CHP+

Child Health Plan *Plus*

Fiscal Year 2024–2025 Compliance Review Report

for

DentaQuest

January 2025

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

HSAG HEALTH SERVICES ADVISORY GROUP

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Summary of Results

Based on conclusions drawn from the review activities, Health Services Advisory Group, Inc. (HSAG) assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. HSAG assigned required actions to any requirement receiving a score of *Partially Met* or *Not Met*. HSAG also identified opportunities for improvement with associated recommendations for some elements, regardless of the score.

DentaQuest showed a strong understanding of federal regulations related to Standard IV. Member Rights, Protections, and Confidentiality and Standard VII. Credentialing and Recredentialing. DentaQuest did not demonstrate evidence of a rudimentary understanding the requirements related to Standard III. Coordination and Continuity of Care and will require significant effort to develop and implement a program to meet the expectations of this standard.

Table 1-1 presents the scores for DentaQuest for each of the standards. Findings for all requirements are summarized in Section 2—Assessment and Findings. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* are included in Appendix A—Compliance Monitoring Tool.

Table 1-1—Summary of Scores for the Standards

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
III. Coordination and Continuity of Care	10	10	1	1	8	0	10%v
IV. Member Rights, Protections, and Confidentiality	5	5	5	0	0	0	100%~
VIII. Credentialing and Recredentialing	32	24	23	1	0	8	96%v
Totals	**47**	**39**	**29**	**2**	**8**	**8**	**74%**

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

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

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

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

Table 1-2 presents the scores for DentaQuest for the credentialing and recredentialing record reviews. Details of the findings for the record reviews are included in Appendix B—Record Review Tools.

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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Credentialing	77	77	77	0	0	100%~
Recredentialing	59	59	59	0	0	100%^
Totals	**136**	**136**	**136**	**0**	**0**	**100%^**

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

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

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

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

Standard III—Coordination and Continuity of Care

Evidence of Compliance and Strengths

DentaQuest provided well-defined Health Insurance Portability and Accountability Act (HIPAA) policies and Office Reference Manual (ORM) procedures evidencing methods for safeguarding member information. DentaQuest provided HIPAA training upon hire and annually to staff members, including those members who were responsible for sharing sensitive information with providers and across agencies. DentaQuest made its HIPAA training available on its website.

DentaQuest's HIPAA Privacy policy was also available publicly on its website. The HIPAA Privacy policy described how DentaQuest would use and share information specific to communicating with family and friends involved in the member's care, as well as communicating with other healthcare providers regarding treatment. During the interview, DentaQuest noted specific member verification procedures used to ensure that only members and their designated parents or guardians are able to get safeguarded information.

DentaQuest provided its Coordination and Continuity of Care For Enrolled Members Standard Operating Procedure (SOP), which outlined and described a process in which DentaQuest would coordinate care for members. The policies and procedures were detailed; however, during the interview and through the documents submitted, DentaQuest was not able to provide evidence that the policies and procedures had been implemented as written.

Recommendations and Opportunities for Improvement

During a review of the "Member Issues" tracking tool (named "DentaQuest MO Communication Log" in the post-interview submission), HSAG noted a member whose grievance to the Department (written as HCPF in the log) was passed along to DentaQuest. In the notes, DentaQuest stated that it could outreach the member to see if the member wanted to submit a "formal complaint." HSAG reminds DentaQuest that once any type of grievance is received, the time frame for resolving the grievance begins immediately. While DentaQuest may outreach the member for additional information, there is no need to request that a member file a "formal" grievance. DentaQuest must investigate the grievance upon receipt and resolve it in the allotted time frame.

Required Actions

In response to the fiscal year (FY) 2021–2022 corrective action plan (CAP), DentaQuest provided HSAG and the Department with a plan to develop and implement procedures to deliver care to and coordinate services for all members. Based on documents submitted for this review period, it was

evident that the plan was not implemented as described in the CAP and responsibilities were disjointed across its providers and its internal departments and staff members. For example, while DentaQuest had an SOP for the coordination and continuity of care for enrolled members, DentaQuest relied on providers to conduct an initial health intake to assess members for special health care needs, but it did not provide training or guidelines regarding expectations and it did not have a process for the providers to communicate care coordination needs to DentaQuest. During the interview, DentaQuest noted that it had an enrollment of 90,000 members and growing. However, the care coordination log showed that no members had received care coordination services in the past three years, which was verbally confirmed by the Child Health Plan *Plus* (CHP+) program manager. As a part of the care coordination discussion during the interview, DentaQuest shared that it tracked inquiries from the Department, the Regional Accountable Entities (RAEs), and other outside entities on its "Member Issues" tracking tool (named "DentaQuest MO Communication Log" in the post-interview submission). Following the compliance review, DentaQuest also submitted its Member Outreach Plan, which focused on raising awareness of dental benefits and increasing utilization. DentaQuest's outreach plan is robust; however, it describes member education and not care coordination. DentaQuest must implement procedures to deliver care to and coordinate services for all members, including:

- Ensuring timely coordination with any of a member's providers for the provision of covered services (for example, emergency, urgent, and routine care).
- Addressing the needs of those members who may require services from multiple providers, facilities, and agencies; and who require complex coordination of benefits and services.
- Ensuring that all members and authorized family members or guardians are involved in treatment planning and consent to any dental treatment.
- Criteria for making referrals and coordinating care with specialists, subspecialists, and community-based organizations.
- Providing continuity of care for newly enrolled members to prevent disruption in the provision of medically necessary services.

While DentaQuest had a member outreach team that was tasked with resolving issues brought forth from outside entities (the Department, RAEs, etc.), no policy or procedure formally designated the role and responsibilities of coordinating the health care services for members identified as needing coordination of care. During the interview, DentaQuest shared its "Member Issues" tracking tool which was submitted after the interview (named "DentaQuest MO Communication Log" in the submission), which DentaQuest used to track external requests pertaining to eligibility, grievances, benefits, and potential fraud. While the "Member Issues" tracking tool could also be used to track care coordination requests from outside entities, there was no evidence that the member outreach team was trained and tasked as complex care coordinators or that they provided potential care management concerns to the CHP+ program manager as described in policy for the purpose of review and tracking. For example, one member listed in the tracking tool was approved for extra cleanings by DentaQuest; however, the member was unable to receive these approved cleanings as it was not designated in the member chart or communicated with the dental provider. The member resorted to filing a billing grievance with the Department to get special health care needs covered services, thereby negating the intention of active care coordination. DentaQuest must ensure that each member has an ongoing source of care appropriate

to the member's needs and a person or entity formally designated as primarily responsible for coordinating the health care services accessed by the member who is trained and tasked to manage complex care coordination.

DentaQuest submitted its SOP, Coordination and Continuity of Care For Enrolled Members, which detailed care coordination procedures. However, DentaQuest did not submit or describe evidence that it implemented coordinated care for members with complex needs or expected providers to coordinate needs or communicate with DentaQuest about assessments that identified members with needs. While DentaQuest developed an SOP for coordinating care, DentaQuest must ensure that assessments conducted by DentaQuest or its delegate that identify care coordination needs are addressed by DentaQuest as outlined and that members are made aware of how to request care coordination support directly through DentaQuest when needed.

While delegation of assessments was not noted in the Coordination and Continuity of Care For Enrolled Members SOP, DentaQuest designated within the CHP+ Provider Agreement that initial screening for special and complex health needs of members was delegated to its providers. "*Assessment. All providers shall assess each member who presents for dental services for any appropriate special healthcare needs with regards to their dental care.*" Within its ORM under Provider Rights and Responsibilities, DentaQuest stated that providers shall assess members who present for services for any special health care needs related to dental care and are responsible for assisting members by referring them to in-network providers for emergency, urgent, routine, or specialized care based on the member's needs and medical necessity. However, DentaQuest did not define what should be included in the assessment, how to document a member's needs, what should be done to assist members identified as having special health care needs, how to inform DentaQuest of a member's need for care coordination, or how to navigate the provider directory to ensure members who may require additional dental services or complex dental treatment receive care appropriate for their needs. While DentaQuest used a monitoring tool to assess its providers, the tool did not include all of the required elements and as such was insufficient. DentaQuest must ensure that it or its delegate provides best efforts to conduct an initial screening of each new member's needs at the member's initial visit and subsequently as warranted, including:

- Subsequent attempts if the initial attempt to contact the member is unsuccessful.
- An assessment for special health care needs, including mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health problems.
- Using the results of the assessment to inform member outreach and care coordination activities.

While DentaQuest tracked member inquiries referred from external agencies in its "Member Issues" tracking tool (named "DentaQuest MO Communication Log" in the submission), there was no evidence provided that DentaQuest communicated the results of the inquires back to the referring entity. Further, DentaQuest did not have a process for providers to share results of member health assessments with DentaQuest to ensure that DentaQuest could close the loop with the member's primary care and specialty providers or care coordinators from other entities. DentaQuest must develop and implement a process to share with other entities serving the member the results of identification and assessment of that member's needs to prevent duplication of those activities.

DentaQuest submitted a provider auditing tool and tracking tool as evidence of monitoring and tracking provider intake assessments. While the audit tool did include a checkbox indicating whether a member was identified as "having needs," "not having needs," or "not enough information," the tool did not include a method for tracking members who indicated that they had special health care needs that benefitted from additional care management to ensure that care needs were met. According to the tracking tool, DentaQuest requested member health records from 30 providers over nine months and only a few providers submitted records, as requested. Of the small submission received, one provider's member health record was missing provider notes, diagnosis, a treatment plan, and dental history. Based on the low response rate and lack of evidence of follow-up or corrective action with nonresponsive providers, DentaQuest did not have a consistent way to ensure or monitor that initial member assessments for special health care needs are occurring, nor is DentaQuest ensuring that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards. DentaQuest must require that all providers submit member health records in a timely manner upon request. DentaQuest must implement corrective action for providers who do not provide member health records in a timely manner, as records are necessary for documenting member health as well as fraud prevention. DentaQuest must improve its auditing and tracking tools to ensure that each provider furnishing services to members maintains and shares, as appropriate, member health records in accordance with professional standards. In reworking its care coordination program, if DentaQuest chooses to continue delegating the initial health assessment intake to its dental providers, DentaQuest must substantially increase its direction and oversight of its providers to ensure that providers are conducting the intake at a consistent rate, that all information is captured, that providers communicate member needs to DentaQuest, that members are receiving coordinated care, and that appropriate external entities are informed of the member's needs and services. DentaQuest must incorporate methods to track this delegated activity and hold providers accountable for not adhering to the requirements.

DentaQuest did not provide evidence of producing or delegating the development of a treatment plan for members with special health care needs. DentaQuest must produce a treatment or service plan for members with special health care needs who are determined, through assessment, to need a course of treatment or regular care monitoring. The treatment plan must be:

- Approved by the Contractor in a timely manner (if such approval is required by the Contractor).
- In accordance with any applicable State quality assurance and utilization review standards (for example, if approval is required due to dental prior-authorization requests).
- Reviewed and revised when the member's circumstances or needs change significantly, or at the request of the member.

DentaQuest did not provide evidence of a mechanism to allow members direct access to a specialist if appropriate. For members with special health care needs determined to need a course of treatment or regular care monitoring, DentaQuest must have a mechanism in place to allow members direct access to a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.

Standard IV—Member Rights, Protections, and Confidentiality

Evidence of Compliance and Strengths

DentaQuest staff members reported that it provided members with information pertaining to their rights and responsibilities through the CHP+ member handbook and the ORM. Members were provided access to both documents on the website at any time and could receive a copy upon request, at no charge. The ORM and CHP+ member handbook both listed the rights and responsibilities that are required in accordance with the federal regulations at 42 CFR 438.100. In addition, during the interview, DentaQuest noted that staff members and providers were trained on member rights to ensure that staff members and providers could assist CHP+ members with their rights and responsibilities.

Within its Non-Discrimination Compliance Program policy, DentaQuest stated, "DentaQuest does not exclude people or treat them differently because of race, color, national origin, age, disability, religion, sex, gender identity, heath status, need for healthcare services, or sexual orientation." This policy communicated that any complaints or allegations that an individual reportedly had been discriminated against would be investigated in accordance with all applicable federal and State civil rights laws and Section 1557 of the Affordable Care Act. DentaQuest staff members reported that members are encouraged to file a grievance for any issue, including a member rights issue.

DentaQuest provided its privacy policy that described how DentaQuest ensured the confidentiality of protected health information (PHI) when creating, maintaining, and sharing information. One section of the policy detailed the required and permitted use and disclosure of PHI, including what individuals or entities DentaQuest was authorized to share information with and for which circumstances it could be shared. The policy also noted all State and federal requirements which DentaQuest complied with relative to the use and disclosure of PHI.

Recommendations and Opportunities for Improvement

HSAG identified no recommendations.

Required Actions

HSAG identified no required actions.

Standard VIII—Credentialing and Recredentialing

Evidence of Compliance and Strengths

DentaQuest provided multiple documents such as the Credentialing Plan Description, Credentials Committee Charter, Credentialing Guidelines policy, and the Provider Maintenance and Ongoing Monitoring policy to support evidence of compliance. Policies, procedures, and record review samples evidenced that DentaQuest followed National Committee for Quality Assurance (NCQA) standards and guidelines to conduct credentialing activities. The Credentialing Guidelines policy detailed the process for initial credentialing and recredentialing. During the interview session, staff members demonstrated an understanding of the internal guidelines and described in detail how providers applied to the network and were approved or denied through validations and the Credentials Committee review.

The Credentials Committee Charter detailed the responsibilities of the Credentials Committee. The Credentials Committee Charter stated, "The Credentials Committee is a standing Committee that is responsible for administering the Credentialing Program Plan on behalf of the Company." Furthermore, it stated, "The Credentials Committee includes representations from a range of participating practitioners." The Credentials Committee Charter included in its description that DentaQuest had three voting members and two non-voting members. The voting members included the vice president of clinical management, the company contracted licensed consultant (non-employee), and the company licensed consultant. The non-voting members included the Credentialing Legal Counsel and the Credentialing Representative. Staff members reported that the Credentials Committee met weekly to discuss providers who are awaiting approval to join the network.

HSAG reviewed a sample of initial credentialing files and found that DentaQuest processed all records in a timely manner. Each provider credentialing file included evidence of license verification, verification of education and training, and verification of work history in the most recent five years, professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner in the most recent five years, and the Drug Enforcement Administration (DEA) verification if it was applicable. HSAG reviewed a sample of recredentialing files and found evidence that DentaQuest conducted ongoing monitoring of its providers against the National Practitioner Data Bank (NPDB), State licensing or certification agencies, the DEA, and federal and State exclusion list databases.

Recommendations and Opportunities for Improvement

HSAG identified no recommendations.

Required Actions

DentaQuest has in place policies and procedures pertaining to the selection and retention of its providers. However, the selection and retention policies and procedures were not listed on the public website. DentaQuest must document the policies and procedures for selection and retention of its providers on its public website.

3. Background and Overview

Background

The prepaid ambulatory health plan (PAHP) is responsible for providing a statewide oral healthcare network and services under Colorado's CHP+ Oral Health Care Benefits Program. Public Law 111-3, Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, requires that each state's Children's Health Insurance Program (CHIP) apply several provisions of Section 1932 of the Social Security Act (the Act) in the same manner as the provisions apply under Title XIX of the Act. This requires PAHPs to comply with provisions of Title 42 of the Code of Federal Regulations (42 CFR) federal Medicaid managed care regulations. The updated Medicaid and CHIP managed care regulations published May 6, 2016, which became applicable to CHIP effective July 1, 2018. Additional revisions were released in December 2020, February 2023, and May 2024. The CFR requires that states conduct a periodic evaluation of their managed care entities (MCEs), including PAHPs, to determine compliance with federal healthcare regulations and managed care contract requirements. The Department of Health Care Policy & Financing (the Department) administers and oversees the CHP+ program (Colorado's implementation of CHIP). The Department has elected to complete this requirement for the PAHP by contracting with an external quality review organization (EQRO), HSAG.

To evaluate the PAHP's compliance with federal managed care regulations and State contract requirements, the Department determined that the review period for FY 2024–2025 was calendar year (CY) 2024. This report documents results of the FY 2024–2025 compliance review activities for DentaQuest. Section 1 includes the summary of scores for each of the standards reviewed this year. Section 2 contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 3 describes the background and methodology used for the FY 2024–2025 compliance monitoring review. Section 4 describes follow-up on the corrective actions required as a result of the FY 2023–2024 compliance review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the credentialing and recredentialing record reviews. Appendix C lists the HSAG, PAHP, and Department personnel who participated in the compliance review process. Appendix D describes the CAP process the PAHP will be required to complete for FY 2024–2025 and the required template for doing so. Appendix E contains a detailed description of HSAG's compliance review activities consistent with the Centers for Medicare & Medicaid Services (CMS) External Quality Review (EQR) *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023.[1] Appendix F contains details of care coordination special focus topic discussions that took place during the virtual compliance review. Appendix F contains details of care coordination special focus topic discussions that took place during the virtual compliance review.

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Aug 20, 2024.

Overview of FY 2024–2025 Compliance Monitoring Activities

For the FY 2024–2025 compliance review process, the Department requested a review of three areas of performance. HSAG developed a review strategy and monitoring tools for the three chosen standards:

- Standard III—Coordination and Continuity of Care
- Standard IV—Member Rights, Protections, and Confidentiality
- Standard VIII—Credentialing and Recredentialing

Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of the three standards.

Compliance Monitoring Review Methodology

In developing the data collection tools and in reviewing documentation related to the three standards, HSAG used the PAHP's contract requirements and regulations specified by the federal Medicaid/CHP+ managed care regulations published May 6, 2016. Additional revisions were released in December 2020, February 2023, and May 2024. HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable.* The Department determined that the review period was CY 2024. HSAG reviewed materials submitted prior to the compliance review activities, materials requested during the compliance review, and considered interviews with key PAHP personnel to determine compliance with federal managed care regulations and contract requirements. Documents consisted of policies and procedures, staff training materials, reports, committee meeting minutes, and member and provider informational materials.

The compliance review processes were consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Appendix E contains a detailed description of HSAG's compliance review activities consistent with those outlined in the CMS EQR protocol. The three standards chosen for the FY 2024–2025 compliance reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services; Standard II—Adequate Capacity and Availability of Services; Standard V—Member Information Requirements; Standard VI—Grievance and Appeal Systems; Standard VII—Provider Selection and Program Integrity; Standard IX—Subcontractual Relationships and Delegation; Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems; and Standard XII—Enrollment and Disenrollment.

Objective of the Compliance Review

The objective of the compliance review was to provide meaningful information to the Department and the PAHP regarding:

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

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

FY 2023–2024 Corrective Action Methodology

As a follow-up to the FY 2023–2024 compliance review, each MCE that received one or more *Partially Met* or *Not Met* scores was required to submit a CAP to the Department addressing those requirements found not to be fully compliant. If applicable, the MCE was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the MCE and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with the MCE until it completed each of the required actions from the FY 2023–2024 compliance monitoring review.

Summary of FY 2023–2024 Required Actions

For FY 2023–2024, HSAG reviewed Standard V—Member Information Requirements, Standard VII—Provider Selection and Program Integrity, Standard IX—Subcontractual Relationships and Delegation, and Standard X—QAPI, Clinical Practice Guidelines, and Health Information Systems.

Related to Standard V—Member Information Requirements, DentaQuest was required to complete one required action:

- Review the member handbook to identify where it does not include easily understood language and implement changes necessary to obtain language at or around eighth-grade reading level.

Related to Standard VII—Provider Selection and Program Integrity, DentaQuest was required to complete one required action:

- Update its policies to include language pertaining to reporting waste and abuse and to protecting whistleblowers.

Related to Standard IX—Subcontractual Relationships and Delegation, HSAG identify no required actions for this standard.

Related to Standard X—QAPI, Clinical Practice Guidelines, and Health Information Systems, DentaQuest was required to complete one required action:

- Develop a distinct list of clinical practice guidelines for review and approval by the Peer Review Committee that are separate from the utilization management (UM) criteria.

Summary of Corrective Action/Document Review

DentaQuest submitted a proposed CAP in February 2024. HSAG and the Department reviewed and approved the proposed CAP and responded to DentaQuest. DentaQuest submitted final documentation and completed the CAP in October 2024.

Summary of Continued Required Actions

DentaQuest successfully completed the FY 2023–2024 CAP, resulting in no continued corrective actions.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements procedures to deliver care to and coordinate services for all members. These procedures meet State requirements, including: • Ensuring timely coordination with any of a member's providers for the provision of covered services (for example, emergency, urgent, and routine care). • Addressing the needs of those members who may require services from multiple providers, facilities, and agencies; and who require complex coordination of benefits and services. • Ensuring that all members and authorized family members or guardians are involved in treatment planning and consent to any dental treatment. • Criteria for making referrals and coordinating care with specialists, subspecialists, and community-based organizations. • Providing continuity of care for newly enrolled members to prevent disruption in the provision of medically necessary services. *42 CFR 438.208* Contract: Exhibit B—1.3.1.3	**Suggested Documents:** Policies and Procedures NET15-INS-SOP - Coordination and Continuity of Care For Enrolled Members Care Coordination Log - Colorado CHP+.xlsx	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
Findings: Based on a review of documents submitted and the interview session, HSAG found that DentaQuest had not implemented procedures to deliver care and coordinate services for all members. While DentaQuest had a SOP for the coordination and continuity of care for enrolled members,		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
DentaQuest relied on providers to assess members and did not have a process for the providers to communicate care coordination needs to DentaQuest. During the interview, DentaQuest noted that it had an enrollment of 90,000 members and growing. However, the care coordination log showed that no members had received care coordination services. During the interview, DentaQuest stated that it tracked inquiries from the Department, the RAEs, and other outside entities on its "Member Issues" tracking tool (named "DentaQuest MO Communication Log" in the post-interview submission). DentaQuest did not present this tool prior to the interview and due to the large number of adults represented in the tool, HSAG is unable to determine if the tool is used for the CHP+ population or DentaQuest's fee-for-service population (which was not part of this compliance review). While this tool could be used for care coordination, it primarily tracked grievances and inquiries pertaining to billing, eligibility, benefits, and access. DentaQuest's policies and SOP do not mention this tool for tracking care coordination, and a separate tool that was submitted for tracking care coordination was submitted with no entries. If DentaQuest was using both tools, external care coordination requests should have been forwarded to the CHP+ program manager and included in the care coordination list per DentaQuest's description. Following the compliance review, DentaQuest also submitted its Member Outreach Plan, which focused on raising awareness of dental benefits and increasing utilization. DentaQuest's outreach plan is robust; however, it describes member education and not care coordination.		
Required Actions: DentaQuest must implement procedures to deliver care to and coordinate services for all members, including: • Ensuring timely coordination with any of a member's providers for the provision of covered services (for example, emergency, urgent, and routine care). • Addressing the needs of those members who may require services from multiple providers, facilities, and agencies; and who require complex coordination of benefits and services. • Ensuring that all members and authorized family members or guardians are involved in treatment planning and consent to any dental treatment. • Criteria for making referrals and coordinating care with specialists, subspecialists, and community-based organizations. • Providing continuity of care for newly enrolled members to prevent disruption in the provision of medically necessary services.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The Contractor ensures that each member has an ongoing source of care appropriate to the member's needs and a person or entity formally designated as primarily responsible for coordinating the health care services accessed by the member. • The member must be provided information on how to contact the primary dental provider. *42 CFR 438.208(b)(1)* Contract: Exhibit B—None	**Suggested Documents:** Welcome Letter Policies and Procedures NET15-INS-SOP - Coordination and Continuity of Care For Enrolled Members MKT03-INS_COMM-Member Communications Distribution CO	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: While DentaQuest had a member outreach team that was tasked with resolving issues brought forth from outside entities (the Department, RAEs, etc.), no policy or procedure formally designated the role and responsibilities of coordinating the health care services for members identified as needing coordination of care. During the interview, DentaQuest shared its "Member Issues" tracking tool which was submitted after the interview (named "DentaQuest MO Communication Log" in the submission). In the log, DentaQuest tracked external requests pertaining to eligibility, grievances, benefits, and potential fraud. While the "Member Issues" tracking tool could also be used to track care coordination requests from outside entities, there was no evidence of how the member outreach coordinator was trained and tasked as a complex care coordinator or that they provided potential care management concerns to the CHP+ program manager as described in policy for the purpose of review and tracking. For example, one member listed in the document was approved for extra cleanings; however, the member was unable to receive these approved cleanings as it was not designated in the member chart or communicated with the dental provider The member needed to resort to filing a billing grievance with the Department to get special health care needs covered services.		
Required Actions: DentaQuest must ensure that each member has an ongoing source of care appropriate to the member's needs and a person or entity formally designated as primarily responsible for coordinating the health care services accessed by the member who is trained and tasked to manage complex care coordination.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor implements procedures to coordinate services the Contractor furnishes the member: • Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. • With the services the member receives from any other managed care plan. • With the services the member receives from community and social support providers. *42 CFR 438.208(b)(2)* Contract: Exhibit B—1.3.1.3.4	**Suggested Documents:** Policies and Procedures NET15-INS-SOP - Coordination and Continuity of Care For Enrolled Members Care Coordination Log - Colorado CHP+.xlsx	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
Findings: DentaQuest submitted its SOP, Coordination and Continuity of Care For Enrolled Members, which detailed care coordination procedures. However, there was no evidence that DentaQuest implemented coordinated care for members with complex needs or expected providers to coordinate needs or communicate with DentaQuest about assessments that identified members with needs.		
Required Actions: While DentaQuest developed an SOP for coordinating care, DentaQuest must ensure that assessments conducted by DentaQuest or its delegate that identify care coordination needs are addressed by DentaQuest as outlined and that members are made aware of how to request care coordination support directly through DentaQuest when needed.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor provides best efforts to conduct an initial screening of each new member's needs within 90 days of enrollment, including: • Subsequent attempts if the initial attempt to contact the member is unsuccessful. • An assessment for special health care needs, including mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health problems. • Using the results of the assessment to inform member outreach and care coordination activities. *42 CFR 438.208(b)(3)* Contract: Exhibit B—None	**Suggested Documents:** Initial Assessment NET15-INS-SOP - Coordination and Continuity of Care For Enrolled Members CHP+ Provider Agreement (Pg 24- e) ORM - Provider Responsibility (page 5)	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
Findings: While this delegation was not noted in the Coordination and Continuity of Care For Enrolled Members SOP, DentaQuest designated within the CHP+ Provider Agreement that initial screening for special and complex health needs of members was delegated to its providers. "*Assessment. All providers shall assess each member who presents for dental services for any appropriate special healthcare needs with regards to their dental care.*" Within its ORM under Provider Rights and Responsibilities, DentaQuest stated that providers shall assess members who present for services for any special health care needs related to dental care and are responsible for assisting members by referring them to in-network providers for emergency, urgent, routine, or specialized care based on the member's needs and medical necessity. However, DentaQuest did not define what should be included in the assessment, how to document a member's needs, what should be done to assist members identified as having special health care needs, how to inform DentaQuest of a member's need for care coordination, and how to navigate the provider directory to ensure members who may require additional dental services or complex dental treatment receive care appropriate for their needs. While DentaQuest used a monitoring tool to assess its providers, the tool did not include all of the required elements and as such was insufficient.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: DentaQuest must ensure that it or its delegate provides best efforts to conduct an initial screening of each new member's needs within 90 days of enrollment, including: • Subsequent attempts if the initial attempt to contact the member is unsuccessful. • An assessment for special health care needs, including mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health problems. • Using the results of the assessment to inform member outreach and care coordination activities.		
5. The Contractor shares with other entities serving the member the results of identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR 438.208(b)(4)* Contract: Exhibit B—1.3.1.3.3	**Suggested Documents:** Policies and Procedures NET15-INS-SOP - Coordination and Continuity of Care For Enrolled Members CHP+ Provider Agreement >Page 2- Participating Practice Obligations, (f) Records CHP ORM-Provider Responsibility (Page 5)	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
Findings: While DentaQuest tracked member inquiries referred from external agencies in its "Member Issues/DentaQuest MO Communication Log," there was no evidence provided that DentaQuest communicated the results of the inquires back to the referring entity. Further, DentaQuest did not have a process for providers to share results of member health assessments with DentaQuest to ensure that DentaQuest could close the loop with the member's primary care and specialty providers or care coordinators from other entities.		
Required Actions: DentaQuest must develop and implement a process to share with other entities serving the member the results of identification and assessment of that member's needs to prevent duplication of those activities.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor 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)* Contract: Exhibit B—1.3.15.17.1	**Suggested Documents:** Provider Agreement Policies and Procedures NET15-INS-SOP - Coordination and Continuity of Care For Enrolled Members CHP+ Provider Agreement >Page 2- Participating Practice Obligations, (f) Records CHP ORM-Provider Responsibility (Page 5)	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
Findings: DentaQuest submitted a provider auditing tool and tracking tool as evidence of monitoring and tracking provider intake assessments. While the audit tool did include a checkbox indicating whether a member was identified as "having needs," "not having needs," or "not enough information," the monitoring tool did not include a method for tracking members who indicated that they had special health care needs that benefitted from additional care management to ensure that care needs were met. According to the tracking tool, DentaQuest requested member health records from 30 providers over nine months and only a few providers submitted records, as requested. Of this small submission, one provider's member health record was missing provider notes, diagnosis, a treatment plan, and dental history. Based on the low response rate and lack of evidence of follow-up or corrective action, DentaQuest is not ensuring that initial member assessments for special health care needs are occurring nor is it ensuring that each provider furnishing services to members maintains and shares, as appropriate, member health records in accordance with professional standards.		
Required Actions: DentaQuest must require that all providers provide member health records in a timely manner upon request. DentaQuest must ensure that providers who do not provide member health records in a timely manner face consequences (including financial consequences and potential termination from the network), as records are necessary for documenting member health as well as fraud prevention. DentaQuest must improve its auditing and tracking tools to ensure that each provider furnishing services to members maintains and shares, as appropriate, member health records in accordance with professional standards.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor 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 (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent applicable. *42 CFR 438.208(b)(6)* Contract: Exhibit B—None	**Suggested Documents:** Policies and Procedures PRIV-ENT.pdf NET15-INS-SOP - Coordination and Continuity of Care For Enrolled Members CHP+ Provider Agreement >Page 2- Participating Practice Obligations, (f) Records CHP ORM- Page 34	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor implements mechanisms to comprehensively assess each CHP+ member identified by the State 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. *42 CFR 438.208(c)(2)* Contract: Exhibit B—1.3.1.3.4	**Suggested Documents:** Assessment for Identifying Special Health Care Needs Colorado Review of Members Records.docx Provider Chart Audit Email Tracker 23-24.xlsx Provider Treatment chart email communication.docx	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
Findings: While DentaQuest delegated the initial assessment to its dental providers, DentaQuest did not implement or disseminate a mechanism to ensure that the provider's assessment was comprehensive or consistent. DentaQuest submitted a provider auditing tool and tracking tool as evidence of monitoring and tracking provider intake assessments. While the audit tool did include a checkbox indicating whether a member was identified		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
as "having needs," "not having needs," or "not enough information," the monitoring tool did not include a method for tracking members who indicated that they had special health care needs that benefitted from additional care management to ensure that care needs were met.		
Required Actions: DentaQuest must implement mechanisms to comprehensively assess each CHP+ member to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring.		
9. The Contractor produces a treatment or service plan for members with special health care needs who are determined, through assessment, to need a course of treatment or regular care monitoring. The treatment plan must be: • Approved by the Contractor in a timely manner (if such approval is required by the Contractor). • In accordance with any applicable State quality assurance and utilization review standards (for example, if approval is required due to dental prior-authorization requests). • Reviewed and revised when the member's circumstances or needs change significantly, or at the request of the member. *42 CFR 438.208(c)(3)* Contract: Exhibit B—1.3.1.3.4	**Suggested Documents:** Policies and Procedures Treatment Plan/Service Plan Colorado Review of Members Records.docx Provider Chart Audit Email Tracker 23-24.xlsx Provider Treatment chart email communication.docx	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
Findings: DentaQuest provided no evidence or producing or delegating the production of a treatment plan for members with special health care needs.		
Required Actions: DentaQuest must produce a treatment or service plan for members with special health care needs who are determined, through assessment, to need a course of treatment or regular care monitoring. The treatment plan must be:		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Approved by the Contractor in a timely manner (if such approval is required by the Contractor). • In accordance with any applicable State quality assurance and utilization review standards (for example, if approval is required due to dental prior-authorization requests). • Reviewed and revised when the member's circumstances or needs change significantly, or at the request of the member.		
10. For members with special health care needs determined to need a course of treatment or regular care monitoring, the Contractor must have a mechanism in place to allow members direct access to a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs. *42 CFR 438.208(c)(4)* Contract: Exhibit B—1.3.1.7.1	**Suggested Documents:** Policies and Procedures Colorado Review of Members Records.docx Provider Chart Audit Email Tracker 23-24.xlsx Provider Treatment chart email communication.docx	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable
Findings: DentaQuest did not provide evidence of a mechanism to allow member direct access to a specialist if appropriate.		
Required Actions: DentaQuest must maintain a policy or procedure outlining its mechanism to ensure that members with special health care needs determined to need a course of treatment or regular care monitoring have direct access to a dental specialist who meets their needs.		

Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	1	X	1.00	=	1
	Partially Met	=	1	X	.00	=	0
	Not Met	=	8	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	10	**Total Score**		=	1
				Total Score ÷ Total Applicable		=	10%

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has written policies regarding the member rights specified in this standard. *42 CFR 438.100(a)(1)* Contract: Exhibit B—1.4.8.1	**Suggested Documents:** Member Handbook Office Reference Manual Member Handbook - Page 15 ORM - Page 4	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor complies with any applicable federal and State laws that pertain to member rights (e.g., non-discrimination, Americans with Disabilities Act) and ensures that its employees and contracted providers observe and protect those rights. *42 CFR 438.100(a)(2) and (d)* Contract: Exhibit B—1.4.8.2	**Suggested Documents:** Non-Discrimination Policy Provider Agreement HR-EIH-34-Equal opportunity and nondiscrimination COM15-Nondiscrimination Compliance Program	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor's policies and procedures ensure that each member is guaranteed the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for the member's dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.	**Suggested Documents:** Policies and Procedures Member Handbook - Page 15 ORM - Page 4 COM15-ENT-Non-discrimination Compliance Program	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Participate in decisions regarding their health care, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. • Request and receive a copy of their medical records and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210). *42 CFR 438.100(b)(2) and (3)* Contract: Exhibit B—1.4.8.2.1-6		
4. The Contractor ensures that each member is free to exercise their rights and that the exercise of those rights does not adversely affect how the Contractor, its network providers, or the Department treat(s) the member. *42 CFR 438.100(c)* Contract: Exhibit B—1.4.8.2.7	**Suggested Documents:** Member Handbook Member Handbook - Page 15 ORM - Page 4	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. For medical records and any other health and enrollment information which identify a particular member, the Contractor uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42 CFR 438.224* Contract: Exhibit B—None	**Suggested Documents:** Policies and Procedures PRIV-ENT	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard IV—Member Rights, Protections, and Confidentiality							
Total	Met	=	5	X	1.00	=	5
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	5	**Total Score**		=	5
				Total Score ÷ Total Applicable		=	100%

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. • The Contractor shall use National Committee on Quality Assurance (NCQA) credentialing and recredentialing standards and guidelines as the uniform and required standards for all applicable providers. *42 CFR 438.214(b)* NCQA CR1 Contract: Exhibit B—1.1.2.8.2, 1.1.2.8.4	**Suggested Documents:** Policies and Procedures Credentialing Plan Credentialing Committee Charter/Minutes PEC01	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners it credentials and recredentials. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. The Contractor shall document and post on its public website policies and procedures for the selection and retention of providers. *42 CFR 438.214(a–b1)* NCQA CR1—Element A1 Contract: Exhibit B—1.1.2.5, 1.1.2.7	**Suggested Documents:** Policies and Procedures Credentialing Plan CR1 Element A.1-Credentialing Plan description First paragraph	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: DentaQuest had written policies and procedures for the selection and retention of its providers. However, DentaQuest did not document and post on its public website the policies and procedures for the selection and retention of its providers.		
Required Actions: DentaQuest must post its policies and procedures for the selection and retention of its providers publicly on its website.		
2.B. The verification sources it uses. NCQA CR1—Element A2	**Suggested Documents:** Policies and Procedures PEC01 A 2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	**Suggested Documents:** Policies and Procedures Credentialing Committee Charter/Minutes CR1 Element A.3-PEC01 Full Policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	**Suggested Documents:** Policies and Procedures Credentialing Plan Credentialing Committee Charter/Minutes	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	CR1 Element A.4-Credentials Committee Charter, PEC01 Full Policy	
2.E. The process for managing credentialing/recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	**Suggested Documents:** Policies and Procedures Credentialing Plan Credentialing Committee Charter/Minutes CR1 Element A.5-PEC01 Procedure A	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.F. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. *Examples include nondiscrimination of applicant, a process for preventing and monitoring discriminatory practices, and monitoring the credentialing/recredentialing process for discriminatory practices at least annually.* *42 CFR 438.214(c)* NCQA CR1—Element A6 Contract: Exhibit B—1.1.2.8.1, 1.1.2.11–12	**Suggested Documents:** Policies and Procedures Credentialing Plan Credentialing Committee Charter/Minutes CR1 Element A.6-PEC01 E 5	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.G. The process for notifying practitioners if information obtained during the Contractor's credentialing process varies substantially from the information they provided to the Contractor. NCQA CR1—Element A7	**Suggested Documents:** Policies and Procedures Credentialing Plan CR1 Element A.7-PEC01 D	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.H. The process for notifying practitioners of the credentialing and recredentialing decision within 60 calendar days of the Credentialing Committee's decision. NCQA CR1—Element A8 Contract: Exhibit B—1.1.2.13	**Suggested Documents:** Policies and Procedures Credentialing Plan CR1 Element A.8-Credentials Committee Charter Responsibilities Paragraph 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.I. The medical director or other designated physician's direct responsibility and participation in the credentialing program. NCQA CR1—Element A9	**Suggested Documents:** Policies and Procedures Credentialing Plan Credentialing Committee Charter/Minutes CR1 Element A.9-PEC01 E Paragraph 1, Credentials Committee Charter	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.J. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law. NCQA CR1—Element A10	**Suggested Documents:** Policies and Procedures Credentialing Plan CR1 Element A.10-PEC01 G	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.K. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification (including board certification, if applicable) and specialty. NCQA CR1—Element A11	**Suggested Documents:** Policies and Procedures Credentialing Plan CR1 Element A.11 – PEC04 A-C	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor notifies practitioners about their rights: 3.A. To review information submitted to support their credentialing or recredentialing application. *The Contractor is not required to make references, recommendations, or peer-review protected information available.* NCQA CR1—Element B1	**Suggested Documents:** Policies and Procedures Credentialing Plan CR1 Element B.1- PEC01 E. & Provider Network	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3.B. To correct erroneous information. NCQA CR1—Element B2	**Suggested Documents:** Policies and Procedures Credentialing Plan CR1 Element B.1- PEC01 E. 4	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3.C. To receive the status of their credentialing or recredentialing application, upon request. NCQA CR1—Element B3	**Suggested Documents:** Policies and Procedures Credentialing Plan CR1 Element B.3-PEC01 E 8	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor designates a credentialing committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions. NCQA CR2	**Suggested Documents:** Policies and Procedures Credentialing Plan Credentialing Committee Charter/Minutes CR2 Element A.1-Credentials Committee Charter Members of the Committee	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Credentialing Committee: • Uses participating practitioners to provide advice and expertise for credentialing decisions. • Reviews credentials for practitioners who do not meet established thresholds. • Ensures that clean files are reviewed and approved by a medical director or designated physician. NCQA CR2—Element A1–3	**Suggested Documents:** Policies and Procedures Credentialing Plan Credentialing Committee Charter/Minutes CR2 Element A.2-Credentials Committee Charter Decision Making Process	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. For credentialing and recredentialing, the Contractor verifies the following within the prescribed time limits: • A current, valid license to practice (verification time limit is 180 calendar days). • A current, valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (verification time limit is prior to the credentialing decision). • Education and training—the highest of the following: graduation from medical/professional school; completion of residency; or board certification (verification time limit is prior to the credentialing decision; if board certification, time limit is 180 calendar days). • Work history—most recent five years; if less, from time of initial licensure—from practitioner's application or CV (verification time limit is 365 calendar days). – If a gap in employment exceeds six months, the	**Suggested Documents:** Policies and Procedures Credentialing Plan CR3 -PEC01 Procedure A 2 and PEC01 Procedure A 1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
practitioner clarifies the gap verbally or in writing and notes clarification in the credentialing file. If the gap in employment exceeds one year, the practitioner clarifies the gap in writing. • History of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner—most recent five years (verification time limit is 180 calendar days). – The organization is not required to obtain this information for practitioners who had a hospital insurance policy during a residency or fellowship. *Note: Education/training and work history are NA for recredentialing. Verification of board certification does not apply to nurse practitioners or other health care professionals unless the organization communicates board certification of those types of providers to members.* NCQA CR3—Element A		
7. The Contractor verifies the following sanction information for credentialing and recredentialing (verification time limit is 180 days): • State sanctions, restrictions on licensure, or limitations on scope of practice. • Medicare and Medicaid sanctions. *42 CFR 438.214(d)(1)*	**Suggested Documents:** Policies and Procedures Credentialing Plan CR1 Element B.2. -PEC01 3. A PEC01 A 2 f	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
NCQA CR3—Element B Contract: Exhibit B—1.1.2.8.4		
8. Applications for credentialing include the following (attestation verification time limit is 365 days): • Reasons for inability to perform the essential functions of the position, with or without accommodation. • Lack of present illegal drug use. • History of loss of license and felony convictions. • History of loss or limitation of privileges or disciplinary actions. • Current malpractice insurance coverage (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate). • Current and signed attestation confirming the correctness and completeness of the application. NCQA CR3—Element C	**Suggested Documents:** Policies and Procedures Credentialing Plan CR3 Element C.1-PEC01 A 1 g. v CR3 Element C.2-PEC01 A 1 g. iii CR3 Element C.3-PEC01 A 1 g. iv CR3 Element C.4-PEC01 A 1 g. vi CR3 Element C.5-PEC01 A 1 i CR3 Element C.6-PEC01 A 1 g	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor formally recredentials its practitioners within the 36-month time frame. NCQA CR4	**Suggested Documents:** Policies and Procedures Credentialing Plan CR4 Element A. Recredentialing Cycle Length - PEC01 B 1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor implements policies and procedures for ongoing monitoring and takes appropriate action, including: • Collecting and reviewing Medicare and Medicaid sanctions. • Collecting and reviewing sanctions or limitations on licensure. • Collecting and reviewing complaints. • Collecting and reviewing information from identified adverse events. • Implementing appropriate interventions when it identifies instances of poor quality related to the above. *42 CFR 438.214(d)(1)* NCQA CR5—Element A Contract: Exhibit B—1.1.2.8.2.2.2, 1.1.2.8.4	**Suggested Documents:** Policies and Procedures Credentialing Plan CR5 Element A.1 – PEC04 F 4 CR5 Element A.2 – PEC04 F 2 CR5 Element A.3 – PEC04 F 5 CR5 Element A.1 – PEC04 F 1 CR5 Element A.1 – PEC04 G	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor has policies and procedures for taking action against a practitioner who does not meet quality standards that include: • The range of actions available to the Contractor. • Making the appeal process known to practitioners. *Examples of range of actions: how the organization reviews practitioners whose conduct could adversely affect members' health or welfare; the range of actions that may be taken to improve practitioner performance before termination; reporting actions taken to the appropriate authorities.*	**Suggested Documents:** Policies and Procedures Credentialing Plan CR6 Element A.1-PEC05 B CR6 Element A.1-PEC05 D	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
NCQA CR6—Element A		
12. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of *organizational* health care delivery providers and specifies that before it contracts with a provider, and for at least every 36 months thereafter: 12.A. The Contractor confirms that the organizational provider is in good standing with State and federal regulatory bodies. *Policies specify the sources used to confirm good standing—which may only include the applicable State or federal agency, agent of the applicable State or federal agency, or copies of credentials (e.g., State licensure) from the provider. Attestations are not acceptable.* *42 CFR 438.214(d)(1)* NCQA CR7—Element A1 Contract: Exhibit B—1.1.2.8.2.2.2, 1.1.2.8.4	**Suggested Documents:** Policies and Procedures Credentialing Plan CR7 Element A.1-PEC01	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
12.B. The Contractor confirms that the organizational provider has been reviewed and approved by an accrediting body. *Policies specify the sources used to confirm accreditation—which may only include applicable accrediting bodies for each type of organizational provider, agent of the applicable agency/accrediting body, or copies of credentials (e.g.,*	**Suggested Documents:** Policies and Procedures Credentialing Plan CR7 Element A.2-PEC01	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
licensure, accreditation report, or letter) from the provider. Attestations are not acceptable. NCQA CR7—Element A2		
12.C. The Contractor conducts an on-site quality assessment if the organizational provider is not accredited. *Policies include on-site quality assessment criteria for each type of unaccredited organizational provider, and a process for ensuring that the provider credentials its practitioners.* *The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following circumstances: The CMS or State review is no more than three years old; the organization obtains a survey report or letter from CMS or the State, from either the provider or from the agency, stating that the facility was reviewed and passed inspection; the report meets the organization's quality assessment criteria or standards. (Exception: Rural areas.)* NCQA CR7—Element A3	**Suggested Documents:** Policies and Procedures Credentialing Plan Audit Tool CR7 Element A.3-PEC01	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
13. The Contractor's organizational provider assessment policies and processes includes: • For behavioral health, facilities providing mental health or substance abuse services in the following settings: – Inpatient – Residential – Ambulatory	Not applicable	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• For physical health, at least the following providers: – Hospitals – Home health agencies – Skilled nursing facilities – Free-standing surgical centers NCQA HP CR7—Elements B and C		
14. The Contractor has documentation that it assesses providers every 36 months. NCQA HP CR7—Elements D and E	**Suggested Documents:** Policies and Procedures Credentialing Plan PEC01 B 1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
15. If the Contractor delegates credentialing/recredentialing activities, the Contractor has a written delegation document with the delegate that: • Is mutually agreed upon. • Describes the delegated activities and responsibilities of the Contractor and the delegated entity. • Requires at least semiannual reporting by the delegated entity to the Contractor (and includes details of what is reported, how, and to whom). • Describes the process by which the Contractor evaluates the delegated entity's performance.	**Suggested Documents:** Policies and Procedures Credentialing Plan Delegation Agreement (if applicable) CR8 Element A.1-PEC10 B CR8 Element A.2-PEC10 B.1-4 CR8 Element A.4.- PEC10 D 1-8 CR8 Element A.4.- PEC10 A 1-6	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Specifies that the organization retains the right to approve, suspend, and terminate individual practitioners, providers, and sites, even if the organization delegates decision making. • Describes the remedies available to the Contractor (including circumstances that result in revocation of the contract) if the delegate does not fulfill its obligations, including revocation of the delegation agreement. NCQA CR8—Element A	CR8 Element A 5 -PEC10 B 4 CR8 Element PEC10 A.6-B 3.	
16. For new delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity to meet NCQA requirements before delegation began. *This requirement is NA if the Contractor does not delegate or if delegation arrangements have been in effect for longer than the look-back period.* NCQA CR8—Element B	**Suggested Documents:** Policies and Procedures Credentialing Plan Audit Tool (if applicable) PEC10 A	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
17. For delegation agreements in effect 12 months or longer, the Contractor: • Annually reviews its delegate's credentialing policies and procedures.	**Suggested Documents:** Policies and Procedures Credentialing Plan Audit Tool (if applicable)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Annually audits credentialing and recredentialing files against its standards for each year that delegation has been in effect. • Annually evaluates delegate performance against its standards for delegated activities. • Semiannually evaluates regular reports specified in the written delegation agreement. • At least annually, monitors the delegate's credentialing system security controls to ensure the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures. • At least annually, acts on all findings from above monitoring for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters. NCQA CR8—Element C	CR8 Element C.1-PEC10 D CR8 Element C.2-PEC10 D CR8 Element C.3-PEC10 D CR8 Element C.4-PEC10 D CR8 C 5 Delegated Addendum CR8 C 6 Delegated Addendum	
18. For delegation agreements that have been in effect for more than 12 months, at least once in each of the past two years, the Contractor identified and followed up on opportunities for improvement, if applicable. NCQA CR8—Element D	**Suggested Documents:** Policies and Procedures Credentialing Plan CR8 Element D. Opportunities for Improvement-PEC10 D. 1 and PEC10 E. 5	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable

Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	23	X	1.00	=	23
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	8	X	NA	=	NA
Total Applicable		=	24	**Total Score**		=	23
Total Score ÷ Total Applicable						=	96%

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2024–2025 External Quality Review
Initial Credentialing Record Review
for DentaQuest

Review Period:	January 1, 2024 – December 31, 2024
Completed By:	Deseray Backman
Date of Review:	November 12–13, 2024
Reviewer:	Crystal Brown
Participating MCE Staff Member During Review:	Deseray Backman

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10
Provider ID #	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****
Provider Type (e.g., MD, PA, NP, LCSW, PsyD, DDS, DMD)	DDS	DMD	DMD	RDH	RDH	DDS	DDS	DDS	DDS	DMD
Provider Specialty (e.g., PCP, surgeon, therapist, periodontist)	Orthodontics	General Dentist	General Dentist	Dental Hygienst	Dental Hygienst	Endodontics	General Dentist	Dentist	General Dentist	Pediatric Dentist
Date of Completed Application [MM/DD/YYYY]	11/9/2023	10/24/2023	1/2/2024	2/20/2024	2/12/2024	2/29/2024	3/11/2024	2/9/2024	3/28/2024	4/3/2024
Date of Initial Credentialing [MM/DD/YYYY]	1/11/2024	2/15/2024	2/28/2024	3/6/2024	4/11/2024	5/7/2024	5/17/2024	6/11/2024	7/11/2024	8/13/2024
Completed Application for Appointment Met? [VIII.8]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Verification of Current and Valid License Yes, No, Not Applicable (NA)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Verification of Current and Valid License Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Board Certification Yes, No, NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Evidence of Board Certification Met? [VIII.6]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Evidence of Valid DEA or CDS Certificate (for prescribing providers only) Yes, No, NA	NA	Yes	Yes	NA	NA	Yes	Yes	Yes	Yes	Yes
Evidence of Valid DEA or CDS Certificate Met? [VIII.6]	NA	Met	Met	NA	NA	Met	Met	Met	Met	Met
Evidence of Education/Training Verification Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Education/Training Verification Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Work History (most recent five years or, if less, from the time of initial licensure) Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Work History Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Malpractice History Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Malpractice History Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence Malpractice Insurance/Required Amount (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate) Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Malpractice Insurance/Required Amount Met? [VIII.8]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Verification That Provider Is Not Excluded From Federal Participation Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Verification That Provider Is Not Excluded From Federal Participation Met? [VIII.7]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Comments:										

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2024–2025 External Quality Review
Initial Credentialing Record Review
for DentaQuest

Scoring	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10
Applicable Elements	7	8	8	7	7	8	8	8	8	8
Compliant (Met) Elements	7	8	8	7	7	8	8	8	8	8
Percent Compliant	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Total Applicable Elements	77									
Total Compliant Elements	77									
Total Percent Compliant	100%									

Notes:

1. Current, valid license with verification that no State sanctions exist
2. Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate (applicable to practitioners qualified to write prescriptions—e.g., psychiatrists, MD, DO)
3. Education/training—the highest of board certification, residency, graduation from medical/professional school
4. Applicable if the practitioner states on the application that he or she is board certified
5. Most recent five years or from time of initial licensure (if less than five years)
6. Malpractice settlements in most recent five years
7. Current malpractice insurance (physicians: $500,000/$1.5 million) verified through certificate of insurance
8. Verified that provider is not excluded from participation in federal programs
9. Application must be complete (see the compliance monitoring tool for elements of complete application)
10. Verification time limits:

Prior to Credentialing Decision
- DEA or CDS certificate
- Education and training

180 Calendar Days
- Current, valid license
- Board certification status
- Malpractice history
- Exclusion from federal programs

365 Calendar Days
- Signed application/attestation
- Work history

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2024–2025 External Quality Review
Recredentialing Record Review
for DentaQuest

Review Period:	January 1, 2024 – December 31, 2024
Completed By:	Deseray Backman
Date of Review:	November 12–13, 2024
Reviewer:	Crystal Brown
Participating MCE Staff Member During Review:	Deseray Backman

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS2	File OS3
Provider ID #	*****	*****	*****	Removed	*****	*****	Removed	*****	*****	*****	*****	*****
Provider Type (e.g., MD, PA, NP, LCSW, PsyD, DDS, DMD)	DDS	DMD	DMD		DDS	DMD		DDS	RDH	DMD	DDS	DDS
Provider Specialty (e.g., PCP, surgeon, therapist, periodontist)	General	Orthodontist	General		Endodontist	Orthodontist		Pediatric	Hygienist	Pediatric	Orthodontist	General
Date of Last Credentialing [MM/DD/YYYY]	2/25/2021	1/31/2021	3/18/2021		4/30/2021	6/22/2021		7/31/2021	8/10/2021	10/29/2021	5/19/2022	7/31/2021
Date of Recredentialing [MM/DD/YYYY]	1/9/2024	1/18/2024	2/5/2024		3/26/2024	5/15/2024		6/24/2024	8/5/2024	9/6/2024	4/25/2024	6/24/2024
Months From Initial Credentialing to Recredentialing	34	35	34		34	34		34	35	34	23	34
Time Frame for Recredentialing Met? [VIII.9] Is completed at least every three years (36 months)	Met	Met	Met		Met	Met		Met	Met	Met	Met	Met
Evidence of Verification of Current and Valid License Yes, No, Not Applicable (NA)	Yes	Yes	Yes		Yes	Yes		Yes	Yes	Yes	Yes	Yes
Evidence of Verification of Current and Valid License Met? [VIII.6]	Met	Met	Met		Met	Met		Met	Met	Met	Met	Met
Evidence of Board Certification Yes, No, NA	NA	NA	NA		NA	NA		Yes	NA	NA	NA	NA
Evidence of Board Certification Met? [VIII.6]	NA	NA	NA		NA	NA		Met	NA	NA	NA	NA
Evidence of Valid DEA or CDS Certificate (for prescribing providers only) Yes, No, NA	Yes	NA	Yes		Yes	Yes		Yes	NA	Yes	Yes	Yes
Evidence of Valid DEA or CDS Certificate Met? [VIII.6]	Met	NA	Met		Met	Met		Met	NA	Met	Met	Met
Evidence of Malpractice History Yes, No, NA	Yes	Yes	Yes		Yes	Yes		Yes	Yes	Yes	Yes	Yes
Evidence of Malpractice History Met? [VIII.6]	Met	Met	Met		Met	Met		Met	Met	Met	Met	Met
Evidence of Malpractice Insurance/Required Amount (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate) Yes, No, NA	Yes	Yes	Yes		Yes	Yes		Yes	Yes	Yes	Yes	Yes
Evidence of Malpractice Insurance/Required Amount Met? [VIII.6]	Met	Met	Met		Met	Met		Met	Met	Met	Met	Met
Evidence of Ongoing Verification That Provider Is Not Excluded From Federal Participation Yes, No, NA	Yes	Yes	Yes		Yes	Yes		Yes	Yes	Yes	Yes	Yes
Evidence of Ongoing Verification That Provider Is Not Excluded From Federal Participation Met? [VIII.10]	Met	Met	Met		Met	Met		Met	Met	Met	Met	Met

Comments:
Files 4 and 7: HSAG removed these files as they did not represent a recredentialing file.

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2024–2025 External Quality Review
Recredentialing Record Review
for DentaQuest

Scoring	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS2	File OS3
Total Applicable Elements	6	5	6		6	6		7	5	6	6	6
Total Compliant (Met) Elements	6	5	6		6	6		7	5	6	6	6
Total Percent Compliant	100%	100%	100%		100%	100%		100%	100%	100%	100%	100%
Total Applicable Elements	**59**											
Total Compliant Elements	**59**											
Total Percent Compliant	**100%**											

Notes:

1. Current, valid license with verification that no State sanctions exist
2. Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate (applicable to practitioners qualified to write prescriptions—e.g., psychiatrists, MD, DO)
3. Applicable if the practitioner states on the application that he or she is board certified
4. Malpractice settlements in most recent five years
5. Current malpractice insurance (physicians: $500,000/$1.5 million) verified through certificate of insurance
6. Verified that provider is not excluded from participation in federal programs
7. Application must be complete (see the compliance monitoring tool for elements of complete application)
8. Verification time limits:

   Prior to Credentialing Decision
   - DEA or CDS certificate

   180 Calendar Days
   - Current, valid license
   - Board certification status
   - Malpractice history
   - Exclusion from federal programs

   365 Calendar Days
   - Signed application/attestation
9. Within 36 months of previous credentialing or recredentialing approval date

Appendix C. Compliance Review Participants

Table C-1 lists the participants in the FY 2024–2025 compliance review of DentaQuest.

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

HSAG Reviewers	Title
Gina Stepuncik	Associate Director
Sara Dixon	Project Manager III
Crystal Brown	Project Manager I
DentaQuest Participants	**Title**
Logan Horn	Colorado CHP+ Project Manager
Sarah Cook	Colorado Contract Manager
Chad Jacquart	Senior Compliance Analyst, Legal
Colleen Whitehouse	Director, Digital Outreach
Norma Ornelas-Roberts	Director, Risk Management
Deseray Backman	Credentialing Delegation Auditor Consultant
Diana Flood	Director, Compliance
Kristen Scott	Director, Quality and Outreach
Nicholas Wooten	Senior Compliance Analyst, Legal
Thomas Yang	Utilization Management Auditing Specialist
Marva Jefferson	Associate Director, Outreach and Engagement
Jennifer Labishak	Senior Manager, Provider Partner
Department Observers	**Title**
Russell Kennedy	Quality and Compliance Specialist
Yvonne Castillo	Medicaid Dental Specialist

Appendix D. Corrective Action Plan Template for FY 2024–2025

If applicable, the MCE is required to submit a CAP to the Department for all elements within each standard scored as *Partially Met* or *Not Met*. The CAP must be submitted within 30 days of receipt of the final report. For each required action, the MCE must identify the planned interventions, training, monitoring and follow-up activities, and proposed documents in order to complete the attached CAP template. Supporting documents should not be submitted and will not be considered until the CAP has been approved by the Department. Following Department approval, the MCE must submit documents based on the approved timeline.

Table D-1—CAP Process

Step	Action
Step 1	**CAPs are submitted**
If applicable, the MCE will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final compliance review report via email or through the file transfer protocol (FTP) site, with an email notification to HSAG and the Department. The MCE must submit the CAP using the template provided. For each element receiving a score of *Partially Met* or *Not Met*, the CAP must describe interventions designed to achieve compliance with the specified requirements, the timelines associated with these activities, anticipated training, monitoring and follow-up activities, and final evidence to be submitted following the completion of the planned interventions.	
Step 2	**Prior approval for timelines exceeding 30 days**
If the MCE is unable to submit the CAP proposal (i.e., the outline of the plan to come into compliance) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing.	
Step 3	**Department approval**
Following review of the CAP, the Department and HSAG will: • Review and approve the planned interventions and instruct the MCE to proceed with implementation, or • Instruct the MCE to revise specific planned interventions, training, monitoring and follow-up activities, and/or documents to be submitted as evidence of completion and also to proceed with resubmission.	
Step 4	**Documentation substantiating implementation**
Once the MCE has received Department approval of the CAP, the MCE will have a time frame of 90 days (three months) to complete proposed actions and submit documents. The MCE will submit documents as evidence of completion one time only on or before the 90-day deadline for all required actions in the CAP. If any revisions to the planned interventions are deemed necessary by the MCE during the 90 days, the MCE should notify the Department and HSAG. If the MCE is unable to submit documents of completion for any required action on or before the three-month deadline, it must obtain approval in advance from the Department to extend the deadline.	

Step	Action
Step 5	**Technical assistance**
At the MCE's request or at the recommendation of the Department and HSAG, technical assistance (TA) calls/webinars are available. The session may be scheduled at the MCE's discretion at any time the MCE determines would be most beneficial. HSAG will not document results of the verbal consultation in the CAP document.	
Step 6	**Review and completion**
Following a review of the CAP and all supporting documentation, the Department or HSAG will inform the MCE as to whether or not the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements. Any documentation that is considered unsatisfactory to complete the CAP requirements at the three-month deadline will result in a continued corrective action with a new date for resubmission established by the Department. HSAG will continue to work with the MCE until all required actions are satisfactorily completed.	

The CAP template follows on the next page.

Table D-2—FY 2024–2025 CAP for DentaQuest

Standard III—Coordination and Continuity of Care
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
1. The Contractor implements procedures to deliver care to and coordinate services for all members. These procedures meet State requirements, including: • Ensuring timely coordination with any of a member's providers for the provision of covered services (for example, emergency, urgent, and routine care). • Addressing the needs of those members who may require services from multiple providers, facilities, and agencies; and who require complex coordination of benefits and services. • Ensuring that all members and authorized family members or guardians are involved in treatment planning and consent to any dental treatment. • Criteria for making referrals and coordinating care with specialists, subspecialists, and community-based organizations. • Providing continuity of care for newly enrolled members to prevent disruption in the provision of medically necessary services. *42 CFR 438.208* Contract: Exhibit B—1.3.1.3
Findings
Based on a review of documents submitted and the interview session, HSAG found that DentaQuest had not implemented procedures to deliver care and coordinate services for all members. While DentaQuest had a SOP for the coordination and continuity of care for enrolled members, DentaQuest relied on providers to assess members and did not have a process for the providers to communicate care coordination needs to DentaQuest. During the interview, DentaQuest noted that it had an enrollment of 90,000 members and growing. However, the care coordination log showed that no members had received care coordination services. During the interview, DentaQuest stated that it tracked inquiries from the Department, the RAEs, and other outside entities on its "Member Issues" tracking tool (named "DentaQuest MO Communication Log" in the post-interview submission). DentaQuest did not present this tool prior to the interview and due to the large number of adults represented in the tool, HSAG is unable to determine if the tool is used for the CHP+ population or DentaQuest's fee-for-service population (which was not part of this compliance review). While this tool could be used for care coordination, it primarily tracked grievances and inquiries pertaining to billing, eligibility, benefits, and access. DentaQuest's policies and SOP do not mention this tool for tracking care coordination, and a separate tool that was submitted for tracking care coordination was submitted with no entries. If DentaQuest was using both tools, external care coordination requests should have been forwarded to the CHP+ program manager and included in the

Standard III—Coordination and Continuity of Care
care coordination list per DentaQuest's description. Following the compliance review, DentaQuest also submitted its Member Outreach Plan, which focused on raising awareness of dental benefits and increasing utilization. DentaQuest's outreach plan is robust; however, it describes member education and not care coordination.
Required Actions
DentaQuest must implement procedures to deliver care to and coordinate services for all members, including: • Ensuring timely coordination with any of a member's providers for the provision of covered services (for example, emergency, urgent, and routine care). • Addressing the needs of those members who may require services from multiple providers, facilities, and agencies; and who require complex coordination of benefits and services. • Ensuring that all members and authorized family members or guardians are involved in treatment planning and consent to any dental treatment. • Criteria for making referrals and coordinating care with specialists, subspecialists, and community-based organizations. • Providing continuity of care for newly enrolled members to prevent disruption in the provision of medically necessary services.
Planned Interventions
Person(s)/Committee(s) Responsible
Training Required
Monitoring and Follow-Up Activities Planned

Standard III—Coordination and Continuity of Care
Documents to Be Submitted as Evidence of Completion
HSAG Initial Review:
Documents Included in Final Submission: ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)***
Date of Final Evidence:

Standard III—Coordination and Continuity of Care
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
2. The Contractor ensures that each member has an ongoing source of care appropriate to the member's needs and a person or entity formally designated as primarily responsible for coordinating the health care services accessed by the member. • The member must be provided information on how to contact the primary dental provider. *42 CFR 438.208(b)(1)* Contract: Exhibit B—None
Findings
While DentaQuest had a member outreach team that was tasked with resolving issues brought forth from outside entities (the Department, RAEs, etc.), no policy or procedure formally designated the role and responsibilities of coordinating the health care services for members identified as needing coordination of care. During the interview, DentaQuest shared its "Member Issues" tracking tool which was submitted after the interview (named "DentaQuest MO Communication Log" in the submission). In the log, DentaQuest tracked external requests pertaining to eligibility, grievances, benefits, and potential fraud. While the "Member Issues" tracking tool could also be used to track care coordination requests from outside entities, there was no evidence of how the member outreach coordinator was trained and tasked as a complex care coordinator or that they provided potential care management concerns to the CHP+ program manager as described in policy for the purpose of review and tracking. For example, one member listed in the document was approved for extra cleanings; however, the member was unable to receive these approved cleanings as it was not designated in the member chart or communicated with the dental provider The member needed to resort to filing a billing grievance with the Department to get special health care needs covered services.
Required Actions
DentaQuest must ensure that each member has an ongoing source of care appropriate to the member's needs and a person or entity formally designated as primarily responsible for coordinating the health care services accessed by the member who is trained and tasked to manage complex care coordination.
Planned Interventions

Standard III—Coordination and Continuity of Care
Person(s)/Committee(s) Responsible
Training Required
Monitoring and Follow-Up Activities Planned
Documents to Be Submitted as Evidence of Completion
HSAG Initial Review:
Documents Included in Final Submission: ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)***
Date of Final Evidence:

Standard III—Coordination and Continuity of Care
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
3. The Contractor implements procedures to coordinate services the Contractor furnishes the member: • Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. • With the services the member receives from any other managed care plan. • With the services the member receives from community and social support providers. *42 CFR 438.208(b)(2)* Contract: Exhibit B—1.3.1.3.4
Findings
DentaQuest submitted its SOP, Coordination and Continuity of Care For Enrolled Members, which detailed care coordination procedures. However, there was no evidence that DentaQuest implemented coordinated care for members with complex needs or expected providers to coordinate needs or communicate with DentaQuest about assessments that identified members with needs.
Required Actions
While DentaQuest developed an SOP for coordinating care, DentaQuest must ensure that assessments conducted by DentaQuest or its delegate that identify care coordination needs are addressed by DentaQuest as outlined and that members are made aware of how to request care coordination support directly through DentaQuest when needed.
Planned Interventions
Person(s)/Committee(s) Responsible

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

Standard III—Coordination and Continuity of Care
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
4. The Contractor provides best efforts to conduct an initial screening of each new member's needs within 90 days of enrollment, including: • Subsequent attempts if the initial attempt to contact the member is unsuccessful. • An assessment for special health care needs, including mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health problems. • Using the results of the assessment to inform member outreach and care coordination activities. *42 CFR 438.208(b)(3)* Contract: Exhibit B—None
Findings
While this delegation was not noted in the Coordination and Continuity of Care For Enrolled Members SOP, DentaQuest designated within the CHP+ Provider Agreement that initial screening for special and complex health needs of members was delegated to its providers. "*Assessment. All providers shall assess each member who presents for dental services for any appropriate special healthcare needs with regards to their dental care.*" Within its ORM under Provider Rights and Responsibilities, DentaQuest stated that providers shall assess members who present for services for any special health care needs related to dental care and are responsible for assisting members by referring them to in-network providers for emergency, urgent, routine, or specialized care based on the member's needs and medical necessity. However, DentaQuest did not define what should be included in the assessment, how to document a member's needs, what should be done to assist members identified as having special health care needs, how to inform DentaQuest of a member's need for care coordination, and how to navigate the provider directory to ensure members who may require additional dental services or complex dental treatment receive care appropriate for their needs. While DentaQuest used a monitoring tool to assess its providers, the tool did not include all of the required elements and as such was insufficient.
Required Actions
DentaQuest must ensure that it or its delegate provides best efforts to conduct an initial screening of each new member's needs within 90 days of enrollment, including: • Subsequent attempts if the initial attempt to contact the member is unsuccessful.

Standard III—Coordination and Continuity of Care
• An assessment for special health care needs, including mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health problems. • Using the results of the assessment to inform member outreach and care coordination activities.
Planned Interventions
Person(s)/Committee(s) Responsible
Training Required
Monitoring and Follow-Up Activities Planned
Documents to Be Submitted as Evidence of Completion
HSAG Initial Review:
Documents Included in Final Submission: ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)***

Standard III—Coordination and Continuity of Care
Date of Final Evidence:

Standard III—Coordination and Continuity of Care
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
5. The Contractor shares with other entities serving the member the results of identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR 438.208(b)(4)* Contract: Exhibit B—1.3.1.3.3
Findings
While DentaQuest tracked member inquiries referred from external agencies in its "Member Issues/DentaQuest MO Communication Log," there was no evidence provided that DentaQuest communicated the results of the inquires back to the referring entity. Further, DentaQuest did not have a process for providers to share results of member health assessments with DentaQuest to ensure that DentaQuest could close the loop with the member's primary care and specialty providers or care coordinators from other entities.
Required Actions
DentaQuest must develop and implement a process to share with other entities serving the member the results of identification and assessment of that member's needs to prevent duplication of those activities.
Planned Interventions
Person(s)/Committee(s) Responsible

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

Standard III—Coordination and Continuity of Care
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
6. The Contractor ensures that 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)* Contract: Exhibit B—1.3.15.17.1
Findings
DentaQuest submitted a provider auditing tool and tracking tool as evidence of monitoring and tracking provider intake assessments. While the audit tool did include a checkbox indicating whether a member was identified as "having needs," "not having needs," or "not enough information," the monitoring tool did not include a method for tracking members who indicated that they had special health care needs that benefitted from additional care management to ensure that care needs were met. According to the tracking tool, DentaQuest requested member health records from 30 providers over nine months and only a few providers submitted records, as requested. Of this small submission, one provider's member health record was missing provider notes, diagnosis, a treatment plan, and dental history. Based on the low response rate and lack of evidence of follow-up or corrective action, DentaQuest is not ensuring that initial member assessments for special health care needs are occurring nor is it ensuring that each provider furnishing services to members maintains and shares, as appropriate, member health records in accordance with professional standards.
Required Actions
DentaQuest must require that all providers provide member health records in a timely manner upon request. DentaQuest must ensure that providers who do not provide member health records in a timely manner face consequences (including financial consequences and potential termination from the network), as records are necessary for documenting member health as well as fraud prevention. DentaQuest must improve its auditing and tracking tools to ensure that each provider furnishing services to members maintains and shares, as appropriate, member health records in accordance with professional standards.
Planned Interventions

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Standard III—Coordination and Continuity of Care
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
8. The Contractor implements mechanisms to comprehensively assess each CHP+ member identified by the State 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. *42 CFR 438.208(c)(2)* Contract: Exhibit B—1.3.1.3.4
Findings
While DentaQuest delegated the initial assessment to its dental providers, DentaQuest did not implement or disseminate a mechanism to ensure that the provider's assessment was comprehensive or consistent. DentaQuest submitted a provider auditing tool and tracking tool as evidence of monitoring and tracking provider intake assessments. While the audit tool did include a checkbox indicating whether a member was identified as "having needs," "not having needs," or "not enough information," the monitoring tool did not include a method for tracking members who indicated that they had special health care needs that benefitted from additional care management to ensure that care needs were met.
Required Actions
DentaQuest must implement mechanisms to comprehensively assess each CHP+ member to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring.
Planned Interventions
Person(s)/Committee(s) Responsible

Standard III—Coordination and Continuity of Care
Training Required
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HSAG Initial Review:
Documents Included in Final Submission: ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)***
Date of Final Evidence:

Standard III—Coordination and Continuity of Care
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
9. The Contractor produces a treatment or service plan for members with special health care needs who are determined, through assessment, to need a course of treatment or regular care monitoring. The treatment plan must be: • Approved by the Contractor in a timely manner (if such approval is required by the Contractor). • In accordance with any applicable State quality assurance and utilization review standards (for example, if approval is required due to dental prior-authorization requests). • Reviewed and revised when the member's circumstances or needs change significantly, or at the request of the member. *42 CFR 438.208(c)(3)* Contract: Exhibit B—1.3.1.3.4
Findings
DentaQuest provided no evidence or producing or delegating the production of a treatment plan for members with special health care needs.
Required Actions
DentaQuest must produce a treatment or service plan for members with special health care needs who are determined, through assessment, to need a course of treatment or regular care monitoring. The treatment plan must be: • Approved by the Contractor in a timely manner (if such approval is required by the Contractor). • In accordance with any applicable State quality assurance and utilization review standards (for example, if approval is required due to dental prior-authorization requests). • Reviewed and revised when the member's circumstances or needs change significantly, or at the request of the member.
Planned Interventions

Standard III—Coordination and Continuity of Care
Person(s)/Committee(s) Responsible
Training Required
Monitoring and Follow-Up Activities Planned
Documents to Be Submitted as Evidence of Completion
HSAG Initial Review:
Documents Included in Final Submission: ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)***
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Standard III—Coordination and Continuity of Care
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
10. For members with special health care needs determined to need a course of treatment or regular care monitoring, the Contractor must have a mechanism in place to allow members direct access to a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs. *42 CFR 438.208(c)(4)* Contract: Exhibit B—1.3.1.7.1
Findings
DentaQuest did not provide evidence of a mechanism to allow member direct access to a specialist if appropriate.
Required Actions
DentaQuest must maintain a policy or procedure outlining its mechanism to ensure that members with special health care needs determined to need a course of treatment or regular care monitoring have direct access to a dental specialist who meets their needs.
Planned Interventions
Person(s)/Committee(s) Responsible
Training Required

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

Standard VIII—Credentialing and Recredentialing
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners it credentials and recredentials. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. The Contractor shall document and post on its public website policies and procedures for the selection and retention of providers. *42 CFR 438.214(a–b1)* NCQA CR1—Element A1 Contract: Exhibit B—1.1.2.5, 1.1.2.7
Findings
DentaQuest had written policies and procedures for the selection and retention of its providers. However, DentaQuest did not document and post on its public website the policies and procedures for the selection and retention of its providers.
Required Actions
DentaQuest must post its policies and procedures for the selection and retention of its providers publicly on its website.
Planned Interventions
Person(s)/Committee(s) Responsible

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

Appendix E. Compliance Monitoring Review Protocol Activities

The following table describes the activities performed throughout the compliance monitoring process. The activities listed below are consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023.

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the review to assess compliance with federal managed care regulations and Department contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop desk request forms, compliance monitoring tools, report templates, agendas; and set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all reviewers to ensure consistency in scoring across MCEs.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided MCEs with proposed review dates, group technical assistance, and training, as needed. • HSAG confirmed a primary MCE contact person for the review and assigned HSAG reviewers to participate in the review. • Sixty days prior to the scheduled date of the review, HSAG notified the MCE in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and review agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the three standards and the review activities. Thirty days prior to the review, the MCE provided documentation for the desk review, as requested. • Documents submitted for the review consisted of the completed desk review form, the compliance monitoring tool with the MCE's section completed, credentialing, recredentialing, and organizational provider credentialing record review tool, sample records, policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and applicable documents to support the special focus topic. • The HSAG review team reviewed all documentation submitted prior to the review and prepared a request for further documentation and an interview guide to use during the review.

For this step,	HSAG completed the following activities:
Activity 3:	**Conduct the Review**
	• During the review, HSAG met with groups of the MCE's key staff members to obtain a complete picture of the MCE's compliance with federal healthcare regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the MCE's performance. • HSAG requested, collected, and reviewed additional documents as needed. • At the close of the review, HSAG provided MCE staff and Department personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the Department-approved FY 2024–2025 Compliance Review Report template to compile the findings and incorporate information from the pre-review and review activities. • HSAG analyzed the findings and calculated final scores based on Department-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the Department**
	• HSAG populated the Department-approved report template. • HSAG submitted the draft Compliance Review Report to the MCE and the Department for review and comment. • HSAG incorporated the MCE and Department comments, as applicable, and finalized the report. • HSAG included a pre-populated CAP template in the final report for all elements determined to be out of compliance with managed care regulations. • HSAG distributed the final report to the MCE and the Department.

Care Coordination

The purpose of the CHP+ Special Focus Topic: Care Coordination interview was to explore the trends, strengths, and challenges that each Colorado CHP+ plan has experienced with the evolution of its care coordination program. A sample of topics covered in each CHP+ discussion included the rate of completion for initial screenings, specifically among members with high-risk pregnancies; addressing health-related social needs and equity; describing successful partnerships and barriers; coordinating chronic disease management; and handoff processes for transitions of care. At the time of this review DentaQuest's care coordination program was insufficient in relation to these topics.

During the review of Standard III—Coordination and Continuity of Care, DentaQuest stated, and the document submission evidenced, that DentaQuest's FY 2021–2022 CAP had not been implemented. DentaQuest's Coordination and Continuity of Care For Enrolled Members SOP did not reflect the activities described in writing or documents submitted in advance of the compliance monitoring review. DentaQuest submitted a blank Care Coordination Change Log, indicating that no care coordination activities had taken place since FY 2021–2022. In the Desk Request Form, DentaQuest indicated that no members had reached out to DentaQuest to coordinate care, adding that DentaQuest felt direct outreach from members would be "unlikely." With DentaQuest's CHP+ PAHP member enrollment stated as 90,000 and growing, HSAG finds it unlikely that none of DentaQuest's CHP+ members could benefit from or need care coordination. While DentaQuest provided its Member Outreach Plan as evidence of compliance for care coordination, HSAG did not identify methods in the plan to ensure members were informed that they could contact DentaQuest directly for help with coordinating care. DentaQuest did not indicate that it was actively working to conduct a root cause analysis and resolve the lack of direct inquiries from members.

HSAG identified the following strength related to care coordination:

- During DentaQuest's FY 2021–2022 CAP, DentaQuest identified and developed some tools that may be useful when developing a complete care coordination program.

HSAG identified the following opportunities related to care coordination:

- Despite strong language from DentaQuest in the Desk Review Form and during the interview indicating that DentaQuest believes care coordination in a dental setting is unlikely, according to its corporate website, DentaQuest offers care coordination for both its Medicaid[1] and Medicare[2] lines of

[1] DentaQuest. Available at: https://www.dentaquest.com/en/what-we-offer/medicaid-chip-solutions. Under the title "Best in Class Member Experience," *Case management - Care coordination connects high-risk members with the resources they need to achieve optimal oral health.* Accessed on: Nov 20, 2024.

[2] DentaQuest. "Improving Access to Dental Health Care Through Case Management." Available at: https://www.dentaquest.com/en/news-and-resources/industry-insights/improving-access-to-dental-health-care-through-case-management. Accessed on: Nov 20, 2024.

business, using dedicated case managers for complex care coordination. DentaQuest has the opportunity to leverage resources already in place within its organization to model a program that aligns with the federal and State contract requirements for ensuring ongoing care coordination for members within DentaQuest's provider network and between dental and medical care settings.

- DentaQuest may consider addressing the lack of direct member requests for care coordination by informing members through the handbook, enrollment packet or other materials, telephonically or electronically, or on the provider directory landing page of its website that DentaQuest is able to ensure ongoing care coordination for complex dental needs and across external partners such as, RAEs, medical homes, primary and specialty care providers, Community Centered Boards (CCBs), case workers, etc.
- If DentaQuest chooses to continue delegating the initial health assessment intake to its dental providers, DentaQuest should provide substantially more direction and oversight of its providers to ensure that information is captured, that members are receiving coordinated care, and that appropriate external entities are informed of the member's needs and services.
- Once DentaQuest has implemented a robust care coordination program, DentaQuest should evaluate the program for effectiveness, trends, grievances, and continuous improvement on an ongoing basis. Evidence of a strong program would include the ability to discuss the topics that were slated for discussion during this interview, including the rate of completion for initial screenings, specifically for members with high-risk pregnancy; health-related social needs and equity; successful partnerships and barriers; chronic disease management coordination; and handoff processes for transitions of care.