost sharing for this contract.	
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	DentaQuest has fully remediated this requirement by developing and implementing a Cost Sharing Policy and incorporating applicable language into the CL02-Ins-Claims Payment Policy. The policy ensures the system can accommodate member cost sharing, including applying cost sharing amounts to claims and reducing provider payments accordingly. Cost sharing requirements and member financial responsibility are communicated through language included in the Member Handbook and ORM materials. - SXIII_SII CL02-Ins-Claims Payment-Exhibit J <Pg. 17 Exhibit J Contract Anchor D.5.03 > - SXIII_SII NET34-INS-Member Cost Sharing and Financial Responsibility Policy <Entire Document> - SXIII_SII_DQ3197 IA_Medicaid Adult (7.26) HBEN <Pg. 27-28 > - SXIII_SII_DQ4080 IA_Medicaid Child (7.26) HBEN <Pg. 27-28 > - SXIII_SII_DQ3198 IA_Medicaid Hawki (7.26) HBEN <Pg. 28-29> - Provider Reference Manual <Pg.46 >		
Individual(s) Responsible: [redacted]			
Completion Date: 05/11/2026			
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.			☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Information Systems Readiness Review Standards Remediation Plan

Standard II—Claims and Encounter Systems

Requirement 2: Claims Submission and Payment Requirements—The PAHP shall:

- Have a claims processing system for both in- and out-of-network providers capable of processing all claims types. The PAHP shall allow in-state network providers to submit claims for reimbursement no more than 180 days from the date of service and shall allow out-of-state providers to submit claims 12 months from the date of service without requiring a PAHP-specified provider number to receive payment.
- Accurately price specific procedures or encounters and maintain detailed records of remittances to providers. Regardless of participating provider status, the PAHP must be able to reimburse Indian Health Care Providers the applicable encounter rates published annually in the Federal Register by the Indian Health Service (IHS), the FQHC rate the providers would receive in Fee-For-Service (FFS) if enrolled in Medicaid as an FQHC, or the amount they would receive if the services were provided under the State Plan's FFS payment methodology.
- Pay 90 percent of all clean claims within 14 days of receipt, 95 percent of all clean claims from providers within 21 calendar days of the date of receipt and pay 99 percent of all clean claims from providers within 90 calendar days of the date of receipt. The PAHP shall accurately adjudicate 90 percent of all clean identified adjustments including reprocessed claims within 30 business days of receipt, and 99 percent within 90 days of receipt. The PAHP shall reprocess all claims processed in error within 30 business days of identification of the error or upon a schedule approved by HHS.
- Develop, implement, and adhere to written policies and procedures, subject to HHS review and approval, to monitor claims adjudication accuracy and for registering and responding to claim disputes from in- and out-of-network providers.
- Obtain HHS approval for any claims forms or payment methodology developed by the PAHP for use by providers and ensure they are in such a format as to assure the submission of encounter data as required under the contract. The PAHP shall comply with any applicable federal regulations, including HIPAA regulations related to transactions, code sets, confidentiality, and submission requirements for protected health information (PHI).
- Require each physician providing services to enrolled members to have a standard unique health identifier in compliance with 42 U.S.C. § 1396u-2(d)(4).
- Require that all providers that submit claims to the PAHP have a National Provider Identifier (NPI) number unless otherwise directed to the Agency in accordance with 45 C.F.R. § 162.410.

The PAHP should provide its policies and procedures for managing the claims processing and payment requirements. Evidence includes process flows, policies and procedures, sample reports, etc.

Reference—42 CFR 447.45, 45 CFR 162.410, 42 USC 1396u-2(d)(4), Iowa Admin. Code r. 441-80.2, HHS Contract Section D.5, D.6, K.41

Score:
☐ Met

☒ Not Met—Action Required

Findings:

Although some elements of this requirement were met, the PAHP submitted SXIII_CL01-INS-Claims Processing_Exhibit Q_Iowa Medicaid after the review, which did not include documentation to meet Requirements 2.b and 2.d.

Required Action:

In order to receive a Met score for this element, the PAHP must:

- Provide a policy or desktop procedure to include the PAHP's process to address Requirements 2.b and 2.d.

Information Systems Readiness Review Standards Remediation Plan		
Standard II—Claims and Encounter Systems		
Information Submitted as Evidence by the PAHP		
Documents Submitted	Description of the Process	
SXIII_CL01-INS-Claims Processing	Windward is DentaQuest's proprietary core operating system. The claims systems has the ability to process claims both in and out of network. Once a provider has entered into an agreement and credentialed they are entered into the Windward system. Once in Windward the providers can be searched via the find-the-dentist feature on the website and their NPI will be used to process claims.	
	DentaQuest submits encounter data (unaltered claims data) for all services in the format prescribed by the health plan. Claims data is extracted from Windward and submitted in encounter files accurately, completely, and truthfully. Error rates can only be calculated and adhered to when DentaQuest receives a HIPAA compliant response file from the health plan. Errors are addressed by specific department and subsequently resubmitted.	
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	DentaQuest has fully remediated this requirement by updating the CL02-Ins-Claims Payment Policy to include language ensuring accurate pricing of claims and compliance with applicable reimbursement methodologies, including IHS and FQHC requirements. For claims adjudication accuracy and monitoring, the organization implemented the QA02-INS-Claim Payment Audit policy and procedure. Additionally, the CGA08-INS-Provider Appeals Policy was implemented to establish processes for registering, tracking, and responding to provider claim disputes. • SXIII_SII_QA02-INS-Claim Payment Audit- <Entire Document> • SXIII_SII CGA08-INS-Provider Appeals Policy <Pg. 9-10 Exhibit W> • SXIII_SII CL02-Ins-Claims Payment-Exhibit J <Pg. 17 Exhibit J Contract Anchor D.5.03 >	
Individual(s) Responsible: [redacted]		
Completion Date: 05/06/2026		
HSAG Feedback: The PAHP's remediation plan and supporting policy documentation are sufficient to demonstrate written readiness with the requirements for this program area; however, the PAHP was unable to provide supporting implementation evidence through multiple information system live review sessions. The PAHP did not demonstrate information system configuration in its test environment to support Requirement 2.b. despite repeated requests and opportunities to do so. The <i>Prov</i>		☐ Accepted ☐ Accepted With Recommendations

Information Systems Readiness Review Standards Remediation Plan	
Standard II—Claims and Encounter Systems	
<i>Ops FQHC IHCP Fee Schedule Set Up Document</i> that the PAHP submitted in May 2026 did not provide evidence of how the PAHP identifies the appropriate FQHC-specific prospective payment system (PPS) encounter rate or the Iowa Indian Health Service (IHS) provider federal All-Inclusive Rate (AIR). Additionally, the submitted process documentation did not explain the full process, missing key details such as how the FQHC or IHS provider are appropriately identified upon claims receipt or if the PAHP is using a wrap payment to ensure the correct rates are paid. Although the PAHP provided written evidence to align with Requirement 2.d., the PAHP did not provide evidence of having its information system ready to implement and adhere to written policies and procedures to monitor claims adjudication accuracy and for registering and responding to claim disputes from in-network and OON providers. During the May 28, 2026, information system review session, the PAHP demonstrated the use of a free text comment field as its primary information system field to ensure appropriate identification of a poststabilization claim and provided a list of key words that align with various codes that map to rejection codes or queues for manual review. These key words do not account for potential manual keying errors, and no process was submitted to explain how the PAHP maintains stringent ongoing monitoring to evaluate for comment fields that include invalid key words. The manual process alone presents a risk to timely and accurate processing of claims, and the additional risk of no clear evidence for how the PAHP ensures this risk is addressed presents a significant risk of inaccurate or untimely claims resolutions. For the PAHP’s information system to be determined ready, during the June 15, 2026, final information system review, it must: • Demonstrate all configuration specific to its Iowa Medicaid program within its Windward information system production environment. • Describe and demonstrate that sufficient monitoring is in place to ensure manual process risks are mitigated. • Clearly show the correctly configured IHS provider payment, the step-by-step methods followed to properly configure Iowa FQHC payments, and demonstrate the end-to-end process in place for processing Iowa FQHC and IHS provider claims, showing exactly how the providers are identified from the beginning of claim receipt, and the manual steps in the process (i.e., email steps with monitoring/oversight, Provider Operations ticket request receipt, the standardized format in which the Client/Provider Engagement team submits the necessary fee schedule ticket details, time frames within which these special fee schedules must be created, the monitoring processes to ensure manual steps’ risks are mitigated, which resources are used to identify correct payments, and how each resource is confirmed to be current and accurate at the time of payment). Due to the significant degree of follow-up required for the PAHP to articulate an understanding of HHS’ requirements as well as the amount of attempts by the PAHP to correctly process test claims in alignment with Iowa-specific guidance, HSAG recommends that the PAHP assign a high degree of oversight specific to claims accuracy in accordance with HHS’ expectations. The PAHP should especially focus on providing this increased level of oversight during the first six months post-implementation to ensure any issues can be immediately addressed. The increased oversight should be further prioritized during any time period when	☒ Not Accepted

Information Systems Readiness Review Standards Remediation Plan		
Standard II—Claims and Encounter Systems		
adjustments are made in Windward that impact claims payment, such as when PA edits are implemented in production or when the provider network has significant increases.		
Requirement 3: Encounter Data—The PAHP shall have the capacity to submit encounter data to the Agency’s MMIS in accordance with the HHS contract including, but not limited to, the following: a. Submit encounter data, including prescribed data fields, to HHS by the twentieth (20th) of the following month (i.e., subsequent to the month for which data are reflected). The PAHP shall comply with standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate. The PAHP shall obtain Agency approval of policies and procedures, to support encounter claim reporting and shall strictly adhere to the Agency-approved policies and procedures as well as standards defined by the Agency for items such as the file structure and content definitions. b. Submit an encounter claim to HHS, or its designee, for every service rendered to an enrolled member for which the PAHP either paid or denied reimbursement and ensure encounter data provides reports of individual patient encounters with the PAHP’s provider network. The PAHP must ensure these claims contain FFS equivalent detail as to procedures, diagnoses, place of service, units of service, billed amounts, reimbursed amounts, and provider identification numbers. The PAHP shall ensure that all encounter data reflects the amount allowed and the amount actually paid to the Provider, including but not limited to the amount paid by any Subcontractor. c. Implement policies and procedures to ensure that encounter claims submissions are accurate. The PAHP must submit timely and accurate reports in the format and timeframe designated by HHS, with an error rate for encounter data that shall not exceed one percent (1%). The PAHP must investigate root cause of report inaccuracies and submit a revised report in the timeframe designated by HHS. All corrections to the monthly encounter data submission must be finalized within forty-five (45) days from the date the initial error report for the month was sent to the PAHP or fifty-nine (59) days from the date the initial encounter data were due. d. Implement a system for monitoring and reporting the completeness of claims and encounter data received from providers. The PAHP shall have in place a system for verifying and ensuring that providers are not submitting claims or encounter data for services that were not provided. The PAHP shall demonstrate its internal standards for measuring completeness, the results of any completeness studies, and any corrective action plans developed to address areas of non-compliance. <i>The PAHP should describe, in detail, its policies and procedures for preparing and submitting encounter data files. Evidence includes process flows, policies and procedures, system manuals, sample reports, etc.</i>		
Reference—42 CFR 438.14(c)(1); 42 CFR 438.242; 42 CFR 438.818; 42 CFR 457.1209; 42 CFR 457.1233; HHS Contract Section K.10(a-d), K.11, K.26, K.42, K.43, K.44 and K.45		
Score:	☐ Met	☒ Not Met—Action Required
Findings:	The PAHP submitted SXIII_CDM02-INS-Encounter Submissions-FINAL after the review; however, HSAG was unable to locate sufficient documentation to indicate readiness. The documents provided by the PAHP did not include Requirements 3.a-d.	
Required Action:	In order to receive a Met score for this element, the PAHP must:	

Information Systems Readiness Review Standards Remediation Plan	
Standard II—Claims and Encounter Systems	
	Provide evidence, such as policies, procedures, system manuals, sample reports, etc. that demonstrate the PAHP’s process to address the elements of Requirements 3.a-d.
Information Submitted as Evidence by the PAHP	
Documents Submitted	Description of the Process
SXIII_CDM02-INS-Encounter Submissions-FINAL	DentaQuest submits encounter data (unaltered claims data) for all services in the format prescribed by the health plan. Claims data is extracted from Windward and submitted in encounter files accurately, completely, and truthfully. Error rates can only be calculated and adhered to when DentaQuest receives a HIPAA compliant.
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	DentaQuest has ensured processes are established to support HSAG required elements 3 a-d as evident in the Encounters & Supplemental File SOP and the IA DHHS 837D X224 BRD. - SXIII_SII_CDM01-INS-SOP-DentaQuest-Encounters_Supplemental-Files<Pg. 1-4> - SXIII_SII_IA DHHS - 837D X224 BRD<Pg. 3-8 >
Individual(s) Responsible: [redacted]	
Completion Date: 05/07/2026	
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area. HSAG recommends that the PAHP make the typo correction in the submitted <i>SXIII_SII_CDM01-INS-SOP-DentaQuest-Encounters_Supplemental-Files<Pg. 1-4></i> policy of “fifty-nine (50) business days” by updating the number in parentheses to “59” instead of “50.” Additionally, DentaQuest is required to successfully submit encounter data to HHS and HSAG will monitor for the status of the encounter acceptance rates.	
☐ Accepted ☒ Accepted With Recommendations ☐ Not Accepted	

Standard I—Enrollment Systems

Information Systems Readiness Review Standards Remediation Plan		
Standard I—Enrollment Systems		
Requirement 3: Member Enrollment Data—The PAHP shall reconcile its eligibility and capitation records for each eligible enrolled member monthly. - If the PAHP discovers a discrepancy in eligibility or capitation, the PAHP shall provide notification in a manner specified by the Agency. - The PAHP shall return any capitation or overpayments to the Agency within sixty (60) days of discovering the discrepancy via procedures determined by the Agency. - If the PAHP receives either enrollment information or capitation for an enrolled member, the PAHP is financially responsible for the enrolled member unless the PAHP has not received capitation for that enrolled member ninety (90) days following notification to the Agency that a capitation was not received. <i>The PAHP should describe, in detail, monthly enrollment reconciliation processes. Types of evidence include process flows, policies and procedures, process manuals, sample reports, etc.</i>		
Reference—HHS Contract Section K.39(b)		
Score:	☐ Met	☒ Not Met—Action Required
Findings:	The PAHP provided a description of the process within the Enrollment Tool related to how the PAHP will reconcile its eligibility with the capitation records (820 file), however, the PAHP did not submit any evidence that supported implemented processes related to Requirements 3.a–c.	
Required Action:	In order to receive a Met score for this element, the PAHP must: Provide policies, procedures, and/or workflows that addresses Requirements 3.a–c as they relate to its reconciliation of eligibility and capitation records.	
Information Submitted as Evidence by the PAHP		
Documents Submitted	Description of the Process	
	DQ has an internal system which pulls in the billed membership at the invoice level. When received, the 820 file is also uploaded to the database. The data within the 820 is analyzed at a member level to determine variances between internal and client values. 820 capitation payment data is to be reconciled against Enrollment data and internal rate data. Variances	

Information Systems Readiness Review Standards Remediation Plan		
Standard I—Enrollment Systems		
		are to be broken down and analyzed for root causes including, but not limited to: timing issues, rate discrepancies, membership/enrollment discrepancies.
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	DentaQuest has fully remediated this requirement by implementing the FIN08-ENT 820 Reconciliation Policy and Process to ensure monthly reconciliation of eligibility and capitation records at the member level. The SI_NET30-INS SOP Iowa Medicaid/CHIP Client Notification Requirements was updated to include requirements for identification of discrepancies, notification to the Agency, and return of overpayments within 60 days. Additionally, established processes across Finance, Enrollment, and Client Engagement teams ensure ongoing monitoring, reporting, and resolution of discrepancies in compliance with contractual requirements. - SXIII_SI_FIN08-ENT - 820 Reconciliation <Entire Document; Pg. 3 – Exhibit – Iowa> - SXIII_SI_NET30-INS-SOP_Iowa Medicaid CHIP Client Notification Requirements <Pg. 3 – Member Enrollment Data. Reconciliation Process >	
Individual(s) Responsible: [redacted]		
Completion Date: 05/08/2026		
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.		☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted
Requirement 5: Managed Care Excluded Populations —The populations in this section are excluded from enrollment in the Medicaid Managed Care program. - Non-qualified aliens receiving time-limited coverage of certain emergency medical conditions. - Beneficiaries who have a Medicaid eligibility period that is retroactive. - Persons eligible for the Program of All-Inclusive Care for the Elderly (PACE) who voluntarily elect PACE coverage. - Persons enrolled in Health Insurance Premium Payment Program (HIPP). - Persons deemed medically needy. - Persons incarcerated and ineligible for full Medicaid benefits. - Persons presumed eligible for services (i.e., presumptive eligibility). - Persons residing in the Iowa Veteran’s Home. - Effective July 1, 2017, beneficiaries who are eligible only for the Family Planning Waiver. - Persons eligible only for the Medicare Savings Program.		

Information Systems Readiness Review Standards Remediation Plan	
Standard I—Enrollment Systems	
k. Alaskan Native and American Indian populations shall be enrolled voluntarily.	
<i>The PAHP should describe its processes for ensuring that enrollment data received and processed into its enrollment data system is for populations eligible for the Managed Care Program only and should describe its process for communicating any issues with or discrepancies in enrollment data to HHS. Types of evidence include process flows, policies and procedures, process manuals, sample reports, etc.</i>	
Reference—HHS Contract Exhibit D.02	
Score:	☐ Met ☒ Not Met—Action Required
Findings:	The PAHP did not provide any evidence or documentation addressing Requirements 5.a–k.
Required Action:	In order to receive a Met score for this element, the PAHP must: Update applicable documents and implement appropriate processes to address Requirements 5.a–k as they relate to managed care excluded populations.
Information Submitted as Evidence by the PAHP	
Documents Submitted	Description of the Process
	We map data into Windward based on client submitted codes that identify populations eligible and not eligible for benefits. The populations listed above will not be mapped into Windward based on the codes associated with them on the client enrollment file.
Plan to Remedy Deficiency: (Include all actions that will be taken to remediate deficiency.)	Policy ENR01-INS-Member Enrollment IA has been updated with the excluded populations on page 5. DentaQuest has confirmed with the State that the 834 will not contain members from excluded populations. If the State does send excluded populations in the future, we will add filtering based on future codes that may be included on the 834 should the state not filter out these members. SXIII_SI_ENR01-INS-Member Enrollment IA <Pg. 5-6>
Individual(s) Responsible: [redacted]	
Completion Date: 05/08/2026	

Information Systems Readiness Review Standards Remediation Plan	
Standard I—Enrollment Systems	
HSAG Feedback: The PAHP’s remediation plan and supporting documentation are sufficient to demonstrate readiness with the requirements for this program area.	☒ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Appendix F. Financial Management Readiness Tool

Standard I—Financial Viability: Reporting and Monitoring

Standard I—Financial Viability: Reporting and Monitoring						
Requirement	Score	Evidence as Submitted by the PAHP				
1. The Contractor shall submit data on the basis of which the Agency determines that the Contractor has made adequate provision against the risk of insolvency. a. The Contractor shall obtain insurance coverage for the types, limits, and amounts as outlined in Section 1.4. b. The Contractor shall provide assurances satisfactory to the Agency that its provision against the risk of insolvency is adequate to ensure that Enrolled Members will not be liable for the Contractor’s debt if the Contractor becomes insolvent. c. The Contractor produces adequate documentation satisfying the State that it has met its solvency requirements. d. The Contractor complies with all statutory requirements for fiscal soundness. The Agency will evaluate the PAHP’s financial soundness. Contract 1.4, I.2.05, I.2.08, I.2.20, J.7.01 ☒ Met ☐ Not Met ☐ NA a. ☒ Yes ☐ No b. ☒ Yes ☐ No c. ☒ Yes ☐ No d. ☒ Yes ☐ No Documents Submitted: Insurance Certificates 2022-2024 RBC Reports 2022-2024 NAIC Financial Statements Audited Financials Form F <tr><td colspan="2"> HSAG Findings: DentaQuest’s submitted insurance certifications, audited financial statements, National Association of Insurance Commissioners (NAIC) annual statements, and Form F satisfy this requirement. Initially, DentaQuest did not provide proof of Products—Completed Operations Aggregate coverage. However, DentaQuest submitted a revised Certificate of Coverage which meets this requirement. HSAG has determined that DentaQuest has demonstrated readiness for this element and has the ability to meet its financial obligations and manage operations. </td><td></td></tr> <tr><td colspan="2"> HSAG Recommendations: None were identified. </td><td></td></tr>	HSAG Findings: DentaQuest’s submitted insurance certifications, audited financial statements, National Association of Insurance Commissioners (NAIC) annual statements, and Form F satisfy this requirement. Initially, DentaQuest did not provide proof of Products—Completed Operations Aggregate coverage. However, DentaQuest submitted a revised Certificate of Coverage which meets this requirement. HSAG has determined that DentaQuest has demonstrated readiness for this element and has the ability to meet its financial obligations and manage operations.			HSAG Recommendations: None were identified.		
HSAG Findings: DentaQuest’s submitted insurance certifications, audited financial statements, National Association of Insurance Commissioners (NAIC) annual statements, and Form F satisfy this requirement. Initially, DentaQuest did not provide proof of Products—Completed Operations Aggregate coverage. However, DentaQuest submitted a revised Certificate of Coverage which meets this requirement. HSAG has determined that DentaQuest has demonstrated readiness for this element and has the ability to meet its financial obligations and manage operations.						
HSAG Recommendations: None were identified.						

Standard I—Financial Viability: Reporting and Monitoring		
Requirement	Score	Evidence as Submitted by the PAHP
2. The Contractor shall submit audited financial reports specific to the Medicaid contract on an annual basis. The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards. a. Were the submitted reports based on statutory accounting practices? b. Were the submitted reports specific to the insurer rather than on a consolidated or combined basis? Contract I.2.08, I.2.19, I.2.20	☒ Met ☐ Not Met ☐ NA a. ☒ Yes ☐ No b. ☒ Yes ☐ No	Documents Submitted: Audited Financials
HSAG Findings: The independent auditor's (Deloitte & Touche LLP) Financial Reports for 2022–2024 provided the necessary information and met the requirements of this element. HSAG has determined that DentaQuest has demonstrated readiness for this element and has the ability to meet its financial obligations and manage operations.		
HSAG Recommendations: None were identified.		
3. The Contractor shall submit to the Agency a copy of the annual audited financial report required by the Iowa Insurance Division. The report shall specify the Contractor's financial activities under the Contract within six (6) months following the end of each calendar year. The report, prepared using Statutory Accounting Principles as designated by the National Association of Insurance Commissioners (NAIC), shall be prepared by an independent Certified Public Accounting on a calendar year basis. What type of opinion was issued by the independent auditor of the most recent financial statements? a. Unqualified Opinion: Financial statements are accurate and compliant. b. Qualified Opinion: Minor issues exist, but overall statements are accurate.	☒ Met ☐ Not Met ☐ NA a. ☒ Yes ☐ No b. ☐ Yes ☒ No c. ☐ Yes ☒ No d. ☐ Yes ☒ No	Documents Submitted: Audited Financials

Standard I—Financial Viability: Reporting and Monitoring		
Requirement	Score	Evidence as Submitted by the PAHP
c. Adverse Opinion: Significant misstatements; financials are not reliable. d. Disclaimer of Opinion: Insufficient evidence to form an opinion. If the opinion was not qualified, what was the reason for the deviation? Contract I.2.19, I.2.20 NAIC Annual Statement Instructions 2025		
HSAG Findings: The independent auditor (Deloitte & Touche LLP) presented an Unmodified Opinion on Statutory Basis of Accounting, and an Adverse Opinion on U.S. Generally Accepted Accounting Principles. Financial statements were prepared in accordance with the accounting practices prescribed or permitted by the Texas Department of Insurance, rather than in accordance with accounting principles generally accepted in the United States. All Audited Financial Statements provided the necessary information and met the requirements of this element. The Audited Financial Statements identified an underwriting loss for the period ending 12/31/2024. HSAG requested information from DentaQuest regarding this loss. DentaQuest provided quarterly statements for 2025, which demonstrated financial recovery and identified causes for the underwriting loss that had been rectified. HSAG has determined that DentaQuest has demonstrated readiness for this element and has the ability to meet its financial obligations and manage operations.		
HSAG Recommendations: None were identified.		
4. Were any differences noted between information included in the Audited Financial Report and the insurer's Annual Financial Statement? a. Total assets b. Net income c. Surplus Contract I.2.19, I.2.20	☒ Met ☐ Not Met ☐ NA a. ☐ Yes ☒ No b. ☒ Yes ☐ No	Documents Submitted: Audited Financials Annual NAIC Financial Statements

Standard I—Financial Viability: Reporting and Monitoring		
Requirement	Score	Evidence as Submitted by the PAHP
	c. ☒ Yes ☐ No	
HSAG Findings: HSAG did not note any significant differences between the Audited Financial Report and insurer’s Annual Financial Statement for the period ending 12/31/2024. HSAG did identify minor differences in amounts reported for net income for the periods ending 12/31/2022 and 12/31/2023, as well as minor differences between reported capital and surplus for the period ending 12/31/2022. Although no significant differences were noted, HSAG did identify a net loss and underwriting loss for the period ending 12/31/2024 when no such losses had been reported in previous financial statements provided by DentaQuest. Upon HSAG’s request, DentaQuest provided HSAG with quarterly statements for the period ending 12/31/2025, which demonstrated no underwriting losses and improved financial performance. Based upon these statements, HSAG has determined that DentaQuest has demonstrated readiness for this element and has the ability to meet its financial obligations and manage operations. HSAG Recommendations: None were identified.		
5. Were the following included in the Statement of Actuarial Opinion (SAO)? a. Does the SAO include a completed Table of Key Indicators? b. Does the SAO state the actuary’s qualifications and affiliation? c. Was the actuary appointed by the board of directors (or its equivalent) or by a committee of the board by December 31 of the calendar year for which the SAO was rendered? d. Is this the same actuary who was appointed for the previous SAO? i. If “no,” did the health entity notify the domiciliary state insurance regulator within 5 business days of the replacement? ii. Within 10 business days of the above notification, did the health entity also provide an additional letter stating whether or not there were any disagreements with the former actuary during the preceding 24 months and also in writing requested the former actuary provide a letter of agreement?	☒ Met ☐ Not Met ☐ NA a. ☒ Yes ☐ No b. ☒ Yes ☐ No c. ☒ Yes ☐ No d. ☐ Yes ☒ No	Documents Submitted: Actuarial Opinions 2022, 2023, 2024, 2025 Actuary Appointment 5- and 10-day notices DQ USA Secretary’s Certificate – Actuary

Standard I—Financial Viability: Reporting and Monitoring		
Requirement	Score	Evidence as Submitted by the PAHP
iii. Did the company provide the responsive letter from the replaced actuary? e. Do the reserve amounts included in the SAO agree with the amounts per the Annual Financial Statement? f. If the Appointed Actuary has not examined the underlying records and has relied upon the data prepared by the health entity or a third party, is there a certification letter attached to the SAO signed by the individual or firm who prepared such underlying data? Contract I.2.19, I.2.20 NAIC Annual Statement Instructions 2025	e. ☒ Yes ☐ No f. ☐ Yes ☒ No	
HSAG Findings: The actuary identified on the Statement of Actuarial Opinion (SAO) provided for the period ending 12/31/2025 differs from the actuary listed on the statements received for 2022–2024. At HSAG’s request, DentaQuest provided the documentation outlined by NAIC under “Replacement of an Appointed Actuary.” HSAG has determined that DentaQuest has demonstrated readiness for this element and has the ability to meet its financial obligations and manage operations.		
HSAG Recommendations: None were identified.		
6. Does the SAO state the following: a. “In my opinion, the amounts carried in the balance sheet on account of the items identified above”: i. Are in accordance with accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles? ii. Are based on actuarial assumptions relevant to contract provisions and appropriate to the purpose for which the statement was prepared? iii. Meet the requirements of the insurance laws and regulations of the state of domicile and are at least as great as the minimum aggregate amounts required by any state in which this statement is filed or are at least as great as the minimum aggregate	☒ Met ☐ Not Met ☐ NA a. ☒ Yes ☐ No b. ☒ Yes ☐ No c. ☒ Yes ☐ No	Documents Submitted: Actuarial Opinion

Standard I—Financial Viability: Reporting and Monitoring		
Requirement	Score	Evidence as Submitted by the PAHP
amounts required by any state. For each state, a separate SAO was submitted to that state that complies with the requirements of that state? iv. Make good and sufficient provision for all unpaid claims and other actuarial liabilities of the organization under the terms of its contracts and agreements. v. Are computed on the basis of assumptions consistent with those used in computing the corresponding items in the Annual Financial Statement of the preceding year-end? vi. Include appropriate provisions for all actuarial items that ought to be established. b. The Annual Financial Statement, Underwriting and Investment Exhibit—Part 2B was reviewed for reasonableness and consistency with the applicable Actuarial Standards of Practice. c. Actuarial methods, considerations, and analyses used in forming my opinion conform to the relevant Standards of Practice as promulgated from time to time by the Actuarial Standards Board, which standards form the basis of this SAO. Contract I.2.20, J.7.04 NAIC Annual Statement Instructions 2025		
HSAG Findings: The 2022–2024 SAOs meet the requirements of this element. HSAG has determined that DentaQuest has demonstrated readiness for this element and has the ability to meet its financial obligations and manage operations.		
HSAG Recommendations: None were identified.		
7. Statement of Actuarial Opinion Worksheet. Were any concerns noted regarding the valuation of the insurer’s reserves in accordance with minimum statutory valuation standards?	☒ Met ☐ Not Met ☐ NA	Documents Submitted: Actuarial Opinion

Standard I—Financial Viability: Reporting and Monitoring		
Requirement	Score	Evidence as Submitted by the PAHP
Contract I.2.05, I.2.08, I.2.20, J.7.04 NAIC Annual Statement Instructions 2025	☐ Yes ☒ No	
HSAG Findings: The submitted SAO Worksheets for 2022–2024 met requirements and did not note any concerns related to reserves. HSAG has determined that DentaQuest has demonstrated readiness for this element and has the ability to meet its financial obligations and manage operations.		
HSAG Recommendations: None were identified.		

Results for Standard I—Financial Viability: Reporting and Monitoring						
Met	=	7	X	1	=	7
Not Met	=	0	X	0	=	0
NA	=	0				
Total Applicable	=	7	Total Score		=	7
Total Score ÷ Total Applicable					=	100%

Standard II—Financial Solvency

Standard II—Financial Solvency		
Requirement	Score	Evidence as Submitted by the PAHP
1. Annual Financial Statement, Underwriting and Investment Exhibit—Part 2B and 2C: a. When comparing the one-year reserve development to capital and surplus did the insurer report a reserve deficiency that is greater than 5 percent of capital and surplus? b. Has there been an increase or decrease in the claim reserve and claim liability as a percentage of incurred claims since prior year-end? c. Has Part 2C exhibited an adverse trend or unusual fluctuation over the last five years? d. Has the reserve been adequate to pay actual claims? e. Have any lines of business been under reserved at the prior year-end? f. If significant concerns regarding reserve development were historically identified, was the assistance of a department or consulting actuary requested in reviewing and assessing the adequacy of the reserves? Contract I.2.08, I.2.19, I.2.20, J.7.04 NAIC Annual Statement Instructions 2025	☒ Met ☐ Not Met ☐ NA a. ☐ Yes ☒ No b. ☐ Yes ☒ No c. ☒ Yes ☐ No d. ☒ Yes ☐ No e. ☐ Yes ☒ No f. ☐ Yes ☒ No	Documents Submitted: Annual NAIC Financial Statements
HSAG Findings: The Annual NAIC Statements for 2022, 2023 and 2024 contained the necessary information and meet the requirements of this element. HSAG observed an underwriting loss for the period ending 12/31/2024. DentaQuest provided documentation for this loss and financials for the period ending 12/31/2025 which demonstrated no additional underwriting losses. The financial statements did not indicate any other fluctuations or patterns of concern. HSAG has determined that DentaQuest has demonstrated readiness for this element and has the ability to meet its financial obligations and manage operations.		
HSAG Recommendations: None were identified.		

Standard II—Financial Solvency		
Requirement	Score	Evidence as Submitted by the PAHP
2. Loss ratios and underwriting losses as indicators of reserve adequacy. a. Were there underwriting losses reported for any line of business? b. Was there greater than a 10 percent change in the loss ratio for any line of business? c. Has the PAHP experienced unusual fluctuations or trends in past years for the ratio of claims unpaid plus aggregate health reserve to incurred claims by line of business? Contract I.2.08, I.2.19, I.2.20, J.7.04 NAIC Annual Statement Instructions 2025	☒ Met ☐ Not Met ☐ NA a. ☒ Yes ☐ No b. ☐ Yes ☒ No c. ☐ Yes ☒ No	Documents Submitted: Annual NAIC Financial Statements
HSAG Findings: Although DentaQuest reported an underwriting loss for the period ending 12/31/2024, this loss was related to a one-time event. DentaQuest demonstrated subsequent recovery. Additionally, DentaQuest’s reserves were adequate to cover claims. Therefore, HSAG has no concerns. The NAIC Statements meet the requirements of this element. HSAG has determined that DentaQuest has demonstrated readiness for this element and has the ability to meet its financial obligations and manage operations.		
HSAG Recommendations: HSAG recommends that DentaQuest conduct rigorous testing of product loading for Iowa to prevent errors such as those that led to the one-time event for dental for the period ending 12/31/2024.		
3. Unpaid claims adjustment expenses a. Is the ratio of unpaid claims adjustment expenses to claims unpaid greater than 10 percent? b. Is the ratio of unpaid claims adjustment expenses to incurred claims adjustment expenses greater than 20 percent? Contract I.2.08, I.2.19, I.2.20, J.7.04 NAIC Annual Statement Instructions 2025	☒ Met ☐ Not Met ☐ NA a. ☐ Yes ☒ No	Documents Submitted: Annual NAIC Financial Statements

Standard II—Financial Solvency		
Requirement	Score	Evidence as Submitted by the PAHP
	b. ☐ Yes ☒ No	
HSAG Findings: Calculations of unpaid claims adjustment expense ratios were below the required limits for all years. Combined review of these documents showed that the requirements of this element were met. HSAG has determined that DentaQuest has demonstrated readiness for this element and has the ability to meet its financial obligations and manage operations.		
HSAG Recommendations: None were identified.		
4. Own Risk and Solvency Assessment (ORSA) Summary Report: Total Assets a. Did the ORSA Summary Report analysis indicate any reserving risks that require further monitoring or follow-up? b. Did the ORSA Summary Report analysis indicate any mitigating strategies for existing or prospective reserving risks? Contract I.2.08, I.2.19, I.2.20, J.7.04 NAIC Annual Statement Instructions 2025	☒ Met ☐ Not Met ☐ NA a. ☐ Yes ☒ No b. ☐ Yes ☒ No	Documents Submitted: Form F
HSAG Findings: DentaQuest provided Form F in lieu of the ORSA. HSAG observed documentation in Form F discussing a one-time provision for U.S. Dental and unfavorable morbidity for the period ending 12/31/2024. However, DentaQuest provided details concerning a one-time payment configuration error which resulted in the provision which has since been rectified as well as improved financial performance. Form F did not indicate any unusual or out of the ordinary reserving risks. Risk monitoring plans are set in place to continue to evaluate risks to the Company. HSAG has determined that DentaQuest has demonstrated readiness for this element and has the ability to meet its financial obligations and manage operations.		
HSAG Recommendations: None were identified.		

Standard II—Financial Solvency		
Requirement	Score	Evidence as Submitted by the PAHP
5. The Health Annual Statement Instructions list A through H as prescribed items. a. If the following items are included in the Annual Financial Statement and required by the Annual Financial Statement Instructions, does the Statement of Actuarial Opinion cover the following in the scope and opinion of amounts per Annual Financial Statement Instruction? i. Claims unpaid (Page 3, Line 1)? ii. Accrued medical incentive pool and bonus payments (Page 3, Line 2)? iii. Unpaid claims adjustment expenses (Page 3, Line 3)? iv. Aggregate health policy reserves (Page 3, Line 4) including unearned premium reserves, premium deficiency reserves, and additional policy reserves from the Underwriting and Investment Exhibit—Part 2D? v. Aggregate health claim reserves (Page 3, Line 7)? vi. Any other loss reserves, actuarial liabilities, or related items presented as liabilities in the annual statement? vii. Specified actuarial items presented as assets in the annual statement? b. Any examples of an item included in item 5.a.vi above include the retrospective premium asset (Page 2, line 15.3)? Contract I.2.08, I.2.19, I.2.20, J.7.04 NAIC Annual Statement Instructions 2025	☒ Met ☐ Not Met ☐ NA a. ☒ Yes ☐ No b. ☐ Yes ☒ No	Documents Submitted: Annual NAIC Financial Statement
HSAG Findings: The submitted SAOs met the requirements of this element. HSAG has determined that DentaQuest has demonstrated readiness for this element and has the ability to meet its financial obligations and manage operations.		
HSAG Recommendations: None were identified.		

Results for Standard II—Financial Solvency						
Met	=	5	X	1	=	5
Not Met	=	0	X	0	=	0
NA	=	0				
Total Applicable	=	5	Total Score	=	5	
Total Score ÷ Total Applicable					=	100%

Appendix G. Financial Management Readiness Review Remediation Plan

The PAHP is not required to submit a Financial Management Readiness Review Remediation Plan as it had no *Not Met* findings for this readiness review component.

Appendix H. PAHP Readiness Review Questionnaire

In order to facilitate the completion of your Readiness Review (RR) and assure that your Prepaid Ambulatory Health Plan (PAHP) is correctly evaluated, please complete **Questions 1–22** and submit to HSAG’s [SAFE](#) site by **February 27, 2026**, to the **IA DQ_Readiness Review/1-Questionnaire** folder. Please ensure that all supporting evidence, as requested, is also uploaded to the SAFE folder.

1. Full name of the organization.

DentaQuest

2. Physical address of the location of the PAHP (Per Contract A.14, the PAHP must set up and maintain a business office or work site within the State of Iowa).

1 Sun Life Park Wellesley Hills, MA 02481-5615

3. Contact Information.

	Primary RR Contact	Secondary RR Contact
Name	[redacted]	[redacted]
Title	Sr. Compliance Analyst	Director, Client Engagement
Phone #	629.207.1023	262.387.3344
E-mail address	[redacted]	[redacted]

4. Primary staff person accountable for each area under review. Add secondary staff members, as applicable, by adding additional lines.

Operational Standard	Name and Title	Email
Standard I—Disenrollment Requirements and Limitations	[redacted], Director Regulatory Compliance and Program Integrity [redacted], Sr. Compliance Analyst	[redacted]
Standard II—Member Information and Member Rights	[redacted], Associate Director, Fulfillment and Digital Engagement	[redacted]

Standard III—Emergency and Poststabilization Services	[redacted], Associate Director, Client Partner	[redacted]
Standard IV—Availability of Services	[redacted], Director Provider Engagement	[redacted]
Standard V—Assurances of Adequate Capacity and Services	[redacted], Director Provider Engagement	[redacted]
Standard VI—Coordination and Continuity of Care	[redacted], Director Quality and Outreach (Clinical) [redacted], Associate Director Case Management	[redacted]
Standard VII—Coverage and Authorization of Services	[redacted], UM Auditing Specialist	[redacted]
Standard VIII—Provider Selection	[redacted], Director Provider Engagement	[redacted]
Standard IX—Confidentiality	[redacted], Director Regulatory Compliance & Privacy	[redacted]
Standard X—Grievance and Appeal Systems	[redacted], Operations Compliance Analyst	[redacted]
Standard XI—Subcontractual Relationships and Delegation	[redacted], Associate Director Procurement	[redacted]
Standard XII—Practice Guidelines	[redacted], UM Auditing Specialist	[redacted]
Standard XIII—Health Information Systems	This program area will be assessed through the Information Systems Review. Please see below.	
Standard XIV—Quality Assessment and Performance Improvement Program	[redacted], Sr. Compliance Analyst	[redacted]
Standard XV—Program Integrity	[redacted], Director Regulatory Compliance and Program Integrity	[redacted]

Information Systems Review	Name and Title	Email
Standard XIII—Health Information Systems	[redacted], AVP Information Security	[redacted]
Enrollment System	[redacted], Director Member Enrollment and Benefits	[redacted]
Claims System	[redacted], Claim Audit Analyst	[redacted]
Encounters System	[redacted], Sr Manager Client Data Applications	[redacted]
Financial Management	Name and Title	Email
Financial Viability: Reporting and Monitoring	[redacted], AVP Corporate Accounting	[redacted]
Financial Solvency	[redacted], AVP Corporate Accounting	[redacted]

Questions 5-10: Please ensure all attachments include all requested documentation (e.g., when a question references a contract section, refer to that section to ensure all contract provisions are addressed). When the PAHP is submitting attachments to support responses to this questionnaire, please save all documents using the naming convention specified in each section.

5. Submit evidence that the PAHP is licensed and in good standing in the State of Iowa as a Health Maintenance Organization (HMO), Limited Service Organization (LSO) or Certificate of Authority (COA) in accordance with Contract A.02.

Naming convention: RRQ_Attachment 5_Licensure

EVIDENCE:
RRQ_Attachment 5_IA Licensure

6. Submit the PAHP’s implementation plan for the Iowa Dental Wellness Plan (Adults and Kids) and Hawki. The implementation plan must:

- Comply with Contract A.21.
- Include all operational areas under Contract A.03.

- c. Include the PAHP's plan to submit all written materials to HHS timely (e.g., policies and procedures, marketing materials, member handbook, provider manual)⁵ as required in accordance with the PAHP's contract with HHS. The plan must include the name of the document, the required timeframe for submission to HHS, the date submitted to HHS, and the date approved by HHS.
- d. Adhere to any format required by HHS, as applicable.

Naming convention: RRQ_Attachment 6_Implementation Plan

Naming convention: RRQ_Attachment 6_HHS Document Approval Plan

EVIDENCE SUBMITTED:

RRQ_Attachment 6_Implementation Plan

RRQ_Attachment 6_Iowa Contract Implementation Dashboard

RRQ_Attachment 6_Internal Iowa 2026 Project Operations Workgroup 02.16.2026

7. Submit an organizational chart showing the functional linkage of all major operational areas specified in Contract A.03. The organizational chart must:

- a. Include the percentage of all work in each functional area performed locally in Iowa in accordance with Contract A.14.⁶
- b. Include the percentage of all work performed by the PAHP's other corporate locations in accordance with Contract A.14.²

Naming convention: RRQ_Attachment 7_Org Chart_Operational Areas

SUBMITTED EVIDENCE

⁵ The HHS document approval plan must be a living document and be updated on an ongoing basis. The PAHP must be prepared to submit the staff training plan periodically (and as requested by HSAG) during the readiness review process.

⁶ The PAHP must have more than 50 percent of all work under the Contract in each functional area performed locally in Iowa, with less than 50 percent of all work performed under the Contract performed by the PAHP's other corporate locations, unless otherwise approved by HHS.

RRQ_Attachment 7_Org Chart_Operational Areas

Each functional area performs 100% of the work. For more details on the operational areas, please see the separate org charts throughout this questionnaire.

8. Submit the PAHP's operational staffing plan⁷. The operational staffing plan must:

- a. Include the requirements of Contract A.05-A.07.
- b. Include how the PAHP assessed the need for staffing and resources to accommodate the membership for the Iowa Dental Wellness Plan (Adult and Kids) and Hawki.
- c. Include recruitment strategies for staffing and resources.
- d. Include the projected number of fulltime equivalent (FTE) positions required for each operational area under Contract A.03, and how many are filled/vacant.
- e. Include the percentage of local staff in each functional area who have been onboarded in accordance with Contract A.11.
- f. Include how the PAHP will evaluate the sufficiency of staffing and resources after July 1, 2026.
- g. Adhere to any format required by HHS, as applicable.

Naming convention: RRQ_Attachment 8_Staffing Plan

EVIDENCE SUBMITTED:

RRQ_Attachment 8_Contract Staffing Specifications A.03 thru A.07

RRQ_Attachment 8_DentaQuest- Iowa Personnel Structure- 2.13.2026

RRQ_Attachment 8_DRAFT DentaQuest Recruitment Postcard

RRQ_Attachment 8_DentaQuest- Iowa Staffing Plan- 2.13.2026

⁷ The operational staff plan must be a living document and be updated on an ongoing basis. The PAHP must be prepared to submit the operational staff plan periodically (and as requested by HSAG) during the readiness review process.

9. Submit the PAHP's training plan⁸ for staff responsible for the Iowa Dental Wellness Plan (Adults and Kids) and Hawki. The training program must:
- Comply with Contract A.13.
 - Include all major operational areas specified in Contract A.03.
 - Include the number of staff in each operational area under Contract A.03 and the number and/or percentage of staff fully trained.
 - Adhere to any format required by HHS, as applicable.

Naming convention: RRQ_Attachment 9_Training Plan

SUBMITTED EVIDENCE:

RRQ_Attachment 9_DentaQuest- Iowa Personnel Structure- 2.13.2026

RRQ_Attachment 9_DentaQuest- Iowa Staffing Plan- 2.13.2026

10. Submit the PAHP's provider network onboarding plan⁹ demonstrating it has the capacity to serve the expected enrollment for the Iowa Dental Wellness Plan (Adult and Kids) and Hawki. The provider network onboarding plan must:
- Clarify if the PAHP will have separate provider networks for the Iowa Dental Wellness Plan (Adult and Kids) and Hawki. If the PAHP's provider network is all inclusive (i.e., one provider network for the Iowa Dental Wellness Plan (Adult and Kids) and Hawki), clarify how the PAHP will distinguish which providers accept members enrolled in the Iowa Dental Wellness Plan—Adult, the Iowa Dental Wellness Plan—Kids, and/or Hawki.
 - Include how the PAHP assessed the need for number/mix of provider types.
 - Include the number/mix of provider types by specialty expected to be contracted with the PAHP by July 1, 2026, and the number/mix of provider types by specialty currently contracted with the PAHP.

⁸ The staff training plan must be a living document and be updated on an ongoing basis. The PAHP must be prepared to submit the staff training plan periodically (and as requested by HSAG) during the readiness review process.

⁹ The provider network onboarding plan must be a living document and be updated on an ongoing basis. The PAHP must be prepared to submit the provider network onboarding plan periodically (and as requested by HSAG) during the readiness review process.

- d. Include an analysis of time/distance standards in accordance with Exhibit C: General Access Standards upon assignment of membership. The analysis must be separate for each covered population (i.e., the Iowa Dental Wellness Plan—Adult, the Iowa Dental Wellness Plan—Kids, and Hawki).
 - i. The initial analysis must be based on projected membership counts and locations.
 - ii. An updated analysis must be provided once actual enrollment data is received.
- e. Include how the PAHP will monitor the sufficiency of its provider network capacity after July 1, 2026.
- f. Include a contingency plan for ensuring access and continuity of care in the event of a gap in the PAHP's provider network.
- g. Adhere to any format required by HHS, as applicable.

Naming convention: RRQ_Attachment 10_Provider Network Onboarding Plan

SUBMITTED EVIDENCE:

RRQ_Attachment 10_Implementation Plan

Questions 11-22: Provide a high-level narrative description in the space provided below for each program area. Please ensure all requested information is included. When responding, the PAHP should not refer to PAHP policies or procedures and/or include federal or state contract language, but instead provide a description of the internal operational processes to support the federal and/or state contract requirements. The responses must be specific to Iowa, and all systems must be configured with Iowa specifications. When the PAHP is submitting attachments to support responses to this questionnaire, please save all documents using the naming convention specified in each section.

11. Describe the enrollment/disenrollment structure, and include:

- a. Organizational chart of enrollment/disenrollment staff.
 - Naming convention: RRQ_Attachment 11_Enroll-Disenroll Org Chart
- b. Describe the delineation of responsibilities between corporate staff and state-level staff.
- c. System(s) used to maintain enrollment and disenrollment information.
- d. Provide a high-level overview of the enrollment/disenrollment processes.

- a. RRQ_Attachment 11_Enroll-Disenroll Org Chart

b. The Corporate Executive team has oversight of the entirety of the DentaQuest company. The Corporate team will be consulted as appropriate for issues or escalation and/or strategic guidance by the Iowa team. The Iowa team is accountable for all deliverables and requirements as outlined in the contract.

c. DentaQuest uses its Windward, its proprietary core operating system to process and access information (call history, eligibility, claims and authorization history, and benefits).

d. DentaQuest receives and processes the enrollment files using the HIPAA 834 version 5010 file format. All eligibility data is automatically loaded in near real-time of receipt into our Windward operating system, ensuring that the data can be processed at any time, even if it was transmitted during non-traditional business hours. All enrollment data is screened for completeness, logic and consistency, and our system maintains audit trails that enable us to comply with audits for validity and completeness at any time. Our Enrollment Analysts investigate and resolve any fatal or informational errors. We will have an analyst assigned to Iowa who will work with the local team to resolve and correct any file discrepancies. The last stage of the process applies the Member's updates in Windward. DentaQuest staff can see these updates immediately. We update the secure Provider Portal in near real time, so changes are available almost immediately after the membership file has been completed. We understand that there may be times when Members may seek to disenroll from our plan. We maintain policies, procedures, and processes to ensure compliance with disenrollment requests. In accordance with requirements, we will ensure all requests, both written and oral, for disenrollment are addressed through our grievance process prior to referral to the Agency.

12. Describe the member services department, and include:

a. Organizational chart of member services staff.

- Naming convention: RRQ_Attachment 12_Member Services Org Chart

b. Describe the delineation of responsibilities between corporate staff and state-level staff.

c. System(s) used to track member inquiries and other calls.

a. RRQ Attachment 12 Member Services Org Chart

b. Management of the Customer Service department (members and providers) is at the Corporate level. The management is responsible for managing the staff, monitoring service level metrics, strategic guidance and escalation of issues. The local team will respond to inquiries from members and providers.

c. DentaQuest uses its Windward system to access information (call history, eligibility, claims and authorization history, and benefits) needed to answer inquiries and to log incoming Member and Provider calls.

13. Describe the provider network management structure, and include:

- a. Organizational chart of provider network staff, including provider services, provider contracting, and credentialing.
 - Naming convention: RRQ_Attachment 13_PNM Org Chart
- b. Describe the delineation of responsibilities between corporate staff and state-level staff.
- c. System(s) used to house credentialing and recredentialing data.
- d. System(s) used to maintain provider-related inquiries.
- e. System(s) used to maintain provider-related demographics and fee schedule information to support claims payment.
- f. A high-level description of the credentialing and recredentialing process.
- g. A high-level description of the contracting process.
- h. A high-level description of the provider services process, including provider orientation.
- i. A high-level description of the provider directory maintenance process.

a. RRQ_Attachment 13_PNM Org Chart

b. The Corporate Executive team has oversight of the entirety of the DentaQuest company. The Corporate team will be consulted as appropriate for issues or escalation and/or strategic guidance by the Iowa team. The Iowa team is accountable for meeting and working with providers and practice office staff.

c. The Credentialing department currently houses all the data in Cactus. As we continually look for ways to improve, we will be upgrading to a new credentialing system, sProvider by Symplr during the third quarter. sProvider is an end-to-end provider data management system, encompassing application, verification, credentialing and reporting.

d. Windward houses all provider-related inquiries

e. Windward houses all provider- related demographics and fee schedule information.

f. DentaQuest is committed to credentialing Providers as expeditiously as possible. Our program, which has been NCQA certified since 2014, adheres to the highest level of standards through rigorous initial vetting processing, ongoing monthly monitoring of Provider credentials, and re-credentialing all Providers every three years. Our process meets URAC, Centers for Medicare and Medicaid Services, and state, and federal requirements. Iowa Providers will begin the credentialing process by completing an enrollment application and providing the necessary

documents to support the credentialing process. This includes information that will allow us to verify that the Provider is licensed and eligible to render services in the state. We will conduct primary source verification on the status of state license and sanction history through the National Practitioner's Data Bank and State Licensing Board; Status of Drug Enforcement Agency registration; Certification in Medicaid/Medicare programs through Medicaid/Medicare Sanction, System for Award Management, Office of Inspector General, and Medicare Opt Out listing; education, including board certification; individual NPI and Group NPI through the NPPES; general anesthesia license, if applicable; and Tax ID number match to the IRS system. Once the Provider completes the initial credentialing process, their information is reviewed and approved by our Credentialing Committee. Upon this approval, our Provider Enrollment staff enters all Provider data, affiliated business(es), and location information into our Windward system. A separate team of quality assurance staff audits a statistically valid, randomly selected sample of Provider enrollment files for accuracy and compliance with applicable state and federal regulations.

g. The DentaQuest recruitment team is trained extensively in the process of contracting providers, which involves targeted outreach efforts. Initially, recruiters engage in proactive outreach via telephone to establish communication with key decision-makers within provider offices. Subsequently, they share contracting materials, ensuring continual correspondence and follow-up. They offer support throughout the completion of the credentialing and contracting paperwork, including the credentialing application materials and provider agreement documents.

h. DentaQuest maintains one contact center for both members and providers.

i. At the time of initial credentialing, and monthly thereafter, the entire provider roster is checked to ensure each Provider maintains appropriate licensure, credentialing, and eligibility in compliance with the Office of Inspector General (OIG) and applicable state laws, rules, and regulations. We monitor license sanctions on an ongoing basis. On a quarterly basis, providers are requested to confirm service office information, location and hours to ensure our directories are up to date.

14. Describe the care coordination structure (i.e., internal case management program), and include:

- a. Organizational chart of care coordination staff.
 - Naming convention: RRQ_Attachment 14_CC Org Chart
- b. Names of key care coordination staff (directors, managers, supervisors, and number of FTEs).
- c. Describe the delineation of responsibilities between corporate staff and state-level staff.
- d. System(s) used to house care coordination data.
- e. Provide a high-level process of identifying members for care coordination.
- f. Provide a high-level process of the transition of care process (e.g., transfer of members from one PAHP to another).

a-b. RRQ Attachment 14 CC Org Chart

c. Corporate staff provide program oversight, management and support to care management program. State level staff interact with enrollees, community partners and state agencies.

d. Windward is used to manage case management data.

e. High level process for identifying enrollees for case management include:

1). Oral Health Screening (OHRA) and Equity Self-Assessments:

- Used to identify enrollees who may be experiencing significant challenges getting dental care or maintaining optimal oral health.
- Partner with Previser to develop a client approved OHRA tool to assess needs based on oral, medical, behavioral, physical health factors, and social determinants.

- OHRA assessment includes questions covering the

following health topics:

- Tooth pain.
- Emergency room usage for dental problems.
- Last dental visit.
- Brushing habits.
- Special health care needs.
- Presence of development, physical, or intellectual disability.
- Pregnancy.
- Health problems, including presence of chronic health conditions.
- Specific barriers/Social Determinants of Health.

2) RISK ASSESSMENT AND STRATIFICATION METHODOLOGY

-At risk members identified via various sources, such as OHRA and Oral Health Equity Self-Assessment. This is incorporated into the member Welcome Call process and member website to provide as many opportunities for enrollees to report to DentaQuest the presence of physical, intellectual, medical, or environmental factors that may present barrier to obtaining needed dental care or maintaining optimal oral health.

f. DentaQuest ensures that: 1. The Enrolled Member has Access to services consistent with the Access they previously had and is permitted to retain their current Provider for ninety (90) days if that Provider is enrolled in Iowa Medicaid; 2. The Enrolled Member is referred to

appropriate Network Providers; 3. For each disenrolling Enrollee, in accordance with federal and state law, DentaQuest fully and timely complies with requests for historical utilization data from the Enrollee's new managed care organization, prepaid inpatient health plan, prepaid ambulatory health plan, primary care case manager, or primary care case management entity; 4. For each disenrolling Enrollee, in accordance with federal and state law, DentaQuest assists the Enrollee's new provider(s) with obtaining copies of the Enrollee's medical records, as appropriate; 5. DentaQuest implements any other procedures specified by CMS to ensure the Enrollee's continued access to services to prevent serious detriment to the Enrollee's health or reduce the risk of hospitalization or institutionalization. 6. DentaQuest shall utilize the model Enrolled Member handbook and notices that describe the transition of care policies for Enrolled Members and Potential Enrolled Members. 7. During the first ninety (90) Days following DentaQuest's entry into the Iowa Dental Wellness Plan and Hawki Dental program, DentaQuest shall allow an Enrolled Member who is receiving covered Benefits from a non-Network Provider at the time enrollment to continue accessing that Provider, even if the network has been closed due to DentaQuest meeting the network Access requirements. DentaQuest is permitted to establish Single Case Agreements with Providers enrolled with Iowa Medicaid or otherwise authorize non-network care past the initial ninety (90) Days of the Contract to provide continuity of care for Enrolled Members receiving out-of-network services. DentaQuest shall make commercially reasonable attempts to contract with Providers from whom an Enrolled Member is receiving ongoing care. Out-of-Network Providers will be reimbursed a percentage of the network rate unless otherwise agreed upon through a Single Case Agreement.

15. Describe the utilization management structure, and include:

- a. **Organizational chart of utilization management staff, including the credentials of each staff member.**
 - **Naming convention: RRQ_Attachment 15_UM Org Chart**
- b. **Describe the delineation of responsibilities between corporate staff and state-level staff.**
- c. **Clinical guidelines used to make prior authorization decisions.**
- d. **System(s) used to record and track service authorizations and denials.**
- e. **A high-level overview of the coverage/service authorizations review process, including the process for handling denials.**
- f. **Describe the delineation between prior authorization processes and pretreatment estimates, if applicable.**
- g. **A high-level overview of the emergency and poststabilization care services processes. The PAHP must include examples of what the PAHP constitutes as emergency dental services and poststabilization care dental services.**

a. RRQ_Attachment 15_UM Org Chart

b. Corporate staff provide program oversight, management and support to utilization management program. State level staff interact with enrollees, community partners and state agencies.

c. Written criteria and clinical guidelines utilized in the process of benefit determination are developed based on: Medicare and State Medicaid guidelines, National Correct Coding Initiatives, professional educational materials (e.g. Best Practice Guidelines of AOA, AAO), specific health plan developed guidelines, accepted industry standards of care, State and Health Plan specific requirements, as well as the information contained in the current CDT and CPT Manual published by the American Medical Association.

d. Windward is used to manage utilization management data.

e. Clinical Review Specialists are responsible for initial review of benefit decisions that require medical necessity review to determine if the request is compliant with the allowed contracted service codes. Requests that do not meet clinical requirements are referred to a Dental Consultant for review and determination of coverage. All authorization decisions are communicated in a written letter of determination to the Provider and to the Member. If a service is denied, either the member or the provider have the ability to submit an appeal. DentaQuest's Utilization Management program is NCQA certified.

f. A pre-treatment estimate is a document provided to patients before dental treatment begins, outlining the proposed procedures, associated costs, and payment terms. A prior authorization is a request for UM review prior to rendering the actual service

g. Post-stabilization requirements under federal managed care regulations (e.g., 42 CFR §438.114) are designed to ensure continuity of care following emergency medical services. Within the dental benefit context, emergency and urgent dental services are addressed through established coverage, authorization, and claims adjudication processes that ensure timely access to care and appropriate reimbursement.

Dental services are evaluated and reimbursed based on the specific CDT procedure codes submitted by the treating provider and in accordance with the member's benefit plan, clinical policies, documentation requirements, and applicable fee schedules. Coverage determinations are tied to the services rendered rather than a separate post-stabilization designation.

Dental reimbursement is based solely on the CDT procedure code billed by providers and the applicable dental benefit coverage, not on a post-stabilization determination.

"Emergency Dental Services" are defined as those services necessary for the treatment of any condition requiring immediate attention for the relief of pain, hemorrhage, acute infection, or traumatic injury to the teeth, supporting structure, jaws, and tissue of the oral cavity. DentaQuest does not require prior authorization for emergent/urgent and post-stabilization services and will pay the claims.

16. Describe the grievance structure, and include:

- a. Organizational chart of staff processing grievances, including the credentials of each staff member.
 - Naming convention: RRQ_Attachment 16_Grievances Org Chart
- b. Describe the delineation of responsibilities between corporate staff and state-level staff.
- c. System(s) used to record and track grievances.
- d. Provide a high-level overview of the grievance resolution process.

a. RRQ_Attachment 16_Grievances Org Chart

b. Corporate staff provide program oversight, management and support to grievance program. State level staff interact with members and providers.

c. DentaQuest uses Salesforce, a customized Grievances and Appeals application that provides us with greater controls, customization, and consistency to exceed client expectations.

d. Grievance Process Overview

Receiving Grievances

Grievances can be submitted verbally or in writing to DentaQuest. When DentaQuest Customer Care receives a call regarding dissatisfaction, representatives will attempt to resolve the issue during the call. If unable to resolve immediately, a case is opened for the Complaints & Grievances (C&G) department to process. Any requests for expedited handling are noted in the submission to C&G. Written grievances received at DentaQuest are also processed by the C&G department.

Filing Requirements

Members or their Authorized Representatives may file grievances at any time.

Review and Resolution Process

Acknowledgement: An acknowledgement is issued within the required turnaround time upon receipt of the grievance.

Investigation: The C&G Specialist investigates the case by coordinating with other departments as needed to reach resolution and contacting the provider office to obtain responses and necessary records when applicable. All Quality of Care concerns are reviewed by a Dental Consultant.

Resolution: The DentaQuest C&G Specialist resolves the case and issues a resolution letter within the required turnaround time.

17. Describe the appeals structure, and include:

- a. Organizational chart of staff processing appeals, including the credentials of each staff member.

- Naming convention: RRQ_Attachment 17_Appeals Org Chart

- b. Describe the delineation of responsibilities between corporate staff and state-level staff.
- c. System(s) used to record and track appeals.
- d. Provide a high-level overview of the appeals resolution process.

a. RRQ_Attachment 17_Appeals Org Chart

b. Corporate staff provide program oversight, management and support to appeals program. State level staff interact with members and providers.

c. DentaQuest uses Salesforce, a customized Grievances and Appeals application that provides us with greater controls, customization, and consistency to exceed client expectations.

d. Appeals Process Overview:

Receiving Appeals

Appeals can be submitted verbally or in writing to DentaQuest. Verbal requests received by Customer Care are forwarded to the Appeals department, while written appeals received by the Health Plan are sent to DentaQuest via secure email.

Filing Requirements

Members or their Authorized Representatives must file appeals within the required timeframe following the initial determination.

Review and Resolution Process

Initial Assessment: The Appeals Specialist reviews the request to determine if expedited resolution is needed and issues an acknowledgement within the required turnaround time.

Investigation: The Appeals Specialist gathers information by contacting the member and provider as needed and coordinates with other departments to research the request. For clinical cases, the specialist arranges a review by an independent Dental Consultant who was not involved in previous determinations. Administrative denials, such as Service Not Covered or Exceeds Benefit Limitation, are reviewed and determined by the Appeals Specialist without clinical consultation.

Resolution: The Appeals Specialist resolves the case and issues a resolution letter within the required timeframe.

18. Describe the delegation oversight structure, and include:

- a. Organizational chart of delegation oversight staff.
 - Naming convention: RRQ_Attachment 18_Delegation Org Chart
- b. Describe the delineation of responsibilities between corporate staff and state-level staff.
- c. Provide a description of the managed care contract obligations the PAHP intends to delegate for the Iowa Dental Wellness Plan (Adults and Kids) and Hawki.
- d. Provide a high-level overview of the delegation oversight processes, including reporting expectations and monitoring activities (e.g., process for determining types of reports, frequency of reporting, and frequency of periodic formal reviews).
- e. Provide a high-level description of the delegation oversight committee(s).
- f. A list of all current and planned subcontractors/delegated entities and the functions being delegated (the PAHP may refer to its Delegation Universe File).

a. RRQ_Attachment 18_Vendor Management Oversight Org Chart

b. Corporate staff are responsible for vendor management and delegation.

c. Obligations that DentaQuest delegates includes items such as: member and surveys, printing of checks and Explanations of Payments, printing and mailing members materials and call center functions

d. DentaQuest monitors our sub-delegated vendors services levels and any key performance indicators on an ongoing basis for each of the individual services that are sub-delegated on behalf of our clients. In addition, DentaQuest works collaboratively with our sub-delegated vendors through several initiatives to help reduce and avoid increased cost in a changing environment. Compliance, Legal, Information Security, Quality, and Vendor Management teams hold bi-weekly and quarterly meetings to discuss vendor metrics and trends and for overall monitoring the vendor relationships. DentaQuest vets and audits its vendors prior to onboarding through a security and compliance review, then reviews are conducted through annual governance throughout the life cycle of the relationship. In addition, DentaQuest's Subject Matter Experts (SMEs) are assigned to monitor the day-to-day operations involved in all vendor selections and pre vendor interviews followed by continuous monitoring through the day-to day operations thereafter. SMEs from our Compliance and Vendor Management departments understand that DentaQuest is responsible for ensuring the security of its member and client data, the quality of its services, and the conformity with its statutory, regulatory, and contractual obligations. From initial retention and routinely thereafter, DentaQuest receives and documents assurances that sub-delegated vendors have the necessary controls in place; and sub-delegated vendors can and have the ability to continue to deliver services in accordance with client and company expectations. Should any vendor or supplier be determined out of compliance with statutory or regulatory compliance requirements, Compliance will draft a Corrective Action Plan for Vendor Management to implement with

the sub-delegated vendor. If a root cause analysis shows that the source of the problem was a reckless disregard of DentaQuest policies or applicable laws and regulations or willful misconduct, the Compliance Corrective Action policy shall yield to all appropriate provisions of applicable disciplinary corrective action plans or policies.

e. The Delegation Oversight Committee (DOC) is a subcommittee of the Quality Oversight Committee. The DOC monitors performance and provides oversight of our subcontractors to confirm that they are consistently meeting our expectations and performance levels. Dana Bohm, AVP, Compliance & Quality Management, is the current chairperson of the DOC. DentaQuest has long maintained a robust process for the managing third parties and mitigating any potential risks created by sub-delegation. From onboarding and throughout the relationship life cycle, DentaQuest's vendor management oversight program ensures that services, governed by state and federal laws and regulations, are delivered in the same form and manner as they are by DentaQuest, and are free from fraud, waste, or abuse.

f. RRQ_Attachment 18_11a_DQ_IA2026_PAHP_RR_File Review_Delegation_D1

19. Describe the health information system structure, and include:

- a. **Organizational chart of information systems staff.**
 - Naming convention: RRQ_Attachment 19_HIS Org Chart
- b. **Data flow chart demonstrating the interaction/integration of all information systems.**
 - Naming convention: RRQ_Attachment 19_HIS Flow Chart
- c. **Describe the delineation of responsibilities between corporate staff and state-level staff.**
- d. **System(s) used to maintain enrollment, claims, and encounter data.**
- e. **Provide a high-level overview of testing (internal and external) that has occurred, or is planned to occur prior to implementation, to ensure accuracy of enrollment, claims, and encounter data. Provide test plans.**

a. RRQ_Attachment 19_HIS Org Chart

b. RRQ_Attachment 19_HIS Flow Chart

c. Corporate staff are responsible for health information systems.

d. DentaQuest uses its Windward, its proprietary core operating system to process and access information (call history, eligibility, claims and authorization history, and benefits).

e. Testing plan is included as part of the Implementation Plan.

20. Describe the quality assessment and performance improvement (QAPI) program structure, and include:

- a. Organizational chart of QAPI staff.
 - Naming convention: RRQ_Attachment 20_QAPI Org Chart
- b. QAPI program committee and subcommittee structure/chart.
 - Naming convention: RRQ_Attachment 20_QAPI Committee Structure
- c. Describe the delineation of responsibilities between corporate staff and state-level staff.

- a. RRQ_Attachment 20_Quality Improvement Organizational Chart_Iowa
- b. RRQ_Attachment 20_Quality Management_Quality Improvement Program_Iowa
- c. Corporate staff provide program oversight, management and support to QAPI program. State level staff interact with members and providers.

21. Describe the program integrity and privacy and security structures, and include:

- a. Organizational chart of program integrity staff.
 - Naming convention: RRQ_Attachment 21_PI Org Chart
- b. Organizational chart of privacy and security staff.
 - Naming convention: RRQ_Attachment 21_Privacy Org Chart
- c. Describe the delineation of responsibilities between corporate staff and state-level staff.
- d. System(s) used to track program integrity issues (e.g., fraud and abuse, HIPAA-related incidents).
- e. Provide a brief description of the program integrity activities conducted by the PAHP.
- f. Provide a brief description of how the PAHP ensures confidentiality of member health information and other confidential data.

- a. Please see RRQ_Attachment 21_Compliance Org Chart 11.12.2025 and RRQ_Attachment 21_Program Integrity Org Chart for IA 02262026 1

b. Please see RRQ_Attachment 21_Compliance Org Chart 11.12.2025 and RRQ_Attachment 21_Program Integrity Org Chart for IA 02262026 1 and RRQ_Attachment 21_PI Org Chart

c. Corporate teams have oversight of the program integrity, privacy and security structures. They are responsible for maintain the programs, monitoring metrics and strategic direction and guidance. The Iowa team is accountable to help meet the deliverables and requirements as outlined in the contract.

d. Fraud Waste and Abuse complaints are documented and tracked in a specialized FPR Unit Case Tracking System, Compliance 360 is used to manage HIPAA-related incidents.

e. The FPR Unit in compliance with 42 CFR 456 will conduct a preliminary investigation upon detection or receipt of internal/external complaints of any potential provider/entity fraud, waste and abuse. The DentaQuest strategy begins with significant effort to prevent fraud, waste or abuse before it occurs, through prior authorization and pre-payment review, system and base edits, and procedure rules. We continue to innovate, develop best practices and anticipate the impact of a changing environment. For example, DentaQuest applies the intelligence learned from investigations to up-front edits when new patterns of FWA emerge and when an edit can prevent payment for an inappropriately billed service.

f. As both a SOC-2 and HITRUST-certified company, DentaQuest employs a sophisticated multi- layered approach to data security. DentaQuest deploys several layers of overlapping security protections that can react and stop various threats. This methodology ensures business continuity and minimizes risks by removing single points of failure in the DentaQuest Information Security and Privacy stacks. The DentaQuest Security and Privacy program is based upon regulations, laws, and best practices frameworks including HIPAA Security and Privacy Rules, Payment Card Industry Data Security Standards (PCI DSS), European Union General Data Protection Regulation (GDPR), Minimum Acceptable Risk Standards for Exchanges (MARS-E) via NIST SP 800-53 version 5, NIST CSF, and CIS 20 Critical Security Controls. DentaQuest's management team performs risk and readiness assessments against the HIPAA Security Rule, including a data protection impact assessment, mapping each law to DentaQuest's PPM in order to identify any gaps for resolution. We maintain strong processes and procedures to provide security and access management with controls to safeguard and prevent unauthorized access to information. Our systems prevent the alteration of finalized records and include an access management function that restricts access to varying hierarchical levels of system functionality and information. Our system controls are paired with policies and procedures to ensure that employees and subcontractors understand, and perform to, their data security obligations. DentaQuest has processes and controls in place to identify, investigate, and resolve instances of improper or unauthorized disclosures of PHI.

22. Describe the financial management structure, and include:**a. Organizational chart of financial management staff.**

- Naming convention: RRQ_Attachment 22_Finance Org Chart

b. Provide a brief description of the process for assessing and maintaining financial solvency.

a. RRQ_Attachment 22_Finance Org Chart

b. Financial solvency is monitored on a recurring basis at the legal entity level. DentaQuest's Corporate Parent, Sun Life, has a formal process for establishing and reviewing minimum capital levels for subsidiary legal entities. Capital levels are projected for each quarter end and, if any projected capital levels are lower than the Corporate-required minimums, capital infusions would be made to ensure capital levels are above the required minimums. The thresholds established at the Corporate level are well in excess of statutory requirements.

Appendix I. PAHP Attestation to Complete Recommendations

Table I-1 includes an attestation form that lists all standards included as part of the readiness review, which is required to be completed by **DentaQuest**. By completing the attestation, **DentaQuest** is confirming that:

- DentaQuest** has reviewed all HSAG findings and recommendations.
- DentaQuest** will address all HSAG recommendations prior to July 1, 2026.
- DentaQuest** will consult with HSAG, as needed, for technical assistance related to implementing HSAG's recommendations.
- DentaQuest** may receive a *Not Met* score during future compliance reviews if HSAG's recommendations are not sufficiently addressed, which will result in a subsequent corrective action plan (CAP).

Table I-1—PAHP Attestation of Adherence to HSAG's Recommendations

Standard		Attestation		Responsible Individual (Name and Position) ¹⁰
Operational Standards				
I	Disenrollment: Requirements and Limitations	☒	By checking this box, the PAHP agrees with statements a–d above.	Information Systems Manager
II	Member Rights and Member Information	☒	By checking this box, the PAHP agrees with statements a–d above.	COO
III	Emergency and Poststabilization Services	☒	By checking this box, the PAHP agrees with statements a–d above.	Iowa Dental Director
IV	Availability of Services	☒	By checking this box, the PAHP agrees with statements a–d above	Provider Services Director
V	Assurances of Adequate Capacity and Services	☒	By checking this box, the PAHP agrees with statements a–d above.	Provider Services Director
VI	Coordination and Continuity of Care	☒	By checking this box, the PAHP agrees with statements a–d above.	Iowa Dental Director
VII	Coverage and Authorization of Services	☒	By checking this box, the PAHP agrees with statements a–d above.	Iowa Dental Director
VIII	Provider Selection	☒	By checking this box, the PAHP agrees with statements a–d above.	Provider Services Director
IX	Confidentiality	☒	By checking this box, the PAHP agrees with statements a–d above.	Chief Compliance Officer

¹⁰ PAHP staff member names have been redacted to protect identity. Staff names are maintained by HSAG and available upon request.

Standard		Attestation		Responsible Individual (Name and Position) ¹⁰
Operational Standards				
X	Grievance and Appeal Systems	☒	By checking this box, the PAHP agrees with statements a–d above.	Grievances & Appeals Manager
XI	Subcontractual Relationships and Delegation	☒	By checking this box, the PAHP agrees with statements a–d above.	Chief Compliance Officer
XII	Practice Guidelines	☒	By checking this box, the PAHP agrees with statements a–d above.	Iowa Dental Director
XIV	Quality Assessment and Performance Improvement Program	☒	By checking this box, the PAHP agrees with statements a–d above.	CEO
XV	Program Integrity	☒	By checking this box, the PAHP agrees with statements a–d above.	Chief Compliance Officer
Information Systems Standards				
XIII	Health Information Systems	☒	By checking this box, the PAHP agrees with statements a–d above.	Information Systems Manager
I	Enrollment Systems	☒	By checking this box, the PAHP agrees with statements a–d above.	Information Systems Manager
II	Claims and Encounter Systems	☒	By checking this box, the PAHP agrees with statements a–d above.	Information Systems Manager
Financial Management Standards				
I	Financial Viability: Reporting and Monitoring	☒	By checking this box, the PAHP agrees with statements a–d above.	CFO
II	Financial Solvency	☒	By checking this box, the PAHP agrees with statements a–d above.	CFO

Electronic Signature of DentaQuest’s Chief Executive Officer (CEO): /s/	Date: 05/11/2026
Electronic Signature of DentaQuest’s Compliance Officer: /s/	Date: 05/11/2026
Additional PAHP Comments:	

Appendix J. Readiness Review Timeline and Virtual Site Review Agendas

Readiness Review Timeline

Readiness Review of New PAHP		
Task Description	Due Date	Responsible Party
Project Initiation		
Developed readiness review timeline and submitted to HHS for review and feedback	11/18/2025	HSAG
Provided feedback and approval on timeline	11/25/2025	HHS
Outreached to the PAHP to obtain Readiness Review lead contact and Secure Access File Exchange (SAFE) access user information	11/25/2025	HSAG
Developed instructions/submission checklist; Operational, Information Systems, and Financial readiness review tools; readiness review questionnaire; enrollment/claims testing scenarios (Information Systems); report template, and submitted to HHS for review and feedback	12/12/2025	HSAG
Provided feedback and approval on the review tools and associated documents	1/9/2026	HHS
Desk Review: Initial and Subsequent		
Uploaded review tools (Operational, Information Systems, and Financial), enrollment/claims testing scenarios, Submission Requirements Checklist, Agenda, Post Site Documentation Tracker, and Questionnaire to SAFE for PAHP retrieval	1/16/2026	HSAG
Retrieved review tools (Operational, Information Systems, and Financial), enrollment/claims testing scenarios, and documents from SAFE	1/16/2026	PAHP
Attended 90-minute webinar to discuss readiness review activity	1/20/2026	HSAG/HHS/PAHP
Submitted universe files for credentialing and delegation file reviews to SAFE	1/23/2026	PAHP
Uploaded sample selections for credentialing and delegation file reviews to SAFE	1/26/2026	HSAG
Submitted completed tools and questionnaire with supporting documents, and case file review documentation for credentialing and delegation sample selections to SAFE	2/27/2026	PAHP

Readiness Review of New PAHP		
Task Description	Due Date	Responsible Party
Conducted initial desk review and documented findings	3/2/2026 – 3/16/2026	HSAG
Submitted additional follow up documentation requested during the virtual site reviews	3/25/2026 – Ongoing	PAHP
Conducted desk reviews based on additional documentation submitted and received prior to and following additional virtual site reviews	3/25/2026 – Ongoing	HSAG
Provided HHS with periodic updates on the PAHP's readiness status	Ongoing	HSAG
Submitted provider network adequacy status/supporting evidence to SAFE	Weekly	PAHP
Monitored provider network adequacy reports	Weekly	HHS/HSAG
Virtual Site Reviews		
Conducted initial virtual site review of the PAHP	3/17/2026 – 3/19/2026	HSAG/HHS/PAHP
Conducted extended virtual site review of the PAHP (Note: an extra one-day review was required based on lack of readiness of the PAHP)	3/23/2026	HSAG/HHS/PAHP
Conducted additional virtual site review of the PAHP's information systems	4/20/2026	HSAG/HHS/PAHP
Provided preliminary readiness review findings to HHS and the PAHP	5/20/2026	HSAG
Conducted additional virtual site review with the PAHP to discuss <i>Not Accepted</i> remediation plans identified through HSAG's subsequent desk review	5/28/2026	HSAG/HHS/PAHP
Conducted final virtual site review of the PAHP's information systems	6/15/2026	HSAG/HHS/PAHP
Conducted ad hoc meetings with the PAHP and HHS, as requested	Ongoing	HSAG/HHS/PAHP
Readiness Review Report and Remediation Plan		
Submitted initial readiness report to include Operational, Information Systems, and Financial components to HHS, along with proposed remediation template	4/24/2026	HSAG
Provided feedback and approval on initial readiness report and remediation plan template	5/1/2026	HHS
Issued approved readiness review report and remediation plan template to the PAHP	5/1/2026	HSAG
Submitted completed remediation plan to SAFE	5/11/2026	PAHP
Provided feedback on remediation plan responses to HHS and the PAHP	5/20/2026	HSAG

Readiness Review of New PAHP		
Task Description	Due Date	Responsible Party
Provided updated remediation plan responses and supporting evidence for remediation plans that were <i>Not Accepted</i>	5/26/2026	PAHP
Reviewed the PAHP's remediation plan and provider network adequacy status/supporting evidence and documented areas that were resolved and those that remained outstanding	6/5/2026	HSAG
Provided final, 508-compliant readiness review report to HHS on PAHP readiness evaluation	6/19/2026	HSAG
Submitted final, 508-compliant readiness review report and HHS' determined readiness status to CMS	As determined by HHS	HHS

Virtual Site Review Agendas

March 2026

Virtual Review Agenda		
Time Period ¹¹	Interview Session and Information Systems (IS) Demonstration conducted by HSAG's Compliance/Readiness Review, Audits, and Financial Management teams ¹²	Primary PAHP Participants ¹³ (please include name, position, and local or corporate employee)
DAY ONE – Tuesday, March 17, 2026		
8:00 am – 8:30 am	Opening Session: • Introductions • HSAG: overview of the virtual review expectations • PAHP: high-level overview of organization (e.g., organizational structure, etc.)	*PAHP primary facilitator for the virtual review: • Project Manager, Corporate employee All presenters will be attending the opening session. DQ Attendees for every session (in addition to facilitator): • Compliance Officer, Local Employee • Associate Director, Client Partner, Corporate Employee • Senior Client Partner, Local Employee • Senior Compliance Analyst, Corporate Employee • Compliance Analyst, Corporate Employee • Associate Vice President, Client Engagement, Corporate Employee

¹¹ Central Time

¹² Please ensure staff are flexible and readily available throughout the day to join sessions as these times may fluctuate depending on the speed of each interview session.

¹³ PAHP staff member names have been redacted to protect identity. Staff names are maintained by HSAG and available upon request.

Virtual Review Agenda		
8:30 am – 11:30 am	Standard III—Emergency and Poststabilization Services Standard VII—Coverage and Authorization of Services System Demonstrations [Including Mock Cases]: Utilization Management System (Prior Authorizations and Use of Historical Authorization Data for Transitions of Care), Claims Processing for Emergency Services	- Utilization Management Auditing Specialist, Corporate Employee - Senior Manager, Utilization Management – Corporate Employee
11:30 am – 12:00 pm	Lunch	
12:00 pm – 1:30 pm	Standard IV—Availability of Services Standard V—Assurances of Adequate Capacity and Services Checklist Review Session: Appointment Times Checklist, Network Adequacy Checklist System Demonstrations: Network Adequacy Reporting	- Director, Provider Engagement – Corporate employee - Director, National Network Solutions – Corporate Employee - Credentialing Delegation Auditor Consultant – Corporate Employee - Senior Manager, Business Analytics – Corporate Employee
3:00 pm – 4:00 pm	Standard XI—Subcontractual Relationships and Delegation File Review Session: Delegated Entities	- Associate Director, Procurement – Corporate Employee - Strategic Sourcing Manager – Corporate Employee - Director, Regulatory Compliance & Program Integrity – Corporate Employee - Director, Regulatory Compliance & Privacy – Corporate Employee - Director, Quality Oversight – Corporate Employee
DAY TWO – Wednesday, March 18, 2026		
8:00 am – 12:00 pm	Standard X—Grievance and Appeal Systems System Demonstrations [Including Mock Cases]: Grievance System, Appeal System	- Operations Compliance Analyst, Complaints Grievances and Appeals – Corporate Employee - Senior Manager, Complaints & Grievances – Corporate Employee - Senior Manager, Appeals – Corporate Employee

Virtual Review Agenda		
12:00 pm – 12:30 pm	Lunch	
12:30 pm – 3:30 pm	Standard II—Member Rights and Member Information Checklist Review Session: Member Rights Checklist, Member Handbook Checklist, Provider Directory Checklist, New Member Communications Checklist, Member Services Helpline Checklist, Marketing Checklist System Demonstrations: Member-Facing Website, Member Services Call Tracking, Online Member Handbook and Provider Directory	• Associate Director, Fulfillment & Digital Engagement – Corporate Employee • Director, Regulatory Compliance & Privacy – Corporate Employee • Director, Regulatory Compliance & Program Integrity – Corporate Employee • Senior Manager, Customer Service – Corporate Employee • Director, Customer Experience – Corporate Employee • Senior Business Systems Analyst – Corporate Employee
3:30 pm – 5:30 pm	Standard VIII—Provider Selection Checklist Review Session: Provider Manual Checklist, Provider Contract Checklist System Demonstrations: Credentialing	• Director, Provider Engagement – Corporate employee • Director, National Network Solutions – Corporate Employee • Credentialing Delegation Auditor Consultant – Corporate Employee
DAY THREE – Thursday, March 19, 2026		
8:00 am – 10:00 am	Standard VI—Coordination and Continuity of Care Checklist Review Session: Care Coordination Checklist, Clinical Records Checklist System Demonstrations [Including Mock Case]: Care Management System (Use of Historical Data for Coordination of Care)	• Associate Director, Case Management – Corporate Employee • Director, Quality and Outreach – Corporate Employee • Utilization Management Auditing Specialist, Corporate Employee • Senior Manager, Utilization Management – Corporate Employee • Senior Manager, Customer Service – Corporate Employee
10:00 am – 12:00 pm	IS Review Standard XIII—Health Information Systems IS Standard I—Enrollment System IS Standard II—Claims and Encounter Systems IS Demonstration:	• Director, Member Enrollment & Benefits – Corporate Employee • Member Enrollment Analyst – Corporate Employee • Claim Audit Analyst – Corporate Employee • Process Improvement Analyst – Corporate Employee

Virtual Review Agenda		
	- Enrollment/Eligibility (Eligibility Group, Demographics, Effective/Termination Dates, Reason for Disenrollment) - Provider Network Management (Provider Demographic and Fee Schedule Data) - Claims Processing System - Encounter Data Reporting System - Member Access Application Programming Interface (API) - Provider Directory API - Service Authorizations (Specific to Claims Processing) Claims Scenarios Walkthrough	- Provider Operations – Corporate Employee - Senior Business Systems Analyst – Corporate Employee - Senior Software Engineer – Corporate Employee - Lead Product Manager, Information Technology – Corporate Employee - Senior Manager, Application Development – Corporate Employee - Lead Business Systems Consultant - Corporate Employee
12:00 pm – 12:30 pm	Lunch	
12:30 pm – 5:30 pm	IS Review (continued) <i>*Note: the IS Review session will include a 10-minute break for participants.</i>	Same as before lunch
DAY FOUR – Monday, March 23, 2026		
8:00 am – 10:00 am	Standard XIV—Quality Assessment and Performance Improvement Program (QAPI) Checklist Review Session: Staff Training Checklist, Staffing Checklist System Demonstrations: Critical Incident Tracking System	- Director, Regulatory Compliance & Program Integrity – Corporate Employee - Director, Quality Oversight – Corporate Employee - Operations Compliance Analyst, Complaints Grievances and Appeals – Corporate Employee - Utilization Management Auditing Specialist, Corporate Employee - Senior Manager, Utilization Management – Corporate Employee

Virtual Review Agenda		
10:00 am – 11:00 am	Standard XII—Practice Guidelines	- Utilization Management Auditing Specialist, Corporate Employee - Senior Manager, Utilization Management – Corporate Employee
11:00 am – 12:30 pm	Standard IX—Confidentiality System Demonstrations: Health Insurance Portability and Accountability Act of 1996 (HIPAA)/Member Privacy Rights Requests, Incidents and Compliance Issues Tracking System(s)	Director, Regulatory Compliance & Privacy – Corporate Employee
12:30 pm – 1:00 pm	Lunch	
1:00 pm – 2:00 pm	Standard I—Disenrollment: Requirements and Limitations System Demonstrations: Tracking of Member Disenrollment Requests	- Director, Regulatory Compliance & Program Integrity – Corporate Employee - Operations Compliance Analyst, Complaints Grievances and Appeals – Corporate Employee
2:00 pm – 3:30 pm	Standard XV—Program Integrity System Demonstrations: Ownership and Control Disclosure Tracking System, Fraud, Waste, and Abuse Tracking System	- Director, Regulatory Compliance & Program Integrity – Corporate Employee - Associate Director, Fraud Prevention & Recovery – Corporate Employee - Associate Vice President, Fraud Prevention & Recovery – Corporate Employee - Claim Retention & Recovery – Corporate Employee
3:30 pm – 4:30 pm	Wrap up and next steps	

April 2026

Virtual Review Agenda	
Time Period ¹⁴	Virtual Site Review
Monday, April 20, 2026	
8:00 am – 2:00 pm	- Attendees: - HSAG Iowa Compliance/Readiness Review Team - HSAG Iowa Information Systems Review Team - HHS staff - DentaQuest staff - Re-review of 22 claim scenarios in testing environment to confirm readiness for production - Benefit configuration for the Iowa Medicaid program - Provider data configuration for the Iowa Medicaid program - End-to-end claims processing - Operational program updates - Provider network contracting status - Member website implementation status - Provider directory implementation status - Provider and member portals implementation status - Staffing/training status

¹⁴ Central Time

May 2026

Virtual Review Agenda	
Time Period ¹⁵	Virtual Site Review
Thursday, May 28, 2026	
9:00 am – 1:00 pm	- Attendees: - HSAG Iowa Compliance/Readiness Review Team - HSAG Iowa Information Systems Review Team - HHS staff - DentaQuest staff - Discussion of the 11 Operational remediation plans that were <i>Not Accepted</i> - Provider network contracting status - Third review of claims scenarios in testing environment to confirm readiness for production - Benefit configuration for the Iowa Medicaid program - Provider data configuration for the Iowa Medicaid program - End-to-end claims processing - Status update of moving systems from test to production - Next steps - Resubmit updated remediation plans to demonstrate readiness for the 11 Operational remediation plans that were <i>Not Accepted</i> - Review all recommendations included in the draft <i>IACY2026_DQ Operational RR CAP_HSAG Feedback for DQ</i> and make updates to materials and processes

¹⁵ Central Time

June 2026

Virtual Review Agenda	
Time Period ¹⁶	Virtual Site Review
Monday, June 15, 2026	
12:30 pm – 4:00 pm	<u>Attendees:</u> • HSAG Iowa Compliance/Readiness Review Team • HSAG Iowa Information Systems Review Team • HHS staff • DentaQuest staff <u>Information System Program Areas:</u> • Claims configuration (not a demonstration of test claims): ○ End-to-end adjudication, including benefit rules ○ Cost sharing ○ Denials/adjustments • Configuration of Emergency (ER) claims and Out-of-Network (OON) provider claims, ○ Demonstration of how ER claims are identified and entered into the system (manual or automated process) • Eligibility/enrollment configuration and process: Member loads, updates, and eligibility spans • Provider configuration: Network status, affiliations, and impact on claims processing ○ Show provider records in production demonstrating identification of these provider-types: FQHC, Indian Health Service provider, endodontist, and general dentist • Demonstration of Iowa fee schedules, including FQHC and Indian Health Service providers • Benefit setup: Configuration aligned to Iowa program requirements-including how system configuration supports appropriate identification of a members who have met maximum benefits

¹⁶ Central Time

Virtual Review Agenda

- Demonstration of how a claim with coordination of benefits (COB) is managed
 - Demonstrate any hard-coded configuration regarding Iowa members' benefits and COB
- Encounter data: Screenshare available information (any test files even if only internal testing is available) and discussion of status of testing with Iowa HHS

Operational Program Areas:

- Status update on Operational program areas:
 - Member enrollment status
 - Provider network contracting status
 - Member website for IA Medicaid
 - Provider directory for IA Medicaid
 - Grievance and appeal system
 - Care management system
 - Utilization management system
 - Member and provider portals
 - Staff hiring and training update

Important to Note:

- As explained during the 6/4/2026 email, demonstrations must reflect systems ready for go-live, not development or planned changes (i.e., production-ready)
 - This session is focused on how Windward will function with the production environment's current configuration
 - Staff members must explain and share results of internal testing before systems are transitioned into production
 - Staff members must provide an update on DentaQuest's go-live plan to ensure no issues occur in 834-file processing and claims processing (e.g., temporary prior authorization processes, staffing coverage nuances, claims monitoring, methods for identifying, tracking, and resolving any claims or member eligibility issues, etc.)